State of Vermont

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-001941)

January 1, 2024 – December 31, 2024

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ARTICLE I: 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) with respect to the State's managed care-like model established under the *Global Commitment to Health Medicaid Demonstration (Project #11-W-001941)* 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. Pursuant to the *Global Commitment to Health Medicaid Demonstration*, Vermont's Medicaid program delivers its services through a unique, non-risk managed care-like model for all beneficiaries. As such, CMS requires that AHS and DVHA operate pursuant to an intergovernmental agreement (IGA) that delineates the division of responsibility between the two agencies, subjects DVHA to the requirements that would be applicable to a non-risk Pre-Paid Inpatient Health Plan (PIHP) and ensures that AHS has proper oversight as the Single State Medicaid Agency. This IGA is intended to fulfill CMS's requirements for the delivery of services through Vermont's managed care-like model. Accordingly:

(a) DVHA, along with the Vermont Department of Health (VDH), the Department of Mental

(b) Health (DMH), the Department of Disabilities Aging, and Independent Living (DAIL), and the Department for Children and Families (DCF, and together with VDH, DMH, and DAIL, the "Intragovernmental Partners") will operate using a Medicaid managed care-like model for all beneficiaries under the Global Commitment to Health Medicaid Demonstration;

(c) For purposes of the demonstration, DVHA will operate as if it were a non-risk PHIP,

(d) and AHS, as the Single State Medicaid Agency, will provide oversight of DVHA in that capacity;

(e) Any DVHA responsibilities or requirements defined in this IGA may be performed by other entities via an IGA, contract, or memorandum of understanding (MOU); and

(f) DVHA and AHS shall coordinate to ensure that the Medicaid program operates in compliance with the CMS-approved Special Terms and Conditions (STCs) for the Global Commitment to Health Medicaid Demonstration.

(g) Should any part of the scope of responsibilities under this agreement relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), DVHA must do no work on that part after the effective date of the loss of program authority. The state must adjust payments to remove costs that are specific to any program or activity that is no longer authorized by law. If DVHA works on a program or activity no longer authorized by law after the date the legal authority for the work ends, DVHA will not be paid for that work. If the state paid DVHA in advance to work on a no-longer- authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state.

However, if DVHA worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to DVHA, DVHA may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

1.2 Agreement Review and Renewal

This IGA shall be effective for the period of January 1, 2024, to December 31, 2024, 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

(a) 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.

(b) DVHA must comply with all applicable requirements in the STCs. In particular, DVHA must comply with program requirements that are outlined in the STCs, even if the outlined services are not found in Vermont's Medicaid State Plan.

(c) 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.

1.4 Prohibited Affiliations

(a) DVHA shall not knowingly have a relationship with either of the following:

(i) 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

(ii) An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described above.

(b) DVHA understands that Federal Financial Participation (FFP) is not available for amounts expended for providers excluded by any federal healthcare program, except for emergency services.

(c) 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 II: DVHA RESPONSIBILITIES

2.1 Eligibility

(a) Eligibility Data Transfers. The AHS eligibility determination systems, VHC, Access Mainframe, and the Medicaid Management Information System (MMIS), shall provide Medicaid eligibility functions under the Global Commitment to Health Medicaid Demonstration. A regular data transfer between the VHC, Access, 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.

(a)

2.2 Beneficiary Outreach, Education, and Informational Materials.

(a) ***New Beneficiaries.*** DVHA shall be responsible for educating individuals to help beneficiaries and potential beneficiaries of the Global Commitment to Health Medicaid Demonstration understand the requirements and benefits of the plan. Education activities may be conducted via mail, by telephone, and/or through face-to-face meetings. DVHA may employ the services of an enrollment broker to assist in outreach and education activities.

(b) ***Language and Format of Information.***

(i) DVHA must provide all information to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.

(ii) DVHA must ensure that written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices:

(1) Are presented in an easily understood language and format;

(2) Are provided in a font size no smaller than 12 point;

(3) Are available in alternative formats and/or through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency;

(4) Are available in the prevalent non-English languages in its particular service area;

(5) Are available in alternative formats upon request of the potential beneficiary or beneficiary at no cost;

(6) Include taglines in the prevalent non-English languages in the state, and in a conspicuously visible font size, explaining the availability of written translation or oral interpretation to understand the information provided;

(7) Include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide information on how to request auxiliary aids and services; and

(8) Include taglines in the prevalent non-English languages in the state and in a conspicuously visible font size that provide the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the DVHA's member/customer service unit.

(i) DVHA must make auxiliary aids and services, and interpretation services, including oral interpretation and the use of aids such as TTY/TDY and American Sign Language (ASL) available upon request of the potential beneficiary or beneficiary at no cost.

(ii) DVHA must notify its beneficiaries that:

(1) Oral interpretation is available for any language, and provide information on how to access those services;

(2) Written translation is available in prevalent languages, and

provide information on how to access those services; and

(3) Auxiliary aids and services are available upon request at no cost for beneficiaries with disabilities and provide information on how to access those services.

(iii) DVHA must ensure that any information provided to beneficiaries electronically is in a format that is readily accessible; placed in a location on DVHA's web site that is prominent and readily accessible, and provided in an electronic form that can be electronically retained and printed. DVHA must notify beneficiaries that the information is available in paper form without charge upon request and must provide, upon request, information in paper form within 5 business days.

(iv) DVHA will assure that all informational material will adopt uniform AHS definitions of the following terms: appeal; co-payment; 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.

(c) ***Beneficiary Handbook***.

(i) DVHA must provide each beneficiary with a beneficiary handbook within a reasonable time after receiving notice of the beneficiary's enrollment.

(1) If there is any significant change in the beneficiary handbook, as defined by AHS, DVHA must provide each beneficiary handbook at least 30 days before the intended effective date of the change.

(2) The beneficiary handbook is considered to be provided if DVHA mails a printed copy of the information to the beneficiary's mailing address; provides the information by email after obtaining the beneficiary's agreement to receive the information by email; posts the information on its website and advises the beneficiary in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

(ii) The beneficiary handbook must be specific to the Global Commitment to Health Medicaid Demonstration and serve as a summary of benefits and coverage available under the Global Commitment to Health Medicaid Demonstration. It must include information that enables the beneficiary to understand how to effectively utilize the Global Commitment to Health Medicaid Demonstration program. Specifically, the beneficiary handbook must include, at a minimum, information on:

(1) Benefits provided by DVHA, including, but not limited to, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and how to access component services if individuals under age 21 entitled to the EPSDT benefit are enrolled;

(2) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled;

(3) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the beneficiary's Primary Care Provider (PCP);

(4) The extent to which, and how, after-hours care is provided;

(5) With respect to emergency care: how emergency care is provided; what constitutes an emergency medical condition; what constitutes an emergency service; the fact that prior authorization is not required for emergency services; and the fact that the beneficiary has a right to use any hospital or other setting for emergency care;

(6) Any restrictions on the beneficiary's freedom of choice among network providers;

(7) The extent to which, and how, beneficiaries may obtain benefits, including family planning services and supplies from out-of-network providers;

(8) The fact that a beneficiary cannot be required to obtain a referral before choosing a family planning provider;

(9) Any cost-sharing imposed for furnished services;

(10) With respect to beneficiary rights and responsibilities, the beneficiary’s right to: receive information on beneficiary and plan information; be treated with respect and with due consideration for his or her dignity and privacy; obtain available and accessible covered services; receive information on available treatment options and alternatives, presented in a

manner appropriate to the beneficiary's condition and ability to understand; participate in decisions regarding his or her 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; request and receive a copy of their medical records and request that they be amended or corrected.

(11) The process of selecting and changing the beneficiary's PCP;

(12) With respect to grievances, appeals, and fair hearings: grievance, appeal, and fair hearing procedures and timeframes; the beneficiary's right to file grievances and appeals; the requirements and timeframes for filing a grievance or appeal; the availability of assistance in the filing process for grievances; the availability of assistance in the filing process for appeals; the beneficiary's right to request a state fair hearing after DVHA has made a determination on a beneficiary's appeal which is adverse to the beneficiary; and a statement that, when requested by the beneficiary, benefits that DVHA seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the beneficiary may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.

(13) How to exercise an advance directive;

(14) With respect to auxiliary aids and services: how to access auxiliary aids and services, including additional information in alternative formats or languages; the toll-free telephone number for member services; the toll-free telephone number for medical management; the toll-free telephone number for any other unit providing services directly to beneficiaries; and how to report suspected fraud or abuse; and

(15) The transition of care policies for beneficiaries and potential beneficiaries.

(d) ***Network Provider Directory.***

(i) DVHA must provide the following information regarding its network providers (which, at a minimum, includes primary care physicians, specialists, hospitals, pharmacies, behavioral health providers, and Long-Term Services and Supports (LTSS) providers) to all beneficiaries:

(1) Names, as well as any group affiliations;

(2) Street addresses;

(3) Telephone numbers;

(4) Website URLs, as appropriate;

(5) Specialties, as appropriate;

(6) Whether the providers will accept new beneficiaries;

(7) The provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office; and

(8) Whether provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

(ii) 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.

(e) ***Formulary.*** DVHA will assure that the following information about its ***formulary*** is available on its web site in a machine-readable file and format:

(i) Which medications are covered (both generic and name brand); and

(ii) Which tier each medication is on.

(f) ***Provider Termination Notices.*** DVHA will make a good faith effort to give written notice of termination of the contracted provider, within the later of 30 days prior to the effective date of the termination or 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

2.3 <u>Marketing</u>

(a) "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 beneficiaries. This term should not be interpreted to include materials distributed by DVHA to beneficiaries or potential beneficiaries in the ordinary course or to increase awareness of eligibility for Medicaid coverage overall. For example, materials sent to potential beneficiaries with reminders about enrollment periods are not Marketing Materials.

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

(c) DVHA's marketing must be accurate and may not mislead, confuse, or defraud the recipients or AHS.

(d) DVHA may not directly or indirectly engage in door-to-door, telephone, email, texting, or other Cold Call Marketing activities.

(e) DVHA may not distribute any Marketing Materials without first obtaining approval of such materials from AHS.

(f) DVHA must distribute Marketing Materials to its entire service area.

2.4 Program Integrity

(a) AHS and DVHA shall comply with all requirements of 42 CFR 438, subpart H, with AHS as the state and DVHA as a PIHP unless specified herein. Pursuant to STC # 6.12, the documentation and reporting requirements related to the risk of insolvency at 42 CFR 438.604(a)(4) are not applicable to DVHA. Additionally, the data, information, and documentation submission requirements of 42 CFR 438.604(a)(1) and (2) are satisfied, provided AHS has direct access to the information systems that maintain such data, documentation, and information.

(b) ***Exclusions.*** DVHA may not:

(i) Employ or contract with providers excluded from participation in Federal health care programs;

(ii) Be controlled by an individual sanctioned by CMS;

(iii) Have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act (the "Act"); any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under a regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

(iv) Employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under a regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or any individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

(c) ***Requirements, Procedures, and Reporting.***

(i) DVHA must inform AHS of all relevant program integrity activities.

(ii) DVHA must submit to AHS:

(1) Data on the basis of which AHS may determine DVHA's compliance with the Medical Loss Ratio (MLR) requirement, along with its calculated MLR.

(2) Documentation on which AHS may base its certification that DVHA complied with the state's requirements for availability and accessibility of services, including the adequacy of the provider network.

(3) Any other data, documentation, or information relating to the performance of DVHA's obligations as required by AHS.

(iii) For any information or data submitted to AHS as required by this IGA, the individual who submits the material must provide a certification, which attests, based on the best information, knowledge, and belief that the data, documentation, and information are accurate, complete, and truthful. The certification must be submitted concurrently with the submission of the data, documentation, and information.

(iv) DVHA may not knowingly have:

(1) A director or officer who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(2) A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(3) A network provider who has been terminated from the Medicare, Medicaid, or CHIP programs pursuant to 42 CFR 455.101;

(4) An employment, consulting, or other agreement for the provision of DVHA contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(5) A subcontracting arrangement with a person or entity who is (or is affiliated with a person/entity that is) debarred, suspended, or

otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(v) DVHA must ensure that all network providers are enrolled as Vermont Medicaid providers consistent with provider disclosure, screening, and enrollment requirements.

(d) ***Disclosures.***

(i) DVHA must provide written disclosure to AHS of the following:

(1) A director or officer who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(2) A network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(3) Any network provider who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(4) Any employment, consulting, or other agreement for the provision of DVHA contract items or services with a person who is (or is affiliated with a person/entity that is) debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(5) Any affiliated individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

(e) ***Compliance Program.***

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

(1) 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, and which will accommodate the annual submission of compliance plans to AHS for review and approval;

(2) 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 provides reports directly to the Commissioner;

(3) 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;

(4) 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;

(5) Effective lines of communication between the compliance officer and the organization's employees;

(6) Enforcement of standards through well-publicized disciplinary guidelines; and

(7) 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.

(ii) DVHA must notify AHS when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Global Commitment to Health Medicaid Demonstration, including termination of the provider agreement. Without limiting the generality of the foregoing, DVHA must notify AHS of any provider agreements that are terminated for cause.

(iii) DVHA must develop a process to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.

(iv) To the extent that DVHA makes or receives annual payments of at least $5,000,000, DVHA must implement and maintain written policies for all

employees, contractors, or agents that provide detailed information about the False Claims Act (FCA) and other Federal and state laws, including information about rights of employees to be protected as whistleblowers.

(v) DVHA must implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that DVHA identifies to the Medicaid Fraud & Residential Abuse Unit (MFRAU) of the Vermont Attorney General's Office.

(vi) DVHA must implement provisions for the suspension of payments to a network provider for which AHS determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. Such provisions must include, at a minimum, the following:

(1) DVHA must suspend all Medicaid payments to a provider after AHS determines that there is a credible allegation of fraud in accordance with 42 CFR.

(2) 455.23 and need not notify the provider of its intention to do so. The duration of suspension must comply with 42 CFR 455.23(c).

(3) DVHA must send notice of its suspension of program payments according to the timeframes set forth in 42 CFR 455.23(b)(1). Such notices must contain the information set forth at 42 CFR 455.23(b)(2).

(4) Whenever payments are suspended, DVHA must make a referral to the state's Medicaid fraud control unit (MFRAU) in accordance with 42 CFR 455.23(d). DVHA must also notify AHS of any payment suspensions.

(5) Any determinations by DVHA that there is good cause not to suspend payments or good cause to only suspend payments in part must be made in accordance with 42 CFR 455.23(e) and (f).

(6) DVHA must ensure that it maintains all materials relating to payment suspensions for the durations outlined in 42 CFR 455.23(g).

(f) ***Treatment of Recoveries.***

(i) DVHA will maintain and implement a mechanism for a network provider or other subcontractor to report to DVHA, in writing, when it has received an overpayment.

(ii) DVHA must specify retention policies for the treatment of recoveries of all overpayments to all network providers, including retention policies specific to the treatment of recoveries of overpayments due to fraud, waste, or abuse. DVHA must specify the process, timeframes, and documentation required for reporting the recovery of overpayments, including in situations where DVHA is not permitted to retain some or all of the

recoveries of overpayments.

(iii) DVHA must report an overpayment that DVHA, a network provider, or any subcontractor receives to AHS within 60 calendar days of identifying the overpayment.

(iv) DVHA will provide an annual report of overpayment recoveries to AHS.

2.5 Provider Network

(a) ***Selection of Providers.*** DVHA must implement written policies and procedures for the selection and retention of network providers, that include, at a minimum, the requirements of 42 CFR 438.214.

(i) DVHA's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

(ii) DVHA is required to give written notice of the reason for its decision when it declines to include individual or groups of providers in its provider network.

(iii) DVHA must comply with any additional provider selection requirements established by AHS.

(b) ***Provider Credentialing.*** DVHA shall ensure that all providers participating in the *Global Commitment to Health Medicaid Demonstration* meet the enrollment requirements established by AHS for the Medicaid program. DVHA must follow the uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate.

(c) ***Non-Discrimination and Anti-Gag.***

(i) DVHA may not prohibit or restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a beneficiary who is his or her patient regarding:

(1) The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(2) Any information the beneficiary needs to decide among all relevant treatment options;

(3) The risks, benefits, and consequences of treatment or non-treatment; or

(4) The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

(ii) DVHA may not take any punitive action against a provider who either requests an expedited resolution or supports a beneficiary's appeal.

(d) ***Provider Notification of Grievance and Appeal Rights*.** DVHA must inform providers and subcontractors providing services under the *Global Commitment to Health Medicaid Demonstration*, at the time they enter into an agreement with DVHA, about:

(i) Beneficiary grievance, appeal, and fair hearing procedures and timeframes as specified in 42 CFR 438.400 through 42 CFR 438.424;

(ii) The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing;

(iii) The availability of assistance to the beneficiary with filing grievances and appeals;

(iv) the beneficiary's right to request a state fair hearing after DVHA has made a determination on a beneficiary's appeal which is adverse to the beneficiary; and

(v) the beneficiary's right to request continuation of benefits that DVHA seeks to reduce or terminate during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the beneficiary may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.

2.6 Network Adequacy

(a) DVHA must ensure that DVHA and its network providers meet AHS standards for timely access to care and services (as developed in accordance with Section 3.11 of this IGA), taking into account the urgency of the need for services. When medically necessary, DHVA must make services available 24 hours a day, 7 days a week. DHVA must establish mechanisms to ensure that its network providers comply with the timely access requirements.

(b) DVHA must monitor network providers regularly to determine compliance with the timely access requirements and take corrective action if its network providers fail to comply with the timely access requirements.

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

(d) DVHA must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

(e) As applicable, DVHA will adhere to the quantitative network adequacy standards developed by AHS in all geographic areas in which DVHA operates for the following provider types: adult PCPs; pediatric PCPs; Obstetrics and Gynecology (OB/GYN) providers; adult mental health providers; adult substance use disorder providers; pediatric mental health providers; pediatric substance use disorder providers; adult specialists (as designated by AHS); pediatric specialists (as designated by AHS); hospitals; pharmacies; pediatric dental providers; and LTSS providers (as designated by AHS).

(f) ***Indian Health Care Providers.***

(i) DVHA must demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the provider network to ensure timely access to services available under the contract from such providers for Indian beneficiaries who are eligible to receive services.

(ii) DVHA must ensure that IHCPs, whether participating or not, be paid for covered services provided to Indian beneficiaries who are eligible to receive services at a negotiated rate between DVHA and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment DVHA would make for the services to a participating provider that is not an IHCP.

(iii) DVHA must ensure that Indian beneficiaries are permitted to obtain covered services from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services. Conversely, DVHA must permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

2.7 Covered Services

(a) The *Global Commitment to Health Medicaid 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 to be made available through its public insurance programs to beneficiaries in the *Global Commitment to Health Medicaid Demonstration*, including all State of Vermont plan services.

(b) ***Emergency Care.***

(i) DVHA must cover and pay for emergency services received by beneficiaries 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 a beneficiary has an emergency medical condition (according to the prudent layperson standard) or is instructed by a representative of DVHA or an Intragovernmental Partner to seek emergency services, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(ii) DVHA may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. DVHA may further not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital, or

(iii) fiscal agent to notify the beneficiary's provider, the responsible Department, or DVHA of the beneficiary's screening and treatment within 10 calendar days of the beneficiary'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.

(iv) DVHA may not hold a beneficiary who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.

(v) DVHA is responsible for coverage and payment of services until the attending emergency physician, or the provider actually treating the beneficiary, determines that the beneficiary is sufficiently stabilized for transfer or discharge. The provider's determination is binding on DVHA.

(c) ***Post-Stabilization Care Services.***

(i) DVHA must cover post-stabilization care services obtained within or outside DVHA's provider network that are:

(1) Pre-approved by a DVHA provider or representative; or

(2) Not pre-approved by a DVHA provider or representative but administered to maintain the beneficiary's stabilized condition within one hour of a request to DVHA for pre-approval of further post-stabilization care.

(3) Not pre-approved but are administered to maintain, improve or resolve a beneficiary's stabilized condition if:

a. DVHA does not respond to a request for pre-approval within one hour;

b. DVHA cannot be contacted; or

c. DVHA's representative and the treating physician cannot agree concerning the beneficiary's treatment and DVHA does not have a physician available for consultation. In this situation, DVHA must allow the treating physician to continue with the care of the beneficiary until the DVHA physician is reached or the beneficiary is discharged.

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

(1) DVHA-contracted physician who has privileges at the treating hospital assumes responsibility for the beneficiary's care;

(2) DVHA-contracted physician assumes responsibility for the beneficiary's care through transfer;

(3) DVHA and the treating physician reach an agreement concerning the beneficiary's care; or

(4) The beneficiary is discharged.

(iii) DVHA shall limit charges to beneficiaries for post-stabilization care services to an amount no greater than what DVHA would charge the beneficiary if the beneficiary had obtained the services through DVHA.

(d) ***Family Planning.*** DVHA is prohibited from restricting the beneficiary's free choice of family planning services and supplies providers.

(e) ***Access to Women's Health Specialist.*** If a female beneficiary's designated primary care physician is not a women's health specialist, the contract requires DVHA to provide the beneficiary with direct access to a women's health specialist within the provider network for covered routine and preventive women's health care services.

(f) ***Second Opinion.*** DVHA must enable a beneficiary to obtain a second opinion from a network provider or arrange for the ability of the beneficiary to obtain a second opinion outside of the network, at no cost to the beneficiary.

(g) ***Unavailable Necessary Medical Services.*** If DVHA's provider network is unable to provide necessary medical services covered under the contract to a particular beneficiary, DVHA must adequately and timely cover the services out of network, for as long as DVHA's provider network is unable to provide them. DVHA must coordinate payment with out- of-network providers and ensure the cost to the beneficiary is no greater than it would be if the services were furnished within the network.

(h) ***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.

(i) ***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 SSA. DVHA will:

(i) Collect drug utilization data that is necessary for the State of Vermont 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 DVHA, including procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program.

(ii) 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.

(iii) Provide a detailed description of its drug utilization review program activities to AHS on an annual basis.

(iv) Conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the SSA Act.

(j) ***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.

(i) DVHA may cover, in addition to services covered under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR Part 438, subpart K.

(ii) If DVHA does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to beneficiaries through a contract with AHS, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(iii) If DVHA includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to beneficiaries through a contract with AHS, it must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

(iv) If DVHA includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to beneficiaries through a contract with AHS, it must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.905(e)(ii).

(v) DVHA must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to beneficiaries.

(vi) If a beneficiary is provided mental health or substance use disorder

benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the beneficiary in every classification in which medical/surgical benefits are provided.

(vii) DVHA may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established medical/surgical benefits in the same classification.

(viii) DVHA may not impose Non-Quantitative Treatment Limitations (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of DVHA as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

(k) ***Long-Term Services and Supports (LTSS) Settings.*** LTSS services must be delivered in settings in compliance with the requirements specified in 42 CFR 441.301(c)(4).

(l) ***Limitations on Coverage for Abortion. DVHA*** may cover abortions in the following situations:

(i) If the pregnancy is the result of an act of rape or incest; or

(ii) 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.

(iii) No other abortions can be covered under this Agreement.

2.8 Medical Necessity

(a) DVHA will cover the services specified under the *Global Commitment to Health Medicaid 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 meet 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.

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

(c) Medical necessity determinations as to State Plan covered services will be made by the Medical Director of DVHA or designee, and, as to non-State Plan waiver services, upon collaboration of DVHA's Intragovernmental Partners. Ultimate authority in such determinations lies with AHS, as the entity to which *Global Commitment to Health Medicaid Demonstration* beneficiaries have the right to appeal.

(d) Within the limits of the benefit plan, DVHA and its Intragovernmental Partners have the responsibility for establishing procedures for referrals and when prior authorization is required.

2.9 Non-Payment

(a) ***Provider-Preventable Conditions***. DVHA is prohibited from making payment for provider-preventable conditions that: are identified in the State Plan; have been found by AHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; have a negative consequence for the beneficiary; are auditable; and include, at a minimum, a wrong surgical or other invasive procedure performed on a patient; a surgical or other invasive procedure performed on the wrong body part; or a surgical or other invasive procedure performed on the wrong patient. DVHA must report all identified provider- preventable conditions in a form and frequency as specified by AHS.

(b) ***Organ Transplants.*** DVHA is prohibited from paying for organ transplants unless the State Plan provides, and ***DVHA*** follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to beneficiaries.

(c) ***Excluded Providers.*** DVHA is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

(d) Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

(i) Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

(ii) Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity unless the state determines there is good cause not to suspend such payments;

(iii) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997; and

(iv) With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

2.10 Payments

(a) DVHA is responsible for ensuring timely payments to contracted providers.

(b) ***Balance Billing.*** DVHA must require that its providers and subcontractors

may not bill beneficiaries, for covered services, any amount greater than would be owed if DVHA paid for the services directly (i.e., no balance billing by providers).

(c) ***Physician Incentive Plan.*** DVHA may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit medically necessary services to a beneficiary.

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

(e) ***Rate*** Approvals.

(i) DVHA need not obtain AHS approval for reimbursement arrangements between DVHA and providers that are based on fee-for-service arrangements.

(ii) DVHA must work with AHS to obtain the prior approval of CMS (pursuant to the processes described in 42 CFR 438.6(c)(2)) for any reimbursement arrangements between DVHA and providers that are a value-based payment style fee schedule consistent with the descriptions in 42 CFR 438.6(c)(1)(i) and (ii).

(f) ***Beneficiary 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). Beneficiary cost-sharing shall be in accordance with the premium and co-payment provisions of the program as established under the State Plan and STC #5 of the *Global Commitment to Health Medicaid Demonstration*.

(g) ***Other Beneficiary Responsibilities.*** Medicaid beneficiaries will not be held liable when DVHA denies a claim from the health care provider who furnished the services. Medicaid beneficiaries are further not liable for payments for covered services furnished under a contract, referral, or other arrangements to the extent that those payments are in excess of the amount that the beneficiary would owe if DVHA provided the services directly.

2.11 Care Coordination

(a) DVHA shall ensure that each beneficiary has an ongoing source of care and an individual or entity formally designated as primarily responsible for coordinating their services. DVHA shall provide the beneficiary with information on how to contact their designated person or entity.

(b) DVHA must implement procedures to coordinate services furnished to a beneficiary between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays, and with the services the beneficiary receives from community and social support providers.

(c) DVHA must make its best efforts to conduct an initial screening of each beneficiary's needs, within 90 days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful. DVHA must share the results of any identification and assessment of a beneficiary's needs to AHS.

(d) DVHA must ensure that each provider furnishing services to beneficiaries maintains and shares a beneficiary health record in accordance with professional standards.

(e) DVHA must ensure that, in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, to the extent that they are applicable.

2.12 Authorization

(a) The term "service authorization request" means a *Global Commitment to Health* Demonstration beneficiary's request for the provision of a service, or a request by the beneficiary's provider. DVHA shall, and will require its Intragovernmental Partners to, 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. Additionally, the authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits set forth in 42 CFR 438.910(d).

(b) DVHA will ensure and will require its Intragovernmental Partners to ensure consistent application of review criteria for authorization decisions. Information on the timing of adverse benefit determinations is outlined in Section 2.18(b) of this Agreement.

(c) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the beneficiary's medical, behavioral health, or LTSS needs. When appropriate in the authorization process, DVHA must consult with the requesting provider for medical services.

(d) DVHA is required to authorize LTSS based on a beneficiary's current needs assessment and consistent with the person-centered service plan described in Section 2.14 of this Agreement.

2.13 Quality and Utilization Management

(a) 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 beneficiary.

(b) DVHA must establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes to its beneficiaries.

(c) DVHA's QAPI must have in effect mechanisms to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care furnished to beneficiaries 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).

(d) DVHA's comprehensive QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to beneficiaries using LTSS, including:

(i) An assessment of care between care settings; and

(ii) A comparison of services and supports received with those set forth in the beneficiary's treatment/service plan.

(e) With respect to LTSS, DVHA must participate in efforts by the state to prevent, detect, and remediate critical incidents, consistent with assuring beneficiary health and welfare, that are based, at a minimum, on the requirements of the state for home and community- based waiver programs.

(f) DVHA shall, and will require its Intragovernmental Partners to, maintain an ongoing program of Performance Improvement Projects (PIPs) that focuses on clinical and non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction. The PIPs shall involve the following:

(i) Measurement of performance using objective quality measures;

(ii) Implementation of system interventions to achieve improvements in quality;

(iii) Evaluation of the effectiveness of the interventions;

(iv) Planning and initiation of activities for increasing or sustaining improvement; and

(v) Reporting the status and results of each project to AHS as requested and in a timely manner, but not less than once a year.

(g) DVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. The practice guidelines must consider the

needs of beneficiaries and must be adopted in consultation with network providers. The practice guidelines must be reviewed and updated periodically as appropriate. Practice guidelines must be disseminated to all affected providers, and to all beneficiaries and potential beneficiaries upon request. Decisions regarding utilization management, beneficiary education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines.

(h) DVHA must annually measure and report to AHS on its performance using the standard measures required by AHS.

2.14 Assessment and Treatment Plans for Special Health Care Needs and LTSS

(a) ***Assessment.***

(i) DVHA shall, and will require its Intragovernmental Partners to, maintain mechanisms to comprehensively assess each beneficiary identified as having special health care needs in order to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring.

(ii) DVHA shall, and will require its Intragovernmental Partners to, also maintain mechanisms to identify persons who need LTSS as defined by the AHS to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring.

(iii) The assessment mechanisms must use appropriate care professionals.

(b) ***Special Health Care Needs.***

(i) Participants in the following programs are identified by AHS as having special health care needs:

(1) Developmental Services, Traumatic Brain Injury, Choices for Care MLTSS program (DAIL).

(2) Community Rehabilitation and Treatment (for adults with serious and persistent mental health treatment needs), and Enhanced Family Treatment for mental health under 22 (for children with a severe emotional disturbance) (DMH).

(ii) For beneficiaries with special health care needs who are determined through the assessment above to need a course of treatment or regular care monitoring, DVHA must and will require its Intragovernmental Partners to have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

(c) ***Treatment Plan.***

(i) DVHA must produce a treatment or service plan for:

(1) Beneficiaries who require LTSS; and

(2) Beneficiaries with special health care needs that are determined through the assessment above to need a course of treatment or regular care monitoring.

(ii) The treatment or service plan for beneficiaries who require LTSS must be:

(1) Developed by an individual meeting LTSS service coordination requirements with beneficiary participation, and in consultation with any providers caring for the beneficiary;

(2) 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);

(3) Developed in accordance with any applicable AHS quality assurance and utilization review standards; and

(4) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR 441.301(c)(3).

(iii) The treatment or service plan for beneficiaries with special health care needs must be:

(1) Developed in accordance with any applicable AHS quality assurance and utilization review standards; and

(2) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly.

2.15 Advance Directives

(a) DVHA must maintain written policies and procedures on advance directives for all adults receiving medical care by or through DVHA, including a description of applicable state law (which must be updated as soon as possible, but no later than 90 days after the effective date of a change in state law on advance directives).

(b) DVHA is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive.

(c) DVHA must educate staff concerning their policies and procedures on advance directives.

2.16 Beneficiary Rights

(a) DVHA must have written policies guaranteeing each beneficiary's right to:

(i) Receive information on their plan;

(ii) Be treated with respect and with due consideration for their dignity and privacy;

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;

(iv) Participate in decisions regarding their health care, including the right to refuse treatment;

(v) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected.

(b) Each beneficiary is free to exercise his or her rights without DVHA or its network providers treating the beneficiary adversely.

2.17 Subcontracts

(a) A subcontractor refers to 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 Medicaid Demonstration. A network provider is not a subcontractor by virtue of the DVHA provider agreement.

(i) DVHA may subcontract with entities within or outside of State government to provide services under the Global Commitment to Health Medicaid Demonstration. Contracts with outside entities will follow all necessary State and federal procurement rules and approvals.

(ii) IGAs with Intragovernmental Partners and 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. Written agreements with such Intragovernmental Partners must specify that the Intragovernmental Partners are required to adhere to all applicable Medicaid laws, regulations, sub regulatory guidance, and contract provisions, and must require the Intragovernmental Partners to comply with 42 CFR 438 as if they were operating as subcontractors of a non-risk PIHP.

(b) If any of DVHA's activities or obligations under this Agreement are delegated to a subcontractor:

(i) The activities and obligations, and related reporting responsibilities, must be specified in a contract or written agreement between DVHA and the subcontractor;

(ii) The contract or written arrangement between DVHA and the subcontractor must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where AHS or DVHA determines that the subcontractor has not performed satisfactorily.

(iii) DVHA must maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement, notwithstanding any relationship(s) that DVHA may have with any subcontractor.

(iv) Any contracts or written arrangements for services pertinent to the Global Commitment to Health *Medicaid Demonstration* must provide that:

(1) AHS, CMS, the United States Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computers, 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 DVHA's contract with the state;

(2) The subcontractor is required to make available, for the purposes of an audit, evaluation, or inspection by AHS, CMS, the HHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid beneficiaries;

(3) The right to audit by AHS, CMS, the HHS Inspector General, the Comptroller General, or their designees, 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; and

(4) If AHS, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

2.18 Grievances and Appeals

(a) ***In General.***

(i) DVHA must have a grievance and appeal system in place.

(ii) DVHA must give beneficiaries any reasonable assistance in completing grievance and appeal forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with Teletypewriter Telephone/Telecommunication Device for the Deaf (TTY/TDD) and interpreter capability.

(iii) DVHA must acknowledge receipt of each grievance and appeal of adverse benefit determinations.

(iv) DVHA must ensure that any decision-makers on grievances and appeals of adverse benefit determinations:

(1) Were not involved in any previous level of review or decision-making, or subordinates of any individual who was involved in a previous level of review or decision-making;

(2) Are individuals with appropriate clinical expertise, as determined by AHS, in treating the beneficiary's condition or disease if the decision involves an appeal of a denial based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeal involving clinical issues; and

(3) Take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

(b) ***Notices of Adverse Benefit Determination.***

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

(1) The adverse benefit determination that DVHA has made or intends to make;

(2) The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable and timely access to and copies of all 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;

(3) The beneficiary's right to request an appeal of DVHA's adverse benefit determination including information about the procedures and timeframes for exercising these rights;

(4) The circumstances under which an appeal process can be expedited and how to request it; and

(5) The beneficiary'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 beneficiary may be required to pay the costs of these services.

(ii) With respect to timing, DVHA must provide notice:

(1) For denial of payment, on the date of the determination.

(2) 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 of the request for service. DVHA may take an extension of up to 14 additional calendar days if the beneficiary or provider requests the extension; or the DVHA justifies to AHS upon request of the need for additional information and how the extension is in the beneficiary's best interest.

(3) For cases in which a provider indicates, or DVHA determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, as expeditiously as the beneficiary's health requires and not more 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 beneficiary requests the extension, or if DHVA justifies to AHS (upon request) a need for additional information and how the extension is in the beneficiary's interest. If this timeframe is extended, DVHA must give the beneficiary written notice of the extension, the reason for the extension, and the beneficiary's rights to appeal this decision.

(4) 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).

(5) At least 10 days before the effective date of adverse benefit determination when it is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

(6) When any of the following occur, a notice of adverse benefit determination must be mailed by the date of the action:

a. The recipient has died.

b. The beneficiary submits a signed written statement requesting service termination.

c. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.

d. The beneficiary has been admitted to an institution where he or she is ineligible under the plan for further services.

e. The beneficiary's address is determined unknown based on returned mail with no forwarding address.

f. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

g. A change in the level of medical care is prescribed by the beneficiary's physician.

h. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.

i. The transfer or discharge from a facility will occur in an expedited fashion.

(iii) In the event that DVHA fails to adhere to notice and timing requirements, the beneficiary is deemed to have exhausted the appeals process and the beneficiary may initiate a State Fair Hearing.

(c) ***Filing Appeals.***

(i) DVHA must allow beneficiaries to file appeals. DVHA must also allow providers, or authorized representatives, acting on behalf of the beneficiary and with the beneficiary's written consent, to request an appeal. DVHA must consider the beneficiary, his/her representative, or the legal representative of a deceased beneficiary's estate as parties to an appeal.

(ii) Appeals may be filed within 60 calendar days from the date on the adverse benefit determination notice.

(iii) Beneficiaries, or their providers or authorized representatives, may file appeals orally or in writing for any DVHA adverse benefit determination. Oral inquiries to an internal appeal of an adverse benefit determination must be treated as appeals to establish the earliest possible filing date.

(iv) DVHA must provide each beneficiary seeking an appeal a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

(v) DVHA must provide each beneficiary and his or her representative with the beneficiary's case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by DVHA (or at the direction of DVHA)) in connection with the appeal of an adverse benefit determination. DVHA must provide the case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

(d) ***Standard Appeals.***

(i) Appeals shall be decided, and written notice sent to the beneficiary as expeditiously as the beneficiary's health requires and not more than 30 days after 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 Designated Agency(DA)/Specialized Service Agency (SSA).If an appeal cannot be resolved within 30 days, the timeframe 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, DVHA must resolve the appeal as expeditiously as the beneficiary's health condition requires and not later than the date the extension expires.

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

(e) ***Expedited Appeals.***

(i) DVHA must establish and maintain an expedited review process for appeals, when DVHA determines (for a request from the beneficiary) or when the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(ii) Expedited appeals must be resolved as expeditiously as the beneficiary's health condition requires and no later than 72 hours from the date DVHA receives the appeal request.

(1) DVHA may extend the expedited appeal resolution timeframe up to a maximum of 14 calendar days if the beneficiary requests the extension, or if DVHA demonstrates (including to the satisfaction of AHS, upon its request) that there is a need for additional information and how the delay is in the best interest of the beneficiary.

(2) If the expedited appeal timeline is extended not at the request of the beneficiary, DVHA must make a 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 beneficiary 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 beneficiary's health condition requires but not later than the date the extension expires.

(iii) DVHA must inform beneficiaries of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. DVHA must inform beneficiaries of this sufficiently in advance of the resolution timeframe for appeals.

(iv) If DVHA denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than 30 calendar days from the day the MCP receives the appeal (with a possible 14-day extension).

(f) ***Notice of Resolution for Appeals.***

(i) When an appeal has been resolved, DVHA must provide the beneficiary with a written decision that complies with HCAR 8.100.3(c), including the results of the appeal resolution and the date of the resolution.

(ii) For decisions not wholly in the beneficiary's favor, DVHA must include the following in the written resolution notice:

(1) The right to request a State Fair Hearing;

(2) How to request a State Fair Hearing;

(3) The right to request and receive benefits pending a State Fair Hearing, and how to request the continuation of benefits; and

(4) Notice that the beneficiary may, consistent with state policy, be liable for the cost of any continued benefits if DVHA's adverse benefit determination is upheld in the hearing.

(iii) DVHA must provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited appeal.

(g) ***Continuation of Benefits.***

(i) DVHA must continue the beneficiary's benefits while an appeal is in process if all of the following occur:

(1) The beneficiary files the request for an appeal within 60 calendar days following the date on the adverse benefit determination notice.

(2) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(3) The beneficiary's services were ordered by an authorized provider.

(4) The period covered by the original authorization has not expired.

(5) The request for continuation of benefits is filed on or before the later of the following:

a. Within 10 calendar days of the MCP sending the notice of adverse benefit determination; or

b. The intended effective date of the proposed adverse benefit determination.

(ii) If at the beneficiary's request, DVHA continues or reinstates the beneficiary's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs: (1) The beneficiary withdraws the appeal or request for State Fair Hearing; (2) the beneficiary does not request a State Fair Hearing and continuation of benefits within 10 calendar days from the date the MCP sends the notice of an adverse appeal resolution; or (3) a State Fair Hearing decision adverse to the beneficiary is issued.

(iii) The beneficiary may be liable for the cost of any continued benefits while the appeal or State Fair Hearing is pending if the final decision is adverse to the beneficiary.

(iv) If DVHA (during an internal appeal) or the State fair hearing officer (during a State fair hearing) 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.

(v) DVHA shall notify the requesting provider and issue written notices to beneficiaries for any decision to deny a service, or to authorize a service in an amount, scope, or duration less than that requested.

(h) ***Grievances.***

(i) A beneficiary may file a grievance at any time, either orally or in writing, to DVHA only.

(ii) All grievances shall be addressed as expeditiously as the beneficiary'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 beneficiary requests an extension or DVHA shows AHS (upon request) that there is need for additional information and that the delay is in the beneficiary's interest. If the grievance timeline is extended not at the request of the beneficiary, DVHA must make a 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 beneficiary of the right to file a grievance if s/he disagrees with the decision to extend the timeline.

(iii) DVHA must notify beneficiaries of the resolution of a grievance according to a method approved by AHS in a format and language that, at a minimum, meets applicable notification standards.

(i) ***Grievance and Appeal Recordkeeping Requirements.*** DVHA must maintain records of grievances and appeals, which must be accurately maintained in a manner accessible to AHS and available upon request to CMS, and which must include:

(i) A general description of the reason for the appeal or grievance.

(ii) The date received.

(iii) The date of each review or, if applicable, review meeting.

(iv) Resolution information for each level of the appeal or grievance, if applicable.

(v) The date of resolution at each level, if applicable.

(vi) The name of the covered person for whom the appeal or grievance was filed.

2.19 Third-Party Liability Activities

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 TPL must include the identification and review of claims with diagnosis codes indicative of trauma, injury, poisoning, and other consequences of external causes.

2.20 Health Information Systems and Beneficiary Data

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

(b) The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

(c) DVHA must comply with Section 6504(a) of the Affordable Care Act, which requires that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act.

(d) DVHA must collect data on the beneficiary and provider characteristics as specified by AHS and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by AHS.

(e) DVHA must verify the accuracy and timeliness of data reported by providers, including data from network providers DVHA is compensating on the basis of capitation payments. DVHA must screen the data received from providers for completeness, logic, and consistency. DVHA must collect data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts. DVHA must make all collected data available to AHS and, upon request, to CMS.

(f) DVHA must implement an Application Programming Interface (API) that meets the criteria specified at 42 CFR 431.60 and include(s):

(i) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one business day after a claim is processed;

(ii) Encounter data, including encounter data from any network providers DVHA is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors no later than one business day after receiving the data from providers;

(iii) Clinical data, including laboratory results, if DVHA maintains any such data, no later than one business day after the data is received; and

(iv) Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information.

(g) DVHA must implement and maintain a publicly accessible standards- based API as described in 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).

(h) DVHA must collect and maintain sufficient beneficiary encounter data to identify the provider who delivers any item(s) or service(s) to beneficiaries. DVHA must submit such beneficiary encounter data to AHS at a frequency and level of detail to be specified by CMS and AHS, based on program administration, oversight, and program integrity needs.

ARTICLE III: AHS RESPONSIBILITIES

3.1 General Oversight

(a) When there are multiple entities involved in the administration of the *Global Commitment to Health Medicaid Demonstration*, AHS must maintain authority, accountability, and oversight of the program. AHS must exercise oversight of all delegated functions to the Intragovernmental Partners and any other contracted entities.

3.2 Eligibility Determination, Enrollment, and Disenrollment

(a) The health care eligibility units (HCEUs) 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 Medicaid Demonstration*.

(b) The HCEUs shall ensure that all beneficiaries enrolled in the Global Commitment to Health Medicaid Demonstration are assigned a unique beneficiary identification number and a Medicaid eligibility classification as applicable.

(c) The HCEUs shall be responsible for all eligibility determinations, including verification of the current status of an individual's Medicaid eligibility.

(d) The HCEUs must accept new enrollment from prospective beneficiaries in the order in which they apply for Medicaid.

(e) The HCEUs are prohibited from discriminating against or using any policy or procedure that has the effect of discriminating against, individuals eligible 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. The HCEUs shall work with DVHA to ensure that Vermont Medicaid providers accept and serve all individuals eligible for, and enrolled in, the *Global Commitment to Health Medicaid Demonstration.*

(f) ***Loss of Eligibility/Disenrollment from the Demonstration.*** The HCEUs shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Medicaid Demonstration*. Loss of eligibility may occur due to:

(i) Death;

(ii) Movement of residence out of the State of Vermont;

(iii) Incarceration;

(iv) No longer meeting the eligibility requirements for medical assistance under the *Global Commitment to Health Medicaid Demonstration*;

or

(v) The beneficiary's request to have his/her eligibility terminated and to be disenrolled from the program, for cause or without cause.

(g) ***Disenrollment***.

(i) In the event that a beneficiary requests to have his/her eligibility terminated and to be disenrolled from the program, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the beneficiary requests disenrollment.

(ii) The HCEUs shall not disenroll any individual except those who have lost eligibility as specified under 2.1(f) of this IGA. This prohibition specifically includes disenrollment on the basis of an adverse change in the beneficiary's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

3.3 Per Member Per Month (PMPM) Rate Setting

(a) AHS shall establish fixed monthly rates for *Global Commitment to Health Medicaid Demonstration* beneficiaries. 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 rates must be developed consistent with the requirements in 42 CFR 438.5 and based on DVHA's actual experience and expected costs.

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

(i) The provider reimbursement rates are not based on the rate of federal financial participation associated with the covered populations;

(ii) The provider reimbursement rates are appropriate for the populations to be covered and the services to be furnished under the contract; and

(iii) The provider reimbursement rates are adequate to meet the requirements for MCOs, PIHPs, and PAHPs in 42 CFR 438.206, 438.207, and 438.208.

3.4 Payments

(a) AHS must ensure that no payment is made to a network provider other than by DVHA for services covered under the Global Commitment to Health Medicaid Demonstration, except when these payments are specifically required to be made by the state in Title XIX of the Act, in 42 CFR, or when AHS makes direct payments to network providers for graduate medical education costs approved under the state plan.

(b) When the amount an IHCP receives from DVHA is less than the amount the IHCP would have received under the applicable encounter rate published annually in the Federal Register by the IHS, AHS must make a supplemental payment to the IHCP to make up the difference

between the amount DVHA pays and the amount the IHCP would have received under the applicable encounter rate.

(c) AHS may establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved state plan. AHS must use a public notice process for setting payment rates in accordance with 42 CFR 447.205, except that, the state must publish a summary of comments, the state's responses, and decisions on the Global Commitment Register website. For purposes of monitoring, AHS must submit to CMS a notification of public notice compliance, such as notification of the beginning and end of the public notice period through the Global Commitment Register listserv and noting compliance in the annual report.

3.5 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 rulemaking, Medicaid State Plan Amendments (SPAs), and consultation on Medicaid program changes.

3.6 Program Integrity

(a) AHS must have processes in place to ensure there is no duplication of federal funding for any aspect of the Global Commitment to Health Medicaid Demonstration.

(b) AHS must establish processes for the oversight and monitoring of the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by DVHA and network providers.

(c) AHS and DVHA shall comply with all requirements of 42 CFR 438, subpart H, with AHS as the state and DVHA as a PIHP unless specified herein. All program integrity requirements in federal statute and regulations that are required of the state in its oversight of a non-risk PIHP shall be the direct responsibility of AHS and may not be delegated to DVHA.

(d) If AHS learns that DVHA has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, or an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if DVHA has a relationship with an individual who is an affiliate of such an individual, AHS may continue an existing agreement with DVHA unless the Secretary directs otherwise. However, AHS 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 despite the prohibited affiliation.

(e) AHS will review the ownership and control disclosures submitted by DVHA and any of DVHA's subcontractors.

(f) AHS must ensure that DVHA and any of its contractors follow standard program integrity principles and practices, including retention of data.

(g) AHS must annually review DVHA's written policies, procedures, and standards of conduct that articulate DVHA's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.

3.7 Oversight and Performance Evaluation.

(a) AHS will be responsible for oversight of DVHA as 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.

(b) AHS will ensure compliance with 42 CFR 438.66 by ensuring its Medicaid compliance policies and procedures continue to provide for a formal, documented process for comprehensive program integrity oversight of DVHA.

(c) In accordance with 42 CFR 438.66, AHS will implement procedures for monitoring all aspects of the managed care program, including DVHA's performance in at least the following areas:

(i) Administration and management;
(ii) Appeal and grievance systems;
(iii) Claims management;
(iv) Beneficiary materials and customer services, including the activities of the beneficiary support system;
(v) Finance, including medical loss ratio reporting;
(vi) Information systems, including encounter data reporting;
(vii) Marketing;
(viii) Medical management, including utilization management and case management;
(ix) Program integrity;
(x) Provider network management, including provider directory standards;
(xi) Availability and accessibility of services, including network adequacy standards;
(xii) Quality improvement;
(xiii) Areas related to the delivery of LTSS not otherwise included above; and
(xiv) All other provisions of the contract, as appropriate.

(d) The External Quality Review Organization (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 EQRO in order to obtain independent monitoring of DVHA's Quality Management Program. AHS shall be responsible for the evaluation, interpretation, and enforcement of findings issued by the EQRO.

(e) In its role as single state agency, AHS will ensure a managed LTSS plan for a comprehensive care model is developed that promotes the integration of home and community-based services, institutional, acute, primary, and behavioral health care.

(f) AHS must meet the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and

requirements across the state's Medicaid program.

3.8 Centers for Medicare and Medicaid Services (CMS) Reporting

AHS shall retain responsibility for the production and submission of reports to 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.

3.9 Beneficiary Support System

AHS shall develop and implement a beneficiary support system consistent with the requirements of 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 with managed long-term services and supports operated by DVHA.

3.10 Third-Party Liability Activities

AHS shall monitor DVHA's experience in identifying sources of TPL (see Section 2.19) or coverage and in collecting funds due to it through these sources.

3.11 Network Adequacy

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

(i) Anticipated enrollment in the Global Commitment to Health Medicaid Demonstration;
(ii) Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
(iii) That services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;
(iv) Number and types of providers required to furnish the contracted services;
(v) Number of providers who are not accepting new patients;
(vi) Geographic location of providers and Global Commitment to Health Medicaid Demonstration beneficiaries, considering distance, travel time, the means of transportation ordinarily used by beneficiaries, and whether the location(s) provide physical access for beneficiaries with disabilities;

(vii) The ability of providers to communicate with limited English proficient beneficiaries in their preferred language;

(viii) The ability of providers to ensure physical access, reasonable

accommodations, culturally competent communications, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities;

(ix) 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.

(x) Elements that would support a beneficiary's choice of provider;

(xi) Strategies that would ensure the health and welfare of the beneficiary and support community integration of the beneficiary; and

(xii) Other considerations that are in the best interest of the beneficiaries that need LTSS.

(b) AHS must ensure that DVHA maintains a network of appropriate providers to furnish adequate access to all covered *Global Commitment to Health Medicaid Demonstration* services.

3.12 State Fair Hearings

(a) AHS shall alone be responsible for developing and implementing State Fair Hearing rules and policies.

(b) AHS shall be responsible for ensuring that State Fair Hearing rules, policies, and practices comply with the federal statutes and regulations, including provisions applicable to DVHA operations.

(c) 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 in Section 2.18(b)(iii). 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.

(d) Beneficiaries have the right to file requests for a State Fair Hearing related to eligibility and premium determinations. With the written consent of the beneficiary, a provider or an authorized representative may request a State Fair Hearing on behalf of the beneficiary. The beneficiary, his/her representative, or the representative of a deceased beneficiary's estate shall be parties to a State Fair Hearing.

(e) 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 beneficiary and provider information within the contract.

(f) AHS will accept a timely request for a State Fair Hearing from a beneficiary and will process the request without delay. A timely request for a State fair hearing means that a beneficiary has requested the State Fair Hearing: within 120 days of the date the notice of resolution of the internal appeal was mailed to the beneficiary 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.

(g) 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 as set forth above in Section 2.18(b)(iii).

(h) Expedited State Fair Hearing shall be resolved as expeditiously as the beneficiary'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 AHS 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.

ARTICLE IV: PMPM RATES AND PAYMENT PROVISIONS

4.1 PMPM Rates

(a) The PMPM rate process and resulting rates are mechanisms that support program monitoring but do not affect available program funding. 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.

(b) DVHA must maintain an MLR of at least 85 percent. If DVHA is unable to maintain at least an 85 percent MLR, the PMPM capitation rates must be reduced to the extent necessary to achieve an 85 percent medical loss ratio.

(c) The PMPM capitation rate will:

(i) Be developed for 12-month periods consistent with the requirements in 42 CFR 438.5 and based on DVHA's actual experience and expected costs;

(ii) 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 Medicaid Demonstration STCs. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and 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);

(iii) Include only costs for services included under 42 CFR 438.3(c)(1)(ii) and services specifically authorized in the Global Commitment to Health Medicaid Demonstration STCs; and

(iv)

(v) Not include any costs for "investments" as described in STC #11.1.

(d) Global *Commitment to Health Medicaid Demonstration* PMPM fixed rates for the period from January 1, 2024, through December 31, 2024, are found in the table below.

Medicaid Eligibility Group (MEG)	CY 2024 PMPM
ABD Dual	$2,401.63
ABD Non-Dual Adult	$2,878.95
ABD Non-Dual Child	$3,257.75
Non - ABD Adult	$608.67
Non - ABD Child	$586.98
Moderate Needs Group	$689.01
New Adult	$584.43
Global Rx	$172.29

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, 2024 - December 31, 2024.

Agreed to:

DocuSigned by:
Jenney Samuelson
C3FDC5F53361483...

Jenney Samuelson, Secretary
Agency of Human Services

Date: 12/29/2023

DocuSigned by:
Addie Strumolo
ABEDE75BDF50473...

Adaline Strumolo, Acting Commissioner
Department of Vermont Health Access (DVHA)

Date: 12/28/2023