Intergovernmental Agreement

Between

Agency of Human Services

and

Department of Vermont Health Access

For the Administration and Operation of the

Global Commitment to Health Medicaid Demonstration
(Project # 11 W-00194/1)

January 1, 2021 – December 31, 2021

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ARTICLE ONE: GENERAL PROVISIONS

1.1 Purpose

The purpose of this Inter-Governmental Agreement (IGA) is to specify the responsibilities of the Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) pertinent to the *Global Commitment to Health Medicaid Demonstration (Project #11-W-00194/1)* under United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) authority of Section 1115(a) of the Social Security Act.

DVHA and its Intergovernmental Partners (Pursuant to Section 2.5.1), will operate using a Medicaid managed care-like model for all enrollees under the *Global Commitment to Health Demonstration.* For purposes of the demonstration, DVHA will operate as if it were a non-risk pre-paid inpatient health plan (PIHP) and AHS, as the Single State Medicaid Agency, will provide oversight of DVHA in that capacity.

Any DVHA responsibilities or requirements defined in this IGA may be performed by other entities pursuant to Section 2.5.1 and an IGA, contract or memorandum of understanding (MOU).

DVHA and AHS shall coordinate to ensure that the Medicaid program operates in compliance with the CMS-approved Special Terms and Conditions (STCs) for this Demonstration. The application of program flexibilities, otherwise afforded to a PIHP under this Demonstration, does not diminish DVHA's role as the unit of government responsible for the operations of the Medicaid program as directed by AHS.

1.2 Agreement Review and Renewal

This IGA represents a comprehensive understanding of each party's responsibilities as pertinent to the Global Commitment to Health Demonstration and DVHA's role operating as a Medicaid managed care-like entity. This IGA shall be effective for the period of January 1, 2021 to December 31, 2021 and shall be amended as necessary. In the event that a new agreement is not executed prior to the expiration date of the agreement, the current agreement shall remain in effect until a successor agreement is signed.

1.3 Compliance

DVHA must adhere to federal regulations at 42 CFR Section 438 that would be applicable to a non- risk PIHP unless specifically stated otherwise in the STCs. DVHA must also ensure long term services and supports protections for individuals who receive long term services and supports under the Choices for Care program, such as person center planning (characteristics are set out in 42 CFR 441.301(c)(1)- (3)) and self-directed supports. In addition, DVHA must comply with the characteristics of home and community-based settings in accordance with 42 CFR 441.301(c)(4) for those Choices for Care services (e.g., those not found in Vermont's Medicaid State Plan) that could be authorized under 1915(c) and 1915(i).

DVHA shall comply with federal program integrity and audit requirements as if it were a non-risk PIHP for services and populations covered under the Demonstration. DVHA is not required to meet documentation and reporting requirements related to the risk of insolvency at 42 CFR 438.604(a)(4). Additionally, the data submission requirements of 42 CFR 438.604(a)(1) and (2) are satisfied, provided AHS has direct access to information systems that maintain such data, documentation, and information.

DVHA must meet the requirements of all applicable federal and state laws and regulations, including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the

Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

1.3.1 Self-Assessment

DVHA and its IGA partners must conduct a self-assessment of Managed Long-Term Services and Supports (MLTSS) under Choices for Care for adherence to state and federal standards of care to include:

- An assessment of existing initiatives designed to improve the delivery of MLTSS, including performance measures or performance improvement projects (PIPs) directed to this population; and
- An examination of processes to identify any potential corrective action steps toward improving the MLTSS system.

1.4 Prohibited Affiliations

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; and

- 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 CHIP, except for emergency services.

For purposes of this IGA, a prohibited relationship is an employment relationship that exists between a debarred, suspended, or otherwise excluded individual, or an affiliate of such person as described above, and a commissioner, deputy commissioner or officer of the Department or a person with an employment consulting or other business arrangement with the Department.

ARTICLE TWO: DVHA RESPONSIBILITIES

2.1 Administration and Management

DVHA must have an executive management function with clear authority over all administrative functions and must maintain sufficient administrative staff and organizational components to comply with all program standards. Staffing must be sufficient to perform services in an appropriate and timely manner.

DVHA shall designate a representative to act as liaison between DVHA and AHS for the duration of this IGA. The representative shall be responsible for:

- Representing DVHA on all matters pertaining to this IGA. Such a representative shall be authorized and empowered to represent DVHA regarding all aspects of this IGA;
- Monitoring DVHA's compliance with the terms of this IGA;
- Receiving and responding to all inquiries and requests made by AHS in the time frames and format specified by AHS in this IGA;
- Meeting with the AHS representative on a periodic or as-needed basis to resolve issues which may arise;
- Coordinating requests from AHS to ensure that staff from DVHA with appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, utilization management, and network management is available to participate in AHS activities and respond to requests by AHS which may include, but not be limited to, requests to participate in training programs designated by AHS, requests to coordinate fraud and abuse activities with AHS, and requests to meet with other State of Vermont agency representatives or other parties;
- Making best efforts to resolve any issues identified either by DVHA or AHS that may arise in connection with this IGA;
- Meeting with AHS at the time and place requested by AHS, if AHS determines that DVHA is not in compliance with the requirements of this IGA;
- Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to prior review and approval by AHS are provided to AHS no less than 10 business days prior to execution or implementation, as applicable; and
- Ensuring that DVHA's responses to document and information requests are prompt and accurate. Whenever document or information requests require review by AHS, the DVHA representative will submit proposed responses and responsive documents or other materials in connection with any such requests to AHS for its prior review and approval.

2.1.1 Management Information System

DVHA shall maintain a management information system that collects, analyzes, integrates and reports data.

The system(s) must collect data on enrollee and provider characteristics, as specified by AHS and on services as set forth under Section 2.12.1 of this IGA. DVHA must collect, retain and report encounter data, defined currently as a provider claim, in accordance with the *Global Commitment to Health Demonstration*'s Terms and Conditions. AHS will have direct access to information systems that maintain data. All collected data must be available to AHS at all times and to the CMS upon request. The system must provide information that would be required from a non-risk PIHP as set forth in Federal regulations as 42 CFR Part 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

2.2 Eligibility and Enrollment

2.2.1 Eligible Population

The following populations are eligible for enrollment in the *Global Commitment to Health Demonstration*:

- Individuals who are eligible for medical assistance in accordance with the State of Vermont Medicaid plan;

- Individuals who are eligible for medical assistance in accordance with the 1115 Medicaid Demonstration as approved and/or amended by CMS;

2.2.2 Eligibility for the Global Commitment to Health Demonstration

All individuals eligible for the State of Vermont's public insurance programs, excluding the following persons:

- Unqualified aliens and qualified aliens subject to the State Plan and Special Terms and Conditions.

DVHA shall be responsible for verification of the current status of an individual's Medicaid eligibility with the Division responsible for eligibility determinations.

DVHA and its IGA partners shall not discriminate or use any policy or practice that has the effect of discriminating against any individual's eligibility to enroll on the basis of health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity or disability. DVHA, the delegated AHS departments and providers will accept and serve all individuals eligible for, and enrolled in, the *Global Commitment to Health Demonstration.*

2.2.3 Data Transfers

The AHS eligibility determination system, Vermont Health Connect (VHC), and the Medicaid Management Information System (MMIS), shall provide Medicaid eligibility functions under the *Global Commitment to Health Demonstration.* A regular data transfer between the VHC and the MMIS shall ensure that identical information on Medicaid eligibility status and the *Global Commitment to Health Demonstration* enrollment status is available concurrently in all information systems to ensure data integrity for payment purposes. DVHA must have the capability to interface with the eligibility VHC and MMIS systems.

2.2.4 Loss of Eligibility/Disenrollment from the Demonstration

DVHA shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Demonstration*. Loss of eligibility may occur due to:

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

DVHA shall compare, on at least a monthly basis, the active Global Commitment to Health enrollee list with the AHS eligibility list to confirm Medicaid status for all Global Commitment to Health enrollees.

2.2.5 Prohibitions

DVHA shall not disenroll any individual except those who have lost eligibility as specified under 2.2.4 of this IGA. This prohibition specifically includes 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.

2.3 Medicaid Policy

AHS as the Single State Agency, retains authority over all Medicaid Policy. PIHP requests for clarification related to State Medicaid policy will be directed to the Medicaid Policy Unit, located within DVHA's organizational structure but operating as the Single State Agency under AHS.

2.4 Program Integrity

DVHA, as the non-risk PIHP, complies with all requirements of 42 CFR 438, subpart H. All program integrity requirements in federal statute and regulations that are required of the state in its oversight of a non-risk PIHP are the direct responsibility of AHS facilitated by the Program Integrity Unit (PI Unit), located within DVHA's organizational structure but operating as the Single State Agency under AHS.

The PI Unit is responsible for performing tasks related to the suspension of payments to providers in cases of fraud in accordance with 42 CFR 455.23. This includes meeting all documentation and record retention requirements outlined in 42 CFR 455.23(g) as well as annually report to CMS summary information outlined in 42 CFR 455.23(g)(3).

DVHA is required to terminate any institutional or individual provider that has been terminated under Medicare or by any other State Medicaid program per Section 6501 of the Affordable Care Act. A termination occurs when a State Medicaid program, CHIP, or the Medicare program has taken action to revoke a Medicaid or CHIP provider's or Medicare provider or supplier's billing privileges and the provider, supplier or eligible professional has exhausted all applicable appeal rights or the timeline for appeal has expired. Reasons for for-cause adverse action terminations may include, but are not limited to, termination for reasons based upon fraud, integrity, or quality. To safeguard the Medicaid program, DVHA must review the Center for Medicaid and Medicare Services (CMS) Data Exchange System (DEX) weekly. The DEX database includes all for-cause terminated providers from Medicare and State Medicaid. During this process, DVHA must compare

actively enrolled Vermont Medicaid providers with those noted in the DEX database – and terminate all matched providers from Vermont Medicaid. All providers must be offered a 30-day reconsideration process. If after 30 days no reconsideration is requested – or if the termination is upheld - DVHA must terminate the provider, report them to the DEX database, and publicly post them under Vermont's Excluded provider list.

2.5 Enrollee Outreach and Education

2.5.1 New Enrollees

DVHA shall be responsible for educating individuals at the time of their enrollment into the *Global Commitment to Health Demonstration.* 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 inoutreach and education activities.

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

- What services are covered and how to access them;
- Restrictions on freedom-of-choice;
- Cost sharing;
- Role and responsibilities of the primary care provider (PCP);
- Importance of selecting and building a relationship with a PCP;
- Information about how to access a list of PCPs in geographic proximity to the enrollee and the availability of a complete network roster;
- Enrollee rights, including appeal and Fair Hearing rights, confidentiality rights, availability of the Health Care Advocate, 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 department;
- Enrollees in the Choices for Care Program will also be educated about systems to prevent, detect and report, investigate and remediate abuse, neglect and exploitation.

2.5.2 Enrollee Handbook

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

The enrollee handbook must be specific to the *Global Commitment to Health Demonstration* and be written in language that is clear and easily understood by an elementary-level reader. The enrollee handbook must include a summary description of the *Global Commitment to Health Demonstration*, 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, advance directives, and the methods by which a member can select a provider based on specific language requirements.

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

- Rights to a State of Vermont Fair Hearing, method for obtaining a hearing, timeframe for filing a request, and rules that govern representation at the hearing;
- Rights 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 may use to obtain assistance in filing a grievance or an appeal, including the Long-Term Care Ombudsmen and/or other independent 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 makes available to providers to challenge a denial by 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 also be included in the enrollee handbook:

- Sufficient information on the amount, duration, and scope of benefits available under the contract in detail to ensure that enrollees understand the benefits to which they are entitled;
- Information for potential enrollees about the basic functions of managed care;
- Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- DVHA responsibilities for coordination of enrollee care;
- Information on specialty referrals, including long term services and supports under the Choices for Care program;
- Information on unrestricted access to family planning services;
- Information on accessing emergent and urgent care (including post-stabilization services and after- hours care);
- Information on enrollee disenrollment;
- Information on enrollees' 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 Demonstration* and any physician incentive plans; and
- Information on how enrollees can access benefits, including information about prior authorization requirements and services from out-of-network providers.

The enrollee handbook also will include:

- What constitutes an emergency medical condition and emergency services;
- That prior authorization is not required for emergency services;
- That the enrollee has the right to use any hospital or other setting for emergency care;
- Toll-free and TTY/TDY numbers for member services and any unit providing services directly to enrollees.

DVHA provides to its enrollees information about providers, which at a minimum, includes primary care physicians, specialists, and hospitals. The information on providers:

- Includes provider names, locations, and telephone numbers;
- Identifies providers that speak any non-English languages;
- Information on specialty referrals; and
- Identifies providers that are not accepting new patients.

DVHA's provider directory for physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers will include the following information:

- The provider's name and 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 assure that the following information about its formulary is available on its 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.

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

DVHA will assure that:

- All informational material will adopt uniform AHS definitions of the following managed care terms:
    - Appeal,
    - Copayment,
    - Durable medical equipment,
    - Emergency medical condition,
    - Emergency medical transportation,
    - Emergency room care,
    - Emergency services,
    - Excluded services,
    - Grievance,
    - Habilitation services and devices,
    - Health insurance,
    - Home health care,
    - Hospice services,
    - Hospitalization,
    - Hospital outpatient care,
    - Medically necessary,
    - Network,
    - Non-participating provider,
    - Physician services plan,
    - Preauthorization,
    - Participating provider,
    - Premium,
    - Prescription drug coverage,
    - Prescription drugs,
    - Primary care physician,
    - Primary care provider,
    - Provider,
    - Rehabilitation services and devices,
    - Skilled nursing care,
    - Specialist, and
    - Urgent care;
- 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.

2.5.3 Languages other than English

DVHA will comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. DVHA will 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 capacities. Enrollee materials that are critical to obtaining services (including at a minimum: provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices), will be made available in all prevalent non-English languages. A prevalent non-English language means any language spoken as a first language by five percent or more of the total statewide *Global Commitment to Health Demonstration* enrollment. DVHA will ensure that all written materials for potential enrollees include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided. Large print means no smaller than 18-point font size.

DVHA will 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, at no cost to the enrollee. AHS contracts with in-person and telephonic interpreter vendors, as well as written translation vendors on behalf of DVHA and other departments under AHS. DVHA and its IGA partners 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 will 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 will also include information on how to access such services.

2.5.4 Advance Directives

DVHA and its IGA partners will comply with the requirements of 42 CFR 422.128 related to maintaining written policies and procedures respecting advance directives. DVHA will require all *Global Commitment to Health Demonstration* providers to comply with these provisions. This requirement includes:

- Maintaining written policies and procedures that meet requirements for advance directives under 42 CFR 422.128;

- Maintaining written policy and procedures concerning advance directives with respect to all adult individuals receiving medical care or assistance by or through DVHA, its sub-contractors or IGA partners;

- Providing written information to those individuals with respect to the following:

  - A description of State of Vermont law and their rights under State of Vermont law to make decisions concerning their medical care, including the right to accept or refuse medical or

surgical treatment and the right to formulate advance directives. Such information must reflect changes in State of Vermont law as soon as possible, but not later than 90 business days after the effective date of the State law,
    - Policies respecting implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience; and
- Informing enrollees that any complaints concerning noncompliance with the advance directive requirements may be filed with the State of Vermont survey and certification agency.

2.5.5 Satisfaction Surveys

DVHA and its IGA partners will conduct enrollee satisfaction surveys. Any changes in the survey tools and methodology must be submitted to AHS for review and approval at least 90 business days prior to implementation of the survey.

DVHA may delegate the execution of a satisfaction survey to a subcontractor as long as the subcontractor uses a survey tool and methodology approved by AHS.

To the extent that they are available, the results of DVHA and/or its IGA partners' enrollee satisfaction surveys will be made available to potential or current enrollees via posting on the DVHA or appropriate IGA partner website.

2.5.6 Enrollee Notification: Provider Termination

DVHA will make a good faith effort to give written notice of termination of the contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

2.5.7 Marketing

2.5.7.1 Terminology

Cold Call Marketing means any unsolicited personal contact by DVHA with a potential enrollee for the purpose of marketing, as defined in this paragraph.

Marketing means any communication, from DVHA to a Medicaid recipient who is not enrolled that can reasonably be interpreted as intended to influence the recipient to enroll in that particular Medicaid product, or either to not enroll in, or to disenroll from, another Medicaid product.

Marketing Materials means materials that are produced in any medium, by or on behalf of DVHA, that can reasonably be interpreted as intended to market to potential enrollees.

2.5.7.2 State Approval of Marketing Materials

DVHA will not distribute any marketing materials without first obtaining approval of such materials from AHS.

2.6 Enrollee Services

DVHA, through its enrollment subcontractor (currently Maximus), will provide an enrollee helpline function for *Global Commitment to Health Demonstration* enrollees. DVHA will make available to its enrollment subcontractor an up-to-date provider listing, including names, telephone numbers, office hours, and other relevant information, for use by the helpline operators.

DVHA will require each of its IGA partners to identify a liaison to respond to inquiries from the helpline operators and to assist in resolution of enrollee issues.

2.7 Network Development

2.7.1 Subcontractors

A subcontractor means any individual or entity that has a contract with DVHA that relates directly or indirectly to the performance of DVHA operations as a non-risk PIHP under the *Global Commitment to Health Demonstration.* 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. 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 AHS or as established under State law.

In addition to services available through the IGA partners, enrollees may access health and mental health services from licensed Medicaid-enrolled providers. Licensed and enrolled Medicaid providers must:

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

Unless authorized by State or federal statute or regulation, DVHA and the IGA partners shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification. DVHA must not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not prohibit DVHA and the IGA partners from limiting network participation based on quality, cost, or other reasonable business purposes as permitted under federal laws and regulations and the STCs. If a provider is denied

enrollment in the Medicaid program, DVHA must provide written notice of its reason(s) for denying enrollment. This provision does not require DVHA and its IGA partners to contract with providers beyond the number necessary to meet the needs of enrollees or use identical reimbursement amounts for different specialties or for different practitioners in the same specialty.

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

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

If any of the non-risk PIHP activities are delegated to a subcontractor, the delegated activities or obligations and related reporting responsibilities will be specified in the written agreement.

Written agreements must provide 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 subcontractor's contractor, that pertain to any aspect of services and activities performed or determination of amounts payable under the non-risk PIHP managed care delivery model. 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. If any of the non-risk PIHP activities are delegated to a subcontractor, the delegated activities or obligations and related reporting responsibilities will be specified in the written agreement. The agreement will provide 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 under this IGA are carried out.

In the event of non-compliance, AHS (as the Single State Agency) will determine the appropriate course of action to ensure compliance. DVHA agrees to make available to AHS and CMS all subcontracts between DVHA and the Departments.

2.7.2 Oversight Process for Subcontractors

DVHA will remain accountable for any functions and responsibilities that it delegates to any subcontractors. DVHA must assure that all subcontractors meet the requirements of 42 CFR 438 that are appropriate to the service or activity delegated under the subcontract in accordance with the requirements and effective dates specified in 42 CFR 438.230. Before any delegation can take place, DVHA must evaluate the prospective subcontractor's ability to perform the activities to be delegated. DVHA monitors the subcontractor's performance via a formal review according to a periodic schedule established by the State, consistent with industry standards or State laws and regulations. If DVHA identifies material deficiencies and areas of improvement meriting the implementation of a corrective action plan (CAP), DVHA will inform AHS and initiate the process for initiating a CAP, in consultation with AHS. AHS retains oversight of the Medicaid program related to DVHA and its IGA partner's overall accountability and adherence to the *Global*

Commitment to Health Demonstration Special Terms and Conditions.

2.8 Provider Services

DVHA will maintain a provider services function that operates during normal business hours. Functions will include:

- Assistance with development of procedures for determining enrollee eligibility;
- Assistance with the submittal of claims for services rendered; and
- Assistance with preparation and submittal of monthly encounter data.

2.8.1 Provider Contracting and Enrollment

DVHA shall maintain written policies, procedures, or operating principles for selection and retention of providers, and those policies, procedures, or operating principles that include, at a minimum, the requirements of 42 CFR 438.214. DVHA shall ensure that all providers participating in the *Global Commitment to Health Demonstration* meet the enrollment requirements established by AHS for the Medicaid program. Upon change in statute and/or pertinent Vermont State licensing standards DVHA shall work with DXC to ensure that the current provider enrollment processes are up to date and are reflective of the necessary changes. Upon approval from DVHA, DXC will enter provider information into the MMIS and program necessary automated edit and audit checks to ensure that all *Global Commitment to Health Demonstration* 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 Demonstration.* Each physician must have a unique identifier. DVHA must provide information to providers at the time of contracting related to DVHA's Grievance, Appeal, and State Fair Hearing process and provider's obligation to comply with advanced directive requirements. DVHA and its enrolled providers may be a party to a Grievance and/or a State Fair Hearing and must participate in the proceedings of such as required by this IGA or state/federal law.

The Grievance and Appeals information for providers must include the:

- Enrollee's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;
- Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
- Availability of assistance in filing, including the long-term care ombudsmen and/or other independent advocates designated by the state to assist participants;
- Toll-free numbers to file oral grievances and appeals;
- Enrollee's right to request continuation of benefits during an appeal or state fair hearing filing and, if the MCO or PIHP's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits; and
- State-determined provider appeal rights to challenge the failure of the organization to cover a service.

2.8.2 Provider Profiling

DVHA, in collaboration with its IGA partners, will conduct periodic provider profiling activities, including producing information on enrollment, service claims, costs, reimbursements, and outcomes for all health services provided to *Global Commitment to Health Demonstration* enrollees. Information used in provider

profiling will include data from all providers of health services within the IGA partner Departments.

2.8.3 Mainstreaming

DVHA's policies and procedures will ensure that network providers do not intentionally discriminate against *Global Commitment to Health Demonstration* 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.

2.9 Covered Services

2.9.1 General

The *Global Commitment to Health Demonstration* includes a comprehensive health care services benefit package, including home and community-based waiver-like services for specific populations. The covered services include all services that AHS requires be made available through its public insurance programs to enrollees in the *Global Commitment to Health Demonstration,* including all State of Vermont plan services in the following categories:

- Acute health care services;
- Preventative health services;
- Behavioral health services, including substance abuse treatment;
- Specialized mental health services for adults and children;
- Long-Term Services and Supports for adults under the Choices for Care Program;
- Developmental disability services;
- Traumatic Brain Injury;
- Rehabilitation Services for adults;
- Pharmacy services; and
- School-based services.

School-Based Services

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program ("IEP") and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a Vermont Medicaid enrolled physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

Federal Individuals with Disabilities Education Improvement Act ("IDEA") statutes and regulations govern the process for assessing needs and developing the IEP. Separate Agency of Education (AOE) due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, IEP or placement have three options available under the AOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an

administrative complaint. The Agency of Education due process and appeals procedures also apply to Global Commitment services authorized under Part C of IDEA.

Pharmacy Services

DVHA will ensure that coverage policies for outpatient drugs as defined in section 1927(k)(2) of the Social Security Act (SSA), meets the standards for such coverage imposed by section 1927 of the Act. DVHA will:

- Collect drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the SSA Act no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP, including procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program.
- Operate a drug utilization review program that complies with the requirements described in section 1927(g) of the SSA Act and 42 CFR part 456, subpart K.
- Provide a detailed description of its drug utilization review program activities to AHS on anannual basis.
- Conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the SSA Act.

2.9.2 Medical Necessity

DVHA will cover the services specified under the *Global Commitment to Health Demonstration* to groups of individuals eligible for coverage through the demonstration. DVHA will, at a minimum, provide State Plan services that are medically or clinically necessary. DVHA may vary the amount, duration, and scope of services offered as long as the amount, duration, and scope of covered services meets the minimum requirements under Title XIX and the STCs for the group being served. Services will be sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. DVHA may place limits on a covered service based on medical necessity and appropriateness criteria; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. DVHA will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, illness, or condition.

Pursuant to 42 CFR 438.210(a)(5), DVHA is responsible for paying for Medicaid-covered services related to: 1) the prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability; 2) the ability to achieve age-appropriate growth and development, 3) the ability to attain, maintain, or regain functional capacity 4) The opportunity for an enrollee with long-term services and supports to have access to benefits of community living to achieve person centered goals, and live and work in settings of their choice

Pursuant to 42 CFR 441.50, DVHA is responsible for providing early and periodic screening and diagnosis of eligible Medicaid beneficiaries under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found, even if services are not otherwise covered under the Medicaid State Plan. DVHA must set standards for the timely provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services which meet reasonable standards of medical practice, as determined by DVHA or its IGA partners after consultation with recognized medical

organizations involved in child health care, and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services.

Medical necessity determinations as to state plan covered services will be made by the Medical Director of DVHA, and, as to non-state plan waiver services, upon collaboration of DVHA's IGA partners. Ultimate authority in such determinations lies with AHS, as the entity to which *Global Commitment to Health Demonstration* enrollees have the right to appeal. AHS will arrange for independent medical review of appeals of medical necessity decisions by DVHA as appropriate.

Within the limits of the benefit plan, DVHA and IGA partners have the responsibility for establishing procedures for referrals and when prior authorization is required either by DVHA or IGA partners.

The benefit package for the *Global Commitment to Health Waiver Demonstration* is defined in the Demonstration's Special Terms and Conditions.

2.9.3 Limitations on Coverage for Abortion

DVHA may only provide for abortions in the following situations:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

No other abortions can be covered under this IGA.

2.9.4 Parity in Mental Health and Substance Use Disorder Benefits

DVHA must provide for services to be delivered in compliance with Subpart K of Part 438 of the Code of Federal Regulations.

2.9.5 Long Term Services and Supports (LTSS) Settings

LTSS services must delivered in settings in compliance with the AHS transition plan to adhere to the requirements specified in 42 CFR 441.301(c)(4).

2.9.6 Individually Assessed Cost Effective Services

DVHA may provide individuals with the option to receive cost-effective treatment as patients in lieu of otherwise covered services in other settings. This option must be voluntary for the individual, and must be based on an assessment and determination that the service is a medically appropriate and cost- effective substitute for the corresponding State Plan service or setting. The State must not claim any expenditures under this expenditure authority that are otherwise not allowable, including but not limited to institutions for mental diseases (IMD), inmates, or room and board. DVHA will document in writing the State Plan substitution, enrollee agreement with the alternative and how the alternative was assessed and determined cost-effective. DVHA will report on expenditures in this category quarterly in a format specified by AHS.

2.10 Access to Services

2.10.1 General

Pursuant to 42 CFR 438.68, Network Adequacy Standards, DVHA must develop and enforce network adequacy standards. In establishing and maintaining network adequacy, DVHA must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Demonstration*;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- That services are sufficient in amount, duration, and 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 Demonstration* enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location(s) provide physical access for enrollees with disabilities.

In addition, DVHA must also consider the following:

- The ability of provider to communicate with limited English proficient beneficiaries in their preferred language;
- The ability of providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities;
- The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.
- Elements that would support a beneficiaries choice of provider;
- Strategies that would ensure the health and welfare of the beneficiary and support community integration of the beneficiary; and
- Other considerations that are in the best interest of the beneficiaries that need LTSS.

Through its contracts with Medicaid providers and the IGA partners, DVHA must ensure that a network of appropriate providers is maintained to furnish adequate access to all covered *Global Commitment to Health Demonstration* services.

For the purpose of this Access to Services Section, the following definitions apply:

- **Emergency care** is care for a medical problem that could result in serious health problems if it is not treated immediately.
- **Urgent care** is care for any problem that might endanger a member's health if it is not treated within 24 hours.
- **Preventative care** is ongoing care designed to evaluate and maintain a member's overall health, rather than treating a specific medical problem.
- **Primary care** includes services furnished by providers specifically trained for and skilled in first-contact and continuing care for persons with undiagnosed signs, symptoms or health concerns. This includes gynecologists, Federally Qualified Health Centers and Rural Health Centers, as well

as specialty care providers who serve as a member's primary care provider.

- When the term **medical problem** is used in this document, the term is meant to include physical, mental health, and substance use problems.
- **Emergency medical condition** means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy or, for a pregnant woman, placing the health of the woman or her unborn child
    - in serious jeopardy;
    - Serious impairment to such persons of bodily functions; and
    - Serious dysfunction of any bodily organ or part of such person.

2.10.2 Twenty-Four Hour Coverage

DVHA must ensure that emergency coverage is available to enrollees on a twenty-four hour per day, seven-day per week basis. Coverage may be delegated to subcontractors, including IGA partners, but DVHA must maintain procedures for monitoring coverage to ensure twenty-four-hour availability.

2.10.3 Emergency Care

DVHA will provide the following information to all enrollees:

- The fact that prior authorization is not required for emergency services
- The process and procedures for the use of the 911 telephone system or its local equivalent
- The location of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Demonstration
- The fact that the enrollee has the right to use any hospital or other setting for emergency care

DVHA is responsible for coverage and payment of emergency services for all enrollees served through the *Global Commitment to Health Demonstration*. Payment for these services shall be made in accordance with the Medicaid fee schedule.

DVHA must cover and pay for emergency services regardless of whether the provider who furnishes the services has a contract with the Medicaid program, and may not deny payment for treatment obtained whenever an enrollee has an emergency medical condition (according to the prudent layperson standard) or is instructed by a representative of DVHA or an IGA partner to seek emergency services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition.

DVHA must maintain a process through which payments can be made to non-enrolled providers when medically necessary, covered services cannot be provided within the existing network or when a member must seek emergency services (and post-emergency stabilization services) outside the network. DVHA has no statutory authority to force a non-enrolled provider to accept its payment for emergency services renderer to an enrolled Vermont Medicaid member, but will maintain and follow a thorough process to encourage non-enrolled providers to accept its payment.

DVHA or its IGA partners may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. DVHA and its IGA partners may further not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital or fiscal agent to notify the enrollee's provider, the responsible Department, or DVHA of the enrollee's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services. This shall not preclude DVHA from refusing to cover non-emergency services that do not meet medically necessity criteria, or refusing payment for non-emergency services in cases where a provider does not provide notice within the 10-day timeframe.

A *Global Commitment to Health Demonstration* enrollee receiving services through the public insurance programs who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entity (DVHA) responsible for coverage and payment.

2.10.4 Post-Stabilization Care Services

"Post-stabilization care services" means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee's condition. Post-stabilization of care is covered on both an inpatient and outpatient basis.

Post-stabilization care services provided on an inpatient hospital basis are paid for by DVHA for all enrollees in the public insurance programs under the *Global Commitment to Health Demonstration.* DVHA may conduct concurrent review for post-stabilization services as soon as medically appropriate. However, DVHA must pay for all inpatient post-stabilization care services that are pre-approved by DVHA, all post-stabilization services that are not pre-approved but are administered to maintain the enrollee's stabilized condition within one hour of a request to DVHA for pre-approval, and all services that are not pre-approved but are administered to maintain, improve or resolve an enrollee's stabilized condition if the:

- DVHA does not respond to a request for pre-approval within one hour;
- DVHA cannot be contacted; or
- DVHA's representative and the treating physician cannot agree concerning the enrollee's treatment and DVHA does not have a physician available for consultation. In this situation, DVHA must allow the treating physician to continue with care of the enrollee until DVHA physician is reached or the enrollee is discharged.

DVHA's financial responsibility for post-stabilization services for services it has not pre-approved ends when any of the following conditions is met the:

- DVHA-contracted physician who has privileges at the treating hospital assumes responsibility for the enrollee's care;
- DVHA-contracted physician assumes responsibility for the enrollee's care through transfer;
- DVHA and the treating physician reach an agreement concerning the enrollee's care; or
- Enrollee is discharged.

DVHA shall limit charges to enrollees for post-stabilization care services to an amount no greater than what DVHA would charge the enrollee if the enrollee had obtained the services through DVHA.

2.10.5 Travel Distance and Wait Times

DVHA shall ensure that travel distance and wait times to services do not exceed the limits described in the Vermont Medicaid Access Plan:
https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRFinalPolicies/1final-access-to-care-plan-oct-2016.pdf

Network adequacy standards for LTSS provider types must be developed consistent with 42 CFR 438.68. DVHA's network monitoring activities for this provider type will focus on statewide coverage, rather than the typical distance standards used for other provider types.
If the travel time standard is exceeded in a particular area, DVHA will work to bring new providers into the network.

All Other Services – All services not specified in the Vermont Medicaid Access Plan shall meet the usual and customary standards for the community.

2.10.6 Appointment Availability

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.

2.10.7 Interpreter Services at Medical Sites

DVHA and the IGA partners shall ensure availability of interpreter services by offering reimbursement. Medical delivery sites will be allowed to seek reimbursement for in person interpreter services provided to enrollees who speak a language other than English as a first language, or who are hearing-impaired, and who request such assistance.

2.10.8 Cultural Considerations

DVHA shall participate in AHS's efforts to promote access and delivery of services in a culturally competent manner to all *Global Commitment to Health Demonstration* enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meet their unique needs.

2.10.9 Choice of Health Professional

Per 42 CFR 438.6(l), Global Commitment to Health enrollees will have choice of health professional within the network of Medicaid providers to the extent possible and appropriate. DVHA shall not impose any

restrictions on the choice of the provider from whom the person may receive family planning services and supplies. DVHA shall not impose any restrictions on choice or changes between primary care providers. Enrollees in specialized programs, may only have access to providers designated or certified by the State for those programs and will not have access to any enrolled provider for services under those programs.

2.10.10 Direct Access to 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 woman's health specialist.

2.10.11 Alternative Treatment

DVHA and the IGA partners shall not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from the following actions:

- Advising or advocating on behalf of an enrollee who is his or her patient for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Providing information to the enrollee as necessary for the enrollee to decide among all relevant treatment options;
- Advising or advocating on behalf of an enrollee for the risks, benefits, and consequences oftreatment or non-treatment;
- Advising or advocating on behalf of the enrollee for the enrollee's right to participate indecisions regarding his or her health care, including the right to refuse treatment, and to expresspreferences about future treatment decisions.

2.10.12 Second Opinion

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, or arrange for the ability of the enrollee to obtain one outside of the network, at no cost to the enrollee.

2.10.13 Accessibility Considerations

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

2.11 Coordination of Services

DVHA shall assist in the coordination of services provided through its network of Medicaid providers and its IGA partners. DVHA will document the name of primary care provider for each enrollee. DVHA shall maintain mechanisms for enrolling specialists as primary care providers, as appropriate for the enrollee's condition and identified needs.

DVHA and IGA partners shall maintain mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of

treatment or regular care monitoring. 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 (for adults with serious and persistent mental health treatment needs), and Enhanced Family Treatment (for children with a severe emotional disturbance) (DMH).

The assessment mechanisms must use appropriate health care professionals. When treatment plans are required, the treatment plan must be developed with the participation of the enrollees' primary care provider and enrollee, in consultation with any specialists caring for the enrollee. When appropriate, DVHA and its IGA partners will create a unified plan to prevent enrollees with special health care needs from receiving duplicative case management/care coordination activities. DVHA and its IGA partners will 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. The treatment plan must be approved by DVHA or IGA partner in a timely manner, if approval is required. The treatment plan must identify specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs. The treatment plan must conform to the State's quality assurance and utilization review standards.

If the contracted network is unable to provide necessary medical services covered under the contract to a particular enrollee, DVHA must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them. The cost to the beneficiary is the same whether they receive necessary services in or out of network (when in network services are not available.

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

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.

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:

i. Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;
ii. 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);
iii. Approved in a timely manner;
iv. In accordance with any applicable AHS quality assurance and utilization review standards; and
v. 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.

2.12 Payment to Providers

2.12.1 General

DVHA and the IGA partners are responsible for ensuring timely payments to contracted providers as defined in 42 CFR 447.45 and 42 CFR 447.46.

DVHA shall ensure that all enrollees enrolled in the *Global Commitment to Health Demonstration* are assigned a unique enrollee identification number, and a Medicaid eligibility classification as applicable.

Medicaid enrollees will not be held liable when DVHA denies a claim from the health care provider who furnished the services. Medicaid enrollees are further not liable for payments for covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the enrollee would owe if DVHA provided the services directly.

DVHA is authorized to set payment rates to providers and is not required to comply with payment provisions in the approved State Plan. DVHA may implement any payment system where:

- The provider's services are described in terms of "X units of services" where the units of the services are appropriate for the type of service and consistent with units prescribed in national coding standards; or
- The provider's services are reimbursed at a specific reimbursement rate per unit of service, regardless of how the specific reimbursement rate is determined (e.g. fixed dollar amount, Diagnostic-Related Group, Prospective Payment Systems).
- The total provider reimbursement is determined by multiplying a. The provider's "X units of services" delivered to an enrollee; and b. The specific reimbursement rate per unit of service.
- Any new payment system that includes a single payment for multiple categories of services as defined in
- §1905 of the Social Security Act, must be submitted to AHS for prior review and approval by CMS at least 90 days prior to implementation by DVHA or an IGA partner

For existing payment approaches not otherwise approved by CMS that includes a single payment for multiple categories of services as defined in §1905 of the Social Security Act, DVHA and AHS will collaborate to document and submit to CMS for review and approval. Submission for CMS review must be timely made in order to obtain CMS approval prior to January 1, 2019. Identified payment approaches include:

- Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) Program
- Blueprint Patient-Centered Medical Home (PCMH)
- Blueprint Community Health Team (CHT)
- Blueprint Women's Health Initiative (WHI)
- Dental Incentive
- Children's Integrated Services (CIS)
- Integrating Family Services (IFS)

DVHA will not make pass-through payments, as defined in 42 CFR 438.6(a), to providers.

2.12.2 Incentive Payments

DVHA and IGA partners may make payments to providers on a risk or incentive basis, provided such arrangements are in compliance with AHS and Federal requirements and guidelines, and disclosed to AHS.

2.12.3 Payments to Primary Care Providers (PCP)

DVHA will ensure that each enrollee enrolled in the public insurance programs, for which the public insurance programs serve as the primary payer, has a primary care provider (PCP). PCPs are paid in accordance with the Medicaid fee schedule.

2.12.4 Enrollee Cost-Sharing

DVHA must not apply co- payment requirements to children under age 21, pregnant women or individuals in long-term care facilities or for excluded services/supplies (e.g., family planning). Enrollee cost sharing shall be in accordance with the premium and co-payment provisions of the program as established under the State Plan and STC #21 of the *Global Commitment to Health Demonstration*.

2.12.5 Provider-Preventable Conditions

DVHA must comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider- preventable conditions as set forth in 42 CFR § 434.6(a)(12) and § 447.26. DVHA must report all identified provider-preventable conditions in a form and frequency as specified by AHS.

2.13 Quality Assurance and Medical Management

2.13.1 Quality Management Plan

DVHA in collaboration with its IGA partners shall maintain a comprehensive Quality Management Plan for the *Global Commitment to Health Demonstration*. The plan must meet all the requirements of 42 CFR 438

and those defined in the Demonstration Special Terms and Conditions and must include LTSS and HCBS quality components. The plan measures must include, but not be limited to:

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

- A special focus on special programs in home and community-based settings and address the following:
  - A self-assessment of CFC adherence to state and federal standards of care to include:
    1. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population, and
    2. Examination of processes to identify any potential corrective action steps toward improving the CFC system;
  - Person-Centered Planning and Integrated Care Settings;
  - Comprehensive and Integrated Service packages;
  - Qualifications of Providers; and
  - Participant Protections.

The Quality Management Plan shall conform to all applicable Federal and State regulations and will be designed to achieve improvements in clinical and non-clinical care as described in 42 CFR 438.330. The Quality Management Plan shall be available to AHS upon request.

DVHA in collaboration with its IGA partners shall also assess their performance using performance measures that align with Medicaid and CHIP adult and child core measures, as well as other Medicaid and Medicare federal measure sets where possible and appropriate. Specific metrics should be made available for each population covered by the Demonstration, including children, pregnant women, non- disabled adults (including parents), individuals receiving HCBS services, and individuals receiving LTSS.

DVHA and its IGA partners shall maintain an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas, and that involves the following:

- Measurement of performance using objective quality measures;
- Implementation of system interventions to achieve improvements in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project to AHS as requested and in a timely manner (including the results of any surveys, audits or evaluations conducted during the project).

DVHA and as applicable, its IGA partners, completes each Performance Improvement Project (PIP) in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality care every year. The CMS or AHS may specify performance measures and topics for performance improvement projects. DVHA and its IGA partners shall conduct projects specified by the CMS or AHS.

2.13.2 Utilization Management Plan

DVHA must have in effect mechanisms to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DVHA has delegated the function of assessing the quality and appropriateness of care furnished to beneficiaries with special health care needs to the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Mental Health (DMH).

DVHA and its IGA partners, when applicable, shall adopt practice guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of the enrollees, and consultation with health care professionals who participate in the *Global Commitment to Health Demonstration* and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. DVHA shall disseminate guidelines in collaboration with its IGA partners and shall require the Departments to disseminate the guidelines among all of their designated providers. These practice guidelines will also be made available to enrollees upon request.

Decisions for utilization management, enrollee education, coverage of services and other areas to which the guidelines apply shall be consistent with the guidelines.

DVHA shall not structure compensation for any entity that conducts utilization management services in such a way as to provide incentives for the denial, limitation or discontinuation of medically necessary services to any enrollee.

2.13.3 Authorization of Services

The term "service authorization request" means a *Global Commitment to Health Demonstration* enrollee's request for the provision of a service, or a request by the enrollee's provider.

DVHA and each of the 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 the requirements and effective dates specified under 42 CFR 438.210.

DVHA and each of the IGA partners 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. Should DVHA or its IGA partners exercise the prior authorization option, review criteria for authorization decisions will be identified for providers. DVHA or its IGA partners will ensure consistent application of review criteria for authorization decisions.

- For standard authorization decisions, the IGA partners 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 IGA partner justifies to AHS upon request of the need for additional information and how the extension is in the enrollee's best interest.

- For cases in which a provider indicates, or the IGA partner 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 IGA partner 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 the IGA partner justifies to DVHA a need for additional information and how the extension is in the enrollee's interest. If the pre- authorization timeframe is extended, DVHA or its IGA partner must notify the enrollee of the extension, the reason for the extension and the enrollee's rights to appeal this decision.

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 and format requirements and effective dates set forth in 42 CFR §438.404.

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 partners 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;
- Reasons for the action;
- 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;
- Enrollee's right to request a Fair Hearing for covered services and how to request that covered services be extended
- The enrollee must exhaust appeal rights prior to making a Fair Hearing request;
- Enrollee's right to request external review by DVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and
- 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.

2.13.4 State of Vermont and Federal Reviews

DVHA must make available to the State of Vermont and/or outside reviewers, on a periodic basis, medical, financial, and other records for review of quality of care and access issues.

The CMS may also designate an outside review agency to conduct an evaluation of the *Global Commitment to Health Demonstration* and its progress toward achieving program goals. DVHA must agree to make available to any CMS designated review agency medical and other records (subject to confidentiality constraints) for review as requested. This shall include AHS External Quality Review Organization.

2.14 Internal Appeals, Grievances and State Fair Hearings

DVHA and IGA partners shall adhere to uniform Health Care Administrative Rule 8.100, Internal Appeals, Grievances, and State Fair Hearings on Medicaid Services which complies with all aspects of 42 CFR 438 Subpart F. AHS shall review and approve any proposed change in internal appeals, grievances and State fair hearing rules and policies. AHS shall be responsible for ensuring internal appeal, grievance and State fair hearing rules, policies and practices comply with the federal statutes and regulations, including provisions applicable to DVHA operations. For purposes of the grievance and internal appeals processes, Designated Agencies (DA) and Specialized Services Agencies (SSA) are contracted agents of DVHA and/or its IGA partners who act within the delegated authority of DVHA/DMH for the DS and MH special populations. Therefore, any decisions these entities make for those special populations that fall under the definition of "adverse benefit determination" as defined at 42 CFR 438.400 are subject to DVHA's internal appeal process. DVHA must maintain records of grievances and internal appeals. The record of each grievance or appeal must contain, at a minimum, all of the following information:

(1) A general description of the reason for the appeal or grievance
(2) The date received
(3) The date of each review or, if applicable, review meeting
(4) Resolution at each level of the appeal or grievance, if applicable
(5) Date of resolution at each level, if applicable
(6) Name of the covered person for whom the appeal or grievance was filed

AHS and DVHA shall ensure that random reviews are conducted to confirm that enrollees are notified in a timely manner.

Grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." This includes, but is not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by DVHA to make an authorization decision or for resolution of an internal appeal, and the denial of an expedited appeal request. 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, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner as defined by the State;
- The failure to act within the time frames provided in 42 CFR (438.408(b)(1) and(2)

regarding the standard resolution of grievances and appeals;

- Failure of to act in a timely manner when required by state rule;
- Denial of an enrollee's request to obtain services outside the network; or
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments and other enrollee financial liabilities.

DVHA will provide information about beneficiary internal appeal, grievance and State fair hearing requirements and processes to all providers and subcontractors at the time they enter into a contract with DVHA.

12.14.1 Right to Appeal

Any Medicaid beneficiary has a right to appeal any decision about his or her amount of coverage. In most cases, the beneficiary must exhaust the internal appeals process before they can request a State fair hearing before the Human Services Board under AHS. HCAR rule 8.100 requires that exhaustion be deemed whenever the notice of resolution of the internal appeal does not meet notice or timeliness requirements.

Regarding issues of coverage, appeals must be filed within 60 days from the date the notice of adverse benefit determination was mailed by DVHA. A request for a State fair hearing challenging the internal appeal decision must be made within 120 days of the date the Medicaid program mailed the notice of resolution of the internal appeal. Mailing is defined as the postmark date which is defined as one business day after the date of the notice.

Medicaid beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 Demonstration internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing. (See below, Enrollee Grievances)

12.14.2 Continued Benefits During Appeal or State Fair Hearing

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice.

If DVHA or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the internal appeal or State fair hearing was pending, DVHA authorizes or provides the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Beneficiaries may waive their right to continued benefits. If they do so and are successful on an internal appeal or State fair hearing, benefits will be paid retroactively.

If DVHA or the State fair hearing officer reverses a decision to deny, limit, or delay services and the beneficiary received the disputed services while the internal appeal and/or State fair hearing processes were pending, DVHA pays for those services.

DVHA may recover from the beneficiary the value of any continued benefits paid during the internal appeal period or the State fair hearing period when the beneficiary withdraws the internal appeal or State fair hearing before the relevant internal or State fair hearing decision is made or following a final disposition of the matter

in favor of DVHA. Beneficiary liability will occur only if a DVHA internal appeal, State fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and DVHA also determines that the beneficiary should be held liable for service costs, and recouping is consistent with state policy.

An issue of law or policy means that the person is questioning the legality of a law or rule rather than the facts used or DVHA's judgment in applying the rules to make the decision being appealed.

12.14.3 Beneficiary Appeals

- Right to Appeal

  Beneficiaries may request an internal appeal of a DVHA adverse benefit determination and may request a State fair hearing before the Human Services Board when the internal appeal resolution is not fully favorable to the beneficiary or when exhaustion is deemed pursuant to Health Care Administrative Rule (HCAR) 8.100.4(d)(2). Enrollees are required to exhaust DVHA's internal appeal process prior to requesting a State fair hearing unless exhaustion is deemed.

  DVHA adverse benefit determinations are considered preliminary decisions subject to appeal. Ifno appeal is filed within the 60-day time frame set out in HCAR at 8.100 et seq., the adverse benefit determination is considered the final DVHA decision. If an internal appeal is filed, the decision rendered as a result of the internal appeal process may be appealed to the Human Services Board. If the internal appeal decision is not appealed to the Human Services Board, then it becomes the final decision.

- Request for Non-Covered Services for Enrollees 21 Years Old and Older

  For enrollees who are 21 years old or older, an appeal may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA for its exceptions request process. Pursuant to HCAR 8.100, a subsequent DVHA denial to cover such service cannot be appealed using DVHA's internal appeal process, but may be appealed through the State fair hearing process.

- Medicaid Financial Eligibility and Premium Determinations

  If a beneficiary files an appeal regarding only a Medicaid financial eligibility or premium determination, the entity that receives the appeal will forward it to the Medicaid eligibility division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by the Medicaid eligibility division. These appeals will not be addressed through the DVHA internal appeal process and will be considered a request for State fair hearing as of the date DVHA received it.

- Filing of Internal Appeals

  Beneficiaries may file internal appeals orally or in writing for any DVHA adverse benefit determination; an oral internal appeal must be followed by a written, signed appeal, unless the beneficiary has requested an expedited appeal. DVHA has discretion to find that a beneficiary has good cause for not following an oral appeal with a written appeal. Oral inquiries to an

internal appeal of an adverse benefit determination are treated as appeals to establish the earliest possible filing date. Providers and authorized representatives of the beneficiary may initiate internal appeals, with the beneficiary's written consent. Internal appeals of adverse benefit determinations must be filed with DVHA within 60 days of the date that DVHA mailed the notice of adverse benefit determination. The date of the internal appeal, if mailed, and the date that DVHA mailed the notice of adverse benefit determination is the postmark date. The postmark date is one business day after the date of the notice.

The appeal process will include assistance by staff members of DVHA with the support of the Health Care Appeals Team as needed, to the beneficiary to initiate and participate in the appeal. Assistance required by HCAR 8.100.4(g) includes but is not limited to completing forms, providing auxiliary aids such as interpreter services, having toll-free numbers that have adequate TTY/TTD capability, and help filing a request for a State fair hearing to any beneficiary who wrongly files a request for review with the Human Services Board prior to exhaustion of the internal appeal. Beneficiaries will not be subject to retribution or retaliation for appealing an action. Beneficiaries may seek assistance from the Long-Term Care Ombudsman, the Health Care Advocate, and/or another entity.

- <u>Written Acknowledgment</u>

Written acknowledgment of the internal appeal shall be mailed within five calendar days of receipt by the part of the department that receives the appeal.

If a beneficiary files an internal appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgment shall explain that the issue has been forwarded to the correct division within AHS, identify the division to which it has been forwarded, and explain that the appeal will be addressed by that division. This does not extend the deadline by which internal appeals must be determined.

- <u>Withdrawal of Appeals</u>

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by DVHA in writing within five calendar days.

- <u>Beneficiary Participation in Internal Appeals</u>

The beneficiary, authorized representative, estate representative of a deceased enrollee (where applicable) or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which DVHA is considering the decision regarding their appeal.

Participation in the internal appeal means that the enrollee has the right to:

- Present evidence
- Present testimony
- Make legal arguments and
- Make factual arguments.

Beneficiaries, their authorized representative, or treating provider may submit additional information.

The enrollee must be informed, sufficiently in advance of the resolution timeline for an internal appeal, of the timeframe for presenting evidence and testimony, making legal and factual arguments, and examining the case file.

Prior to the appeal meeting, DVHA, with the support of the Health Care Appeals Team, shall provide the beneficiary, their authorized representative, or their provider with opportunity to examine and, if requested, get copies of the beneficiary's case file and all the information in its possession, or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and copies of all necessary and relevant medical records. This includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting service limits. The department will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

- Appeals Reviewer

The individual who makes the decision on the internal appeal shall not be involved in any previous level of review or decision-making that is the subject of the internal appeal and shall not be a subordinate of such individual. Internal appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the internal appeal who, when deciding an internal appeal of a denial that is based on medical necessity or an internal appeal that involves clinical issues, possess(es) the requisite expertise, as determined by the state, in treating the beneficiary's condition or disease. The appeal reviewer shall considerall comments, documents, records, and other information submitted by the beneficiary or his/her representative or provider without regard to whether such information was submitted or considered in the initial adverse benefit determination.

- Resolution

DVHA shall inform the beneficiary of the time available for participation in the internal appeal sufficiently in advance of the resolution timeframe for the appeal including, when the appeal meeting will be held.

Appeal meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If the beneficiary, their authorized representative, or treating provider are not able to meet within the 30-day time limit or within the 14-day extension, a decision will be rendered by DVHA without a meeting with the beneficiary, their authorized representative, or treating provider. The beneficiary, his/her authorized representative, or provider shall have an opportunity to submit evidence and argument by other means to the appeals reviewer for consideration in making a decision.

Internal appeals shall be decided and written notice sent to the beneficiary as expeditiously as the enrollee's health requires and not more than 30 days of receipt of the internal appeal. The 30-day period begins with the receipt of the internal appeal and includes any review at the level of the DA/SSA. If an appeal cannot be resolved within 30 days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by DVHA, if DVHA demonstrates (including to the satisfaction of AHS, upon its request) that there is a need for additional information and how the extension is in the best interest of the beneficiary. If the timeline is

extended, the DVHA must resolve the appeal as expeditiously as the enrollee's health condition requires and not later than the date the extension expires.

If DVHA extends the time frame and it is not at the request of the beneficiary, DVHA must make reasonable efforts to give the enrollee prompt oral notice of the delay and, within 2 calendar days, must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if s/he disagrees with the decision to extend the timeline.

The maximum total time period for the standard resolution of an internal appeal, including any extension requested by the beneficiary or based on DVHA's determination that additional information is needed, and that delay is in the best interest of the enrollee, is 44 days.

When an appeal has been resolved, DVHA or its IGA partner must provide the enrollee with a written decision that complies with HCAR 8.100.3(c), including:

- The decision, including the basis for the decision, in sufficient detail for the beneficiary to understand the decision,
- A summary of the beneficiary's appeal.
- A summary of the evidence or documentation used by the reviewer in making the decision, including clinical review criteria used to make a decision relating to medical care,
- The date the decision was completed and the effective date of the decision,
- The telephone number of the Health Care Advocate at Vermont Legal Aid, Inc. and
- For decisions not wholly in the enrollee's favor:
  - The right to request a State Fair Hearing,
  - How to request a State Fair Hearing,
- The timeframe for requesting a State fair hearing,
- The circumstances in which a State fair hearing will be expedited and how to request it,
- The right to continue to receive benefits pending a State Fair Hearing and the time frame for doing so (must be requested within 11 days of the notice of internal appeal resolution),
- How to request the continuation of benefits during the State Fair Hearing process, the timeframe, whether standard or expedited, in which AHS (including the Human Services Board) must take final administrative action, and
- If DVHA or its IGA partner's decision is upheld in a State Fair Hearing, the enrollee may be liable for the cost of any continued benefits, to the extent that doing so is consistent with state policy.

12.14.4 Expedited Internal Appeal Requests

DVHA must have an expedited internal appeal process. Expedited internal appeals are required when DVHA determines (when request is from a beneficiary) or the provider indicates the beneficiary (when the provider is making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or mental or physical health or ability to attain, maintain, or regain maximum function.

Requests for expedited appeals may be made orally or in writing with DVHA for any adverse benefit determinations subject to appeal. DVHA will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal. When an expedited appeal has been requested, the enrollee will be contacted by telephone to inform the enrollee that all evidence and allegations of fact or law must be presented as soon as possible within the 72 hours resolution period for the expedited appeal.

If the expedited internal appeal request meets the criteria for an expedited appeal, it must be resolved as expeditiously as the enrollee's health condition requires and no later than 72 hours from the date DVHA receives the appeal.

If the request for an expedited appeal does not meet expedited criteria and is denied, DVHA will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 30-day time frame. DVHA will make reasonable efforts to give the beneficiary prompt oral notice for the denial which shall be followed by written notice. DVHA will give notice to the enrollee that s/he may file a grievance of the denial of the request for an expedited appeal.

The written notice for any expedited appeal determination shall conform with the notice of resolution of internal appeal requirements at HCAR8.100.3(c).

DVHA may extend the expedited appeal resolution timeframe up to a maximum of 14 calendar days if the enrollee requests the extension, or if DVHA demonstrates (including to the satisfaction of AHS, upon its request) that there is need for additional information and how the delay is in the best interest of the enrollee. If the expedited appeal timeline is extended not at the request of the beneficiary, DVHA must make reasonable effort to give the beneficiary prompt oral notice of the delay, followed up within two calendar days with a written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if s/he disagrees with the decision to extend the timeline. DVHA must resolve the appeal as expeditiously as the enrollee's health condition requires but not later than the date the extension expires. The maximum total time for the resolution of an expedited appeal, including any extension requested by the enrollee or based upon DVHA's demonstration that additional information is needed, and that delay is in the best interest of the enrollee, is 17 calendar days.

12.14.5 Notices of Adverse Benefit Determination, Continuation of Services,Beneficiary Liability for Service Costs

A. <u>Beneficiary Notice of Adverse Benefit Determination</u>

A Medicaid service decision with timely and adequate written notice of an adverse benefit determination must explain the following in the written notice:

- The adverse benefit determination that DVHA has made or intends to make.
- The specific rule that supports the adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable and timely access to and copies ofall documents, records, and other information relevant to the adverse benefit determination.

Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- The enrollee's right to request an appeal of DVHA's adverse benefit determination including information about the procedures and timeframes for exercising these rights.
- The circumstances under which an appeal process can be expedited and how to request it.
- The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.
- The methods for requesting an appeal.

Timeframes for notice of adverse benefit determination: DVHA must provide notice:

- for denial of payment, at the time of any action affecting the claim,
- for standard services authorization decisions that deny or limit services, as expeditiously as the beneficiary's health requests but not more than 14 days following receipt for the request for service,
- for expedited service authorization decisions, as expeditiously as the beneficiary's health requires and not more 72 hours after receipt of the request for service,
- for service authorization decisions not reached within the proper timeframes, on the date that the timeframe expires (service authorization decisions not reached within the proper timeframes constitute a denial and thus are an adverse benefit determination), and
- at least 11 days before the effective date of adverse benefit determination when it is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

Timeframes for notice of adverse benefit determination: DVHA must provide notice on the date of adverse benefit determination when it is a denial of payment.

B. Continuation of Services (See also 2.11.2 and 2.11.4.3) 1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered health service termination or reduction under the following circumstances:

a. DVHA appeal was filed in a timely manner, meaning on or before the later of the following:
   - ♦ Within 11 days of DVHA mailing the notice of adverse benefit determination or
   - ♦ Before the intended effective date of DVHA's proposed adverse benefit determination, whichever is later.

b. The appeal involves the termination, suspension or reduction of a previously authorized service.

c. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.

2. Where properly requested, a service must be continued until any one of the following occurs:

a. The beneficiary withdraws the appeal or requests a State fair hearing; or

b. DVHA issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing and continued services within the applicable timeframe;
c. A fair hearing is conducted, and the Human Services Board issues a final order and decision upholding DVHA's adverse benefit determination.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries.

D. Beneficiary Liability for Cost of Services (See also 2.11.2)

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

To the extent that it is consistent with state policy on recoupment, DVHA may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant DVHA or State fair hearing decision is made or following a final disposition of the matter in favor of DVHA. Beneficiary liability will occur only if an appeal, State fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and DVHA also determines that the beneficiary should be held liable for service costs, and recoupment would be consistent with state policy.

E. Notices including Non-English Notices

All notices, including notices of adverse benefit determination and notices of internal appeal resolution, must be written, unless specified otherwise in this IGA. These notices must be in plain language and must be accessible for persons with limited English proficiency and persons with disabilities.

DVHA must ensure that written materials and all notices to beneficiaries are written in plain language which means language that the intended audience, including individuals with limited English proficient, can readily understand and use because that language is concise, well organized, and follows best practices of plan language for that audience.

Persons with limited English proficiency shall be provided language services at no cost to the individual including oral interpretation, written translations, and taglines in non-English languages, including the availability of language services Written notices must be translated for the individuals who speak non-English languages (as defined by the State per 42 CFR 438.10(c)). Notices must include language clarifying that oral interpretation is available for non-English languages and how to access it.

DVHA will ensure that written materials and notices are available in alternative formats, and in an appropriate manner that takes into consideration those with special needs, for whom English is a second language, and for persons with disabilities DVHA must inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats. This includes a requirement that DVHA provide the individual with

auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

12.14.6 State Fair Hearing

In most cases, the beneficiaries must exhaust the internal appeal prior to making a State fair hearing request, unless exhaustion is deemed as set forth above. A beneficiary who seeks review of a service not subject to the internal appeal process pursuant to HCAE 8.100.1 does not have to exhaust the internal appeal process.

DVHA will accept a timely request for a State fair hearing from an enrollee and will process the request without delay. A timely request for a State fair hearing means that an enrollee has requested the State fair hearing: within 120 days of the date the notice of resolution of the internal appeal was mailed to the enrollee by DVHA (mailing is the postmark date which is considered one business day after the date of the notice), or, if there was no internal appeal (for those services for which the internal appeal process does not apply), then within 120 days after the mailing of the notice of adverse benefit determination. .

Beneficiaries have the right to file requests for State fair hearings related to eligibility and premium determinations. AHS shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations. Hearing descriptions must be included in enrollee and provider information within the contract. With the written consent of the beneficiary, a provider or an authorized representative may request a State fair hearing on behalf of the beneficiary.

- Beneficiaries also have the right to file a request for an expedited State fair hearing after exhausting the internal appeal process for expedited appeals, unless exhaustion is deemed for the reasons described above. The beneficiary, his/her representative, or the representative of a deceased enrollee's estate shall be parties to a State Fair Hearing. Expedited State fair hearings shall be resolved as expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency (the Human Services Board) received the case record and information for an appeal that DVHA indicates meets the standard for an expedited appeal. When the matter is not expedited (i.e., standard resolution), the final administrative decision must be sent to the beneficiary within 90 days from the date the beneficiary filed the internal appeal, not counting the number of days the beneficiary took to subsequently file for a State fair hearing.

12.14.7 Beneficiary Grievances

12.14.7.1 Filing Grievances

Grievance is defined at 2.11 and includes an enrollee's right to dispute an extension of time proposed by DVHA to make authorization decisions, to extend the timeline for a notice of a notice of resolution of an internal appeal, and whenever an expedited appeal request is denied as not meeting the expedited standard. A grievance may be expressed orally or in writing by the enrollee and/or their representative.

A provider may serve as the enrollee's representative for the purpose of filing a grievance and assisting the enrollee with the proceedings of the grievance. Individuals may file a grievance through DVHA Customer Service or directly with any department. A beneficiary or with the written consent of the beneficiary, an authorized representative on behalf of the beneficiary, can file a grievance at any time and the grievance must be considered.

In handling grievances, DVHA must give any reasonable assistance to the enrollee in initiating and participating in the grievance, including completing forms, taking procedural steps related to the grievance, and providing auxiliary aids and services such as interpreter services and toll-free numbers that have adequate TTY/TTD interpreter capability. DVHA must have a process to ensure that the individuals who make decisions on grievances are individuals who:

- Are not involved in any previous level of review or decision-making and are not a subordinate of such individual.
- Are health care professionals who have the appropriate clinical expertise in treating the beneficiary's condition or disease, if deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves a clinical issue.

12.14.7.2 Written Acknowledgment

Written acknowledgment of the grievance must be mailed within five calendar days of receipt by DVHA. The acknowledgment must be made by the part of DVHA responsible for the service area that is the subject of the grievance. If DVHA decides the issue within the five-day time frame, it need not send separate notices of acknowledgment and decision. The decision notice is sufficient in such cases.

12.14.7.3 Withdrawal of Grievances

Beneficiaries or designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by in writing within five calendar days.

12.14.7.4 Disposition

DVHA may extend the timeline for processing a grievance by up to 14 calendar days if it shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the enrollee's interest. If DVHA extends the timeline for a grievance, it must give the enrollee written notice within 2 calendar days of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. All grievances shall be addressed as expeditiously as the enrollee's health requires and not more than 90 calendar days of receipt or 90 calendar days plus up to an additional 14 calendar days if the enrollee requests an extension. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with DVHA, as well as information on how to initiate such review. If the grievance decision constitutes an action adverse to the beneficiary, then the beneficiary shall be entitled to all fair hearing rights.

12.14.7.5 Grievance Review

A. <u>Initiating a Grievance Review</u>

If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by DVHA within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance. [For clarification, a grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." If the grievance decision constitutes an action adverse to the beneficiary, the grievance review process shall not delay or inhibit an enrollee's ability to request a fair hearing.]

B. Written Acknowledgment

DVHA will acknowledge grievance review requests within five calendar days of receipt.

C. Disposition

The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review, which is considered final.

12.14.7.6 Responsibility for Addressing Grievances

DVHA, a subcontractor or an IGA partner receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving grievances initiated under these rules.

12.14.7.7 Compliance with HCAR 8.100

DVHA must comply with all notice, appeal, grievance, State fair hearing and other requirements set forth in HCAR 8.100.

12.15 Enrollee Records

DVHA and its IGA partners shall guard the confidentiality and privacy of individually identifiable health information contained in enrollee records in a manner consistent with 45 CFR parts 160 and 164 (Health Insurance Portability and Accountability Act) to the extent that these requirements are applicable. Specific requirements include the following: policies and procedures for protecting enrollee information; procedures for authorizing access to enrollee information; physical security procedures; and information system security procedures. Enrollee records must include all recipient information required for utilization review as specified in 42 CFR 456.

12.16 Reporting Requirements

12.15.1 Encounter Data

The State has defined an encounter as a claim. DVHA shall maintain claims history data for all *Global Commitment to Health Demonstration* enrollees through contractual arrangements with its Fiscal Agent. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Demonstration. AHS will have direct access to information systems and DVHA shall make such claims/encounter data available to AHS and CMS upon request.

12.15.2 Data Validation

Encounter data is currently defined by AHS as a "claim". All claims for payments are currently submitted to DXC and undergo a series of automated edits and audits to ensure accuracy, timeliness, correctness, logic, consistency and completeness. Any claim failing edits will be rejected and must be re-submitted. Claims data will be collected in a format that is consistent with the HIPAA transaction standards in place on the date of service. Claims must represent services provided to Global Commitment to Health Demonstration enrollees only. DVHA will perform validation on a random sample of all claims to ensure that services were actually provided. AHS will have direct access to all information systems.

2.17 Financial Reporting

DVHA, its IGA partners and AHS shall collaborate to generate and maintain the following financial information and records:

- Quarterly comparisons of projected vs. actual expenditures;
- Quarterly report of DVHA revenues and expenses for the *Global Commitment to Health Demonstration*;
- Quarterly analysis of expenditures by service type; and
- All reports and data necessary to support Demonstration reporting requirements, including any systems modification needed in calendar year 2019 to support the collection and reporting of Medical Loss Ratio (MLR) beginning with the rate period effective April 1,2019.

DVHA will submit a quarterly report of overpayment recoveries to AHS.

AHS, the U.S. Department of Health and Human Services and the U.S. Government Accountability Office shall have the right to inspect and audit any financial records of DVHA and its IGA partners. The right to audit exists for 10 years from the final date of this contract period or the date of completion of any audit, whichever is later.

12.17.1 Network Reporting

AHS shall review variable definitions used by DVHA and any relevant reporting by DVHA's contractors relative to beneficiary access to services to ensure that providers enrolled in the Vermont Medicaid Program offers an appropriate range of covered services adequate for the anticipated number of enrollees for a given service area; and that it the network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the enrollees in the service area.

At the time it enters this IGA, and on a quarterly basis, DVHA will provide AHS with a network adequacy report that includes: geographic service area, a summary of all complaints received through DVHA's member services call center and maps that show provider-to-member ratios for primary care providers and specialists in the network. Whenever a significant change has been made to the provider network, DVHA will notify AHS immediately.

DVHA and its IGA Partners will assure that a system, policies and procedures are in place through which providers must identify report and investigate critical incidents that occur within the delivery of Choices for Care Program services. Providers will also be educated about systems to prevent, detect and report,

investigate and remediate abuse, neglect and exploitation for persons receiving Choices for Care Program services.

2.18 Fraud and Abuse

DVHA in collaboration with its IGA partners must have both administrative and management procedures, and a mandatory compliance plan, to guard against fraud and abuse. The procedures and compliance plan must include the following:

- Written policies, procedures and standards of conduct that articulate a commitment to comply with all applicable Federal and State standards;
- Designation of a compliance officer and a compliance committee that are accountable to senior management;
- Effective training and education for the compliance officer and all of DVHA's employees;
- Effective lines of communication between the compliance officer and employees;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Provision for internal monitoring and auditing; and
- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

DVHA must further require any employees, contractors, and grantees that provide goods or services for the *Global Commitment to Health Demonstration* to furnish, upon reasonable request, to DVHA, the Vermont Attorney General, and the United States DHHS, any record, document, or other information necessary for a review, audit, or investigation of program fraud or abuse, and shall establish procedures to report all suspected fraud and abuse to AHS and the Vermont Attorney General. For each case of suspected fraud and abuse reported, DVHA shall supply (as applicable) the name and identification number; source of the complaint or issue; type of provider; nature of the complaint or issue; the approximate dollars involved; and the legal and administrative disposition of the case. DVHA must provide access to both original documents and provide free copies of requested documents on a reasonable basis. Such access may not be limited by confidentiality provisions of the plan or its contractors.

DVHA will ensure that its compliance program, includes at a minimum, the following elements:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements;
- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Commissioner;
- The establishment of a Regulatory Compliance Committee at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract;
- A system for training and education for the Compliance Officer, senior management, and employees for the Federal and State standards and requirements under the contract;
- Effective lines of communication between the compliance officer and the organization's employees;
- Enforcement of standards through well-publicized disciplinary guidelines; and
- Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they

are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

DVHA will maintain and implement a mechanism for a network provider to report when it has received an overpayment. The provider must notify DVHA in writing of the reason for the overpayment. The provider must return the overpayment to DVHA within 60 calendar days after the date on which the overpayment was identified.

DVHA will promptly report of all improper payments identified or recovered, specifying the improper payments due to potential fraud, to AHS and law enforcement when applicable.

DVHA will assure prompt notification to the AHS division responsible for eligibility when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including the following:

- Changes in the enrollee's residence or notification of an enrollee's mail that is returned as undeliverable.
- Changes in the enrollee's income.
- The death of an enrollee.

Provider participation in the Medicaid program is synonymous with participation in the *Global Commitment to Health Demonstration* public managed care model. DVHA will report changes in a provider's circumstances, including the termination of the provider agreements that have significant impact on access to care.

DVHA will implement:

- Methods to verify, by sampling or other techniques, whether services that have been represented to have been delivered by network providers were received by enrollees and the apply suchverification processes on a regular basis;
- Written policies for all employees, contractors or agents, that provide detailed information aboutthe False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;and
- Provisions for the suspension of payments to a network provider for which the State determinesthere is a credible allegation of fraud in accordance with 42 CFR455.23.

2.19 Records Retention

2.19.1 General

DVHA must maintain books and records relating to the *Global Commitment to Health Demonstration* services and expenditures, including reports to the State and source information used in preparation of these reports. These records include, but are not limited to, financial statements, records relating to quality of care, medical records, and prescription files. DVHA also agrees to comply with all standards for record keeping specified by AHS. In addition, DVHA agrees to permit inspection of its records.

DVHA, as applicable, will have procedures in place to retain and require subcontractors to retain the following information: enrollee grievance and appeal records in §438.416, base data in §438.5(c), MLR

reports in § 438.8(k), and the data, information, and documentation specified in §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

2.19.2 Confidentiality of Information

DVHA agrees that all information, records, and data collected in connection 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.

2.20 Disclosure Requirements

DVHA must comply with any applicable Federal and State of Vermont laws that pertain to enrollee rights, and must ensure that its staff and affiliated providers observe and protect these rights. DVHA must have a written policy on *Global Commitment to Health Demonstration* enrollee rights that addresses the enrollee's right to:

- Be treated with respect and with due consideration of his or her dignity and privacy;
- Be provided with information about the Demonstration Program, its services, practitioners, and enrollee rights and responsibilities;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;
- Be able to choose health care providers within the limits of DVHA network;
- Participate in decision-making regarding their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- Voice grievances about the program or care received;
- Formulate advance directives;
- Have access to copies of his/her medical record and to request that the medical record be amended or corrected; and
- Receive services in accordance with the requirements and effectives date specified by 42CFR
- 438.206 through 438.210.

DVHA must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights

does not adversely affect the way DVHA or its providers treat the enrollee.

DVHA must comply with disclosure requirements in 1902(a)(7) of the Social Security Act and 42 CFR 431, Subpart F, and 42 CFR 455, Subpart B. DVHA also must inform *Global Commitment to Health Demonstration* enrollees about:

- Rights and responsibilities, including rights to terminate enrollment;
- Policies on advance directives;
- Provisions for after-hours coverage; and
- Procedures for DVHA-approved disenrollments.

ARTICLE THREE: AHS RESPONSIBILITIES

3.1 Eligibility Determination

AHS shall maintain sole responsibility for the establishment of eligibility requirements and standards for Medicaid, as well as any other eligibility requirements for expansion populations under the *Global Commitment to Health Demonstration.*

3.2 Per Member Per Month (PMPM) Rate Setting

AHS shall establish fixed monthly rates for *Global Commitment to Health Demonstration* enrollees. The fixed per member per month (PMPM) amount, must be developed and certified as actuarially sound in accordance with 42 CFR 438.4 through 438.7. The PMPM rate should allow DVHA to achieve an MLR of at least 85 percent. The PMPM rates shall not include any administrative costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation or the STCs. The rates must be developed consistent with the requirements in 42 CFR 438.5 and based on DVHA's actual experience and expected costs.

The fixed PMPM rates and certification shall be used to determine that:

1. The provider reimbursement rates are not based on the rate of Federal financial participation associated with the covered populations;
2. The provider reimbursement rates are appropriate for the populations to be covered and the services to be furnished under the contract; and
3. The provider reimbursement rates are adequate to meet the requirements on MCOs, PIHPs,and PAHPs in §§438.206, 438.207, and 438.208.

3.3 Medicaid Policy

AHS retains authority over all Medicaid Policy. To promote and improve Medicaid policy alignment and accountability, the Medicaid Policy Unit supports all AHS departments, operating as extensions of the Single State Agency, with Medicaid policy activities. This includes 1115 waiver activities, administrative rule making, Medicaid State Plan Amendments (SPAs), and consultation on Medicaid program changes.

3.4 Program Integrity

AHS, as Single State Agency, complies with all requirements of 42 CFR 438, subpart H. All program integrity requirements in federal statute and regulations that are required of the state in its oversight of a non-risk PIHP are the direct responsibility of AHS facilitated by the Program Integrity Unit, located within DVHA's organizational structure but operating as the Single State Agency under AHS.

In accordance with 42 CFR 455.23, the Program Integrity Unit investigates fraud and informs AHS when there is a credible allegation of fraud that may result in the suspension of a payments to a provider.

3.5 Oversight and Performance Evaluation

AHS will be responsible for oversight of the managed care-like model acting as a non-risk PIHP, ensuring compliance with state and federal statutes, regulations, special terms and conditions, waiver, and expenditure authority. AHS shall be responsible for evaluation, interpretation and enforcement of findings issued by the

external quality review organization.

AHS will ensure that the views of beneficiaries, individuals representing beneficiaries and other stakeholders are solicited during any modifications to the design, implementation and oversight of the State's managed Long-Term Services and Supports.

AHS will implement procedures for monitoring all aspects of the managed care program, including DVHA's performance in at least the following areas:

1. Administration and management;
2. Appeal and grievance systems;
3. Claims management;
4. Enrollee materials and customer services, including the activities of the beneficiary support system;
5. Finance, including medical loss ratio reporting;
6. Information systems, including encounter data reporting;
7. Marketing;
8. Medical management, including utilization management and case management;
9. Program integrity;
10. Provider network management, including provider directory standards;
11. Availability and accessibility of services, including network adequacy standards;
12. Quality improvement;
13. Areas related to the delivery of LTSS not otherwise included above; and
14. All other provisions of the contract, as appropriate.

AHS will use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum:

1. Enrollment and disenrollment trends;
2. Enrollee grievance and appeal logs;
3. Provider complaint and appeal logs;
4. Findings from the State's External Quality Review process;
5. Results from any enrollee or provider satisfaction survey conducted by AHS orDVHA;
6. Performance on required quality measures;
7. Medical management committee reports and minutes;
8. DVHA's annual quality improvement plan;
9. Financial and encounter data;
10. The medical loss ratio summary reports required by § 438.8;
11. Customer service performance data submitted by DVHA and performance data submitted by the beneficiary support system; and
12. Any other data related to the provision of LTSS not otherwise included above.

AHS shall at its discretion do the following:

Define measurable performance standards for DVHA and its subcontractors in all of the following areas:

- Service Accessibility
- Enrollee Satisfaction
- Quality Assurance & Medical Management, including Long Term Services and Supports under

the Choices for Care Program.
- Grievance & Appeal Resolution
- Reporting
- Monitor and evaluate DVHA's compliance with the terms of this IGA, including performance standards;
- Meet with DVHA a minimum of twice a year to assess the performance of its Quality Assurance Program;
- Review reports submitted by DVHA, including specifically quarterly reports on grievances and appeals received by DVHA and its IGA partners;
- Request additional reports that AHS deems necessary for purposes of monitoring and evaluating the performance of DVHA under this IGA;
- Engage in audit activities performed by AHS staff and/or its sub-contracted EQRO designed to determine if DVHA and its IGA partners are in compliance with standards established by AHS for access to care, structure and operations, and, quality measurement and improvement;
- Perform periodic financial reviews of DVHA's performance of responsibilities. This may include, but is not limited to a review of the following:
  - Administration
  - Operations
  - Financial performance
- Provide DVHA and/or its IGA partners prior notice of any on-site visit by AHS or its agents to conduct an audit, and further notify DVHA of any records that must be made available for review;
- Inform DVHA and/or its IGA partners of the results of any performance evaluations conducted by AHS or its agents; and
- Develop Corrective Action Plans (CAP) to address any areas of non-compliance or poor performance identified as part of the evaluation process. In the event a CAP is issued to DVHA or one of its IGA partners, DVHA will be required to file a formal response within the time period specified in the CAP. AHS will review and approve or modify the response, as appropriate. AHS will monitor implementation of the CAP response through progress reports and interim audits until it is satisfied that the deficiency has been corrected.

The EQRO shall perform an annual, external independent review of the quality outcomes, timeliness of, and access to, the services covered under this IGA. AHS shall contract with an External Quality Review Organization (EQRO) in order to obtain independent monitoring of DVHA's Quality Management Program.

3.6 Access to and Analysis of Encounter Data

AHS shall have access to the claims data as reported by DVHA or its IGA partners. AHS may, at its discretion, conduct an evaluation of the claims to identify any changes from historical utilization rates, areas of potential over- or under-utilization, and any other issues that may affect the success of the program.

3.7 Centers for Medicare and Medicaid Services (CMS) Reporting

AHS shall retain sole responsibility for production and submission of reports to the CMS, including all fiscal reports. DVHA agrees to cooperate with AHS in the preparation of any required reports, including providing any necessary data and analysis, preparation of materials for submission to the CMS, and assisting in the preparation of responses to any questions or issues the CMS may raise with respect to the reports.

3.8 Participant/Applicant Waiting List Monitoring

AHS shall report on the status of the waiting lists for Choices for Care services during regular progress calls between CMS and the state and in reports submitted to CMS by the state.

3.9 Beneficiary Support System

AHS shall ensure that enrollees have access to beneficiary support services as defined in 42 CFR 438.71. AHS shall ensure the independence and conflict of interest requirements in 42 CFR 438.71(c)(2) are satisfied by ensuring that contracts or grants for these activities are managed by staff outside of DVHA and that staff responsible for any beneficiary support system activities report to a department or agency outside of DVHA. AHS will monitor beneficiary support system quarterly reports and take action where systemic issues are identified.

3.10 Third Party Liability (TPL)

DVHA will be responsible for identifying and pursuing accident insurance and estate recovery and all other sources of third party liability (TPL). DVHA's process for identification of potential sources of third party liability must include identification and review of claims with diagnosis codes indicative of trauma, or injury, poisoning and other consequences of external causes. AHS shall monitor DVHA's experience in identifying sources of third party liability or coverage and in collecting funds due to it through these sources.

3.11 Sanctions

The Department of Vermont Health Access (DVHA) may be subject to sanctions by the Agency of Human Services (AHS) if AHS determines that DVHA acted or failed to act as follows:

1. DVHA fails substantially to provide medically necessary services, required by law or contract, to an enrollee covered under the contract;
2. DVHA imposes on enrollees premiums or charges that exceed Medicaid limits;
3. DVHA discriminates among enrollees on the basis of their health care status or need for health care services;
4. DVHA misrepresents or falsifies information that it furnished to CMS or AHS;
5. DVHA misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
6. DVHA fails to comply with the requirements for physician incentive plans;
7. DVHA provides marketing materials that are unapproved by AHS or that contain false or intentionally misleading information; and
8. DVHA has violated federal law or regulations, including the applicable sections of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

If the State learns that DVHA has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the State:

1. Must notify the Secretary of the noncompliance.
2. May continue an existing agreement with the MCE unless the Secretary directs otherwise.
3. May not renew or extend the existing agreement with DVHA unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

3.11.1 Sanctions by CMS

DVHA acknowledges that payments for new enrollees under this contract will be denied when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements of 42 CFR 438.730.

3.11.2 Types of Sanctions

AHS reserves the right to impose the following sanctions if it determines that DVHA has violated any of the items enumerated in Section 3.8:

- Appointment of temporary management as provided in 42 CFR 438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollment, including default enrollment, after the effective date ofthe sanction;
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or AHS is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur.

3.11.3 Temporary Management

AHS may impose temporary management if it finds that:

- There is continued egregious behavior by DVHA, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
- There is substantial risk to enrollees' health; or
- The sanction is necessary to ensure the health of DVHA's enrollees while improvements are made to remedy violations under 438.700 or until there is an orderly contract termination or reorganization of DVHA.

Nothing in this subpart should be construed as requiring AHS to impose temporary management in these situations. However, AHS will impose temporary management if it finds that DVHA has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. AHS will also grant enrollees the right to terminate enrollment without cause and will notify affected enrollees of their right to terminate. AHS will not delay imposition of temporary management to provide a hearing before imposing this sanction. AHS will not terminate temporary management until it determines that DVHA can ensure that the sanctioned behavior will not reoccur.

3.11.4 Termination of the Contract

AHS may terminate its contract with DVHA and provide enrollee benefits through other options included in the State plan if AHS determines that DVHA has failed to:

- Carry out the substantive terms of its contract.
- Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Act.

3.11.5 Due Process

AHS will notify DVHA prior to the imposition of sanctions through a written notice that explains the basis and nature of the sanction.

Prior to terminating DVHA's contract under 42 CFR 438.708, AHS will provide DVHA with a pre-termination hearing. AHS will:

- Give DVHA written notice of AHS' intent to terminate, the reason for termination, and the time and place of the hearing;
- Give DVHA (after the hearing) written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the effective date of termination; and
- For an affirming decision, give DVHA enrollees notice of the termination and information, consistent with 438.10, on their options for receiving Medicaid services following the effective date of termination.

During the disenrollment process, and after AHS notifies DVHA of its intent to terminate the contract, AHS may:

- Give DVHA enrollees written notice of AHS' intent to terminate the contract.
- Allow enrollees to disenroll immediately without cause.

ARTICLE FOUR: PMPM RATES AND PAYMENT PROVISIONS

4.1 PMPM Rates

The PMPM rates provided under the *Global Commitment to Health Demonstration* will comply with the actuarial certification requirements of 42 CFR Part 438. AHS shall ensure that no claims paid by DVHA to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

The PMPM capitation rate will:

- Be developed consistent with the requirements in 42 CFR 438.5 and based on DVHA's actual experience and expected costs;
- Not include any administrative services and costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation, or the Global Commitment to Health Demonstration Special Terms and Conditions. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and External Quality Review Organization (EQRO), administration of a State Fair Hearing system, the Beneficiary Support System in 42 CFR 438.71 and STC 31, and the provider screening and enrollment process under 42 CFR 438.602(b);
- Include only costs for services included under 42 CFR 438.3(c)(1)(ii) and services specifically authorized in the Global Commitment to Health Demonstration Special Terms and Conditions.

The PMPM rate process and resulting rates are mechanisms that support program monitoring but do not affect available program funding. Demonstration PMPM fixed rates for the period from January 1,2021 through December 31, 2021 are found in the table below.

	Monthly Capitation Rate
ABD Adult	$2,245.83
ABD Child	2,937.38
ABD Dual	2,364.58
Global Rx	107.97
Moderate Needs	669.53
New Adult	436.24
Non-ABD Adult	584.09
Non-ABD Child	494.25

Attachment A: Acronyms

ABD Aged Blind Disabled
AHS Agency of Human Services
AOE Agency of Education
ASL American Sign Language
BBA Balanced Budget Act
CAP Corrective Action Plan
CFR Code of Federal Regulations
CMS Centers for Medicare & Medicaid Services
CFC Choices for Care
CLIA Clinical Laboratory Improvements Amendments
CRT Community Rehabilitation and Treatment
DA/SSA Designated Agency/Specialized Services Agency
DAIL Department of Disabilities, Aging and Independent Living
DCF Department for Children and Families
DHHS Department of Health and Human Services (United States)
DVHA Department of Vermont Health Access
DXC DXC Technology
EQRO External Quality Review Organization
ER Emergency Room
FFP Federal Financial Participation
HCBS Home and Community Based Services
HIPAA Health Insurance Portability and Accountability Act
IGA Intergovernmental Agreement
MLTSS Managed Long Term Services and Supports (e.g.,Choices for Care)
MMIS Medicaid Management Information System
NF Nursing Facility
PA Prior Authorization
PCP Primary Care Provider
PIP Performance Improvement Project
PMPM Per Member Per Month
Rx Pharmacy
SUBCONTRACTORS Vendors, organizations
TPL Third Party Liability
TTY/TTD Teletypewriter/Telecommunications Device for the
Deaf VDH Vermont Department of Health

Signature Page

Intergovernmental Agreement between Agency of Human Services and Department of Vermont Health Access for the Administration and Operation of the Global Commitment to Health Demonstration January 1, 2021 - December 31, 2021.

Agreed to:

Michael K. Smith, Secretary
Agency of Human Services

Date: 12-29-2020

Cory Gustafson, Commissioner
Department of Vermont Health Access (DVHA)

Date: 12-29-2020