



## **Agreement**

**Between**

**Vermont Department of Disabilities,  
Aging & Independent Living**

**and**

**(MYCARE PROVIDER)**

**For Participation in**

***MyCare Vermont  
Integrated Long Term Care Program***

*Preliminary Draft Model Contract  
November 16, 2007*

## **TABLE OF CONTENTS**

<b><u>ARTICLE I: DEFINITIONS</u></b>	<b>Page 4</b>
<b><u>ARTICLE II: SERVICE PROVISION</u></b>	<b>Page 11</b>
<b><u>ARTICLE III: REIMBURSEMENT PROVISIONS</u></b>	<b>Page 45</b>
<b><u>ARTICLE IV: OUTREACH AND ENROLLMENT</u></b>	<b>Page 49</b>
<b><u>ARTICLE V: GRIEVANCES AND APPEALS</u></b>	<b>Page 60</b>
<b><u>ARTICLE VI: QUALITY MANAGEMENT AND UTILIZATION REVIEW</u></b>	<b>Page 61</b>
<b><u>ARTICLE VII: RECORD RETENTION, AUDIT, AND INSPECTION</u></b>	<b>Page 71</b>
<b><u>ARTICLE VIII: CONFIDENTIALITY</u></b>	<b>Page 73</b>
<b><u>ARTICLE IX: TERMS AND CONDITIONS</u></b>	<b>Page 74</b>
<b><u>ARTICLE X: REPORTS</u></b>	<b>Page 79</b>
<b><u>ARTICLE XI: TERMINATION OF AGREEMENT</u></b>	<b>Page 83</b>
<b><u>ARTICLE XII: EFFECTIVE TERM, RENEGOTIATION, AND MODIFICATION</u></b>	<b>Page 85</b>

## **Attachments List**

***[Attachments not included in draft, unless otherwise noted]***

---

- Attachment 1 - *MyCare* Provider Service Area
- Attachment 2 - *MyCare* Provider Maximum Enrollment
- Attachment 3 - Sample Enrollment Agreement
- Attachment 4 - Quarterly Report Formats
- Attachment 5 - Customary State Contract Provisions *(included)*
- Attachment 6 - Business Associate Agreement *(included)*
- Attachment 7 - Agency of Human Services Customary Contract Provisions *(included)*

## **ARTICLE I: DEFINITIONS**

As used in this Agreement, each of the following terms shall have the specified meaning unless the context clearly indicates otherwise.

### **1.1 Action** shall mean:

- A. Denial or limited authorization of a requested service, including the type or level of service.
- B. Reduction, suspension, or termination of a previously authorized service.
- C. Denial, in whole or part, of payment for a service.
- D. Failure to provide services in a timely manner as determined by the Participant.
- E. Failure of *MyCare* Provider to act within the timeframes; or
- F. Denial of a participant's request to obtain services outside the network:
  - i. From any other provider (in terms of training, experience, and specialization) not available within the network
  - ii. From a provider not part of the network who is the main source of a service to the participant - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the participant is given a choice of participating providers and is transitioned to a participating provider within 60 days.
  - iii. Because the only plan or provider available does not provide the service because of moral or religious objections.
  - iv. Because the participant's provider determines that the participant needs related services that would subject the participant to unnecessary risk if received separately and not all related services are available within the network.
  - v. The State determines that other circumstances warrant out-of-network treatment.

### **1.2 Acute/primary care** shall mean medical services including comprehensive care for routine, urgent and chronic medical needs.

### **1.3 Advanced Directives** shall mean a written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated.

- 1.4 Appeal** shall mean a request for review of an action.
- 1.5 Behavioral health** shall mean social, housekeeping and support services to improve or maintain function, health, and/or activities of daily living.
- 1.6 Capitated Services** shall mean those services listed in Article II, Section 2.1 S of this Agreement for which the Provider receives a monthly Capitation Payment from the Department covering the component for which Medicaid is responsible.
- 1.7 Capitation Payment** shall mean the monthly payment issued to the Provider by the Department on behalf of a Participant, in return for which the Provider accepts risk for providing Capitated Services, and the responsibility for fulfilling the terms of this Agreement.
- 1.8 Capitation Rate** shall mean the monthly rate, established by the Department, to which the Provider is entitled for each Participant.
- 1.9 Choices for Care** shall mean the State of Vermont's Section 1115 Demonstration Waiver for long-term care participants.
- 1.10 CMS** shall mean Centers for Medicare and Medicaid Services of the Department of Health and Human Services.
- 1.11 Cold Call Marketing** shall mean any unsolicited personal contact by the Provider with a potential Participant for the purpose of marketing, which is any communication from Provider to a Medicaid Participant who is not enrolled in the plan, that can reasonably be interpreted as intended to influence the Participant to enroll in the Provider's plan, or either to not enroll in, or to disenroll from another Medicaid product.
- 1.12 Community-Based Primary Care Providers** shall mean primary care physicians, specialist physicians and Nurse Practitioners in private or group practice who treat one or more *MyCare Vermont* participants but are not directly employed by the *MyCare* Provider.
- 1.13 Covered Services** shall mean those medically necessary services, listed in Article II, Sections 2.1, S, to which Medicaid-eligible participants are entitled under the current State Plan.
- 1.14 Department of Disabilities, Aging and Independent Living (DAIL or Department)** shall mean the State of Vermont's governmental unit responsible for administration of the *MyCare* program.

- 1.15 Discovery Meeting** shall mean a discussion that includes the Interdisciplinary Team members and participant to identify and explore the participant's goals, desires and strengths, and to build personal relationships between ICT members and the participant.
- 1.16 Emergency Services** shall mean medical care rendered in an inpatient or outpatient setting that is furnished in or out of the provider's service area by a source other than the provider or its contracted providers in response to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- 1.17 Enrollee** shall mean a Participant who is currently enrolled in the Plan.
- 1.18 Enrollment/Disenrollment Process** shall include the actions performed by the Department to make a Medicaid-eligible Participant a member of the Provider's Plan or to discontinue membership in the Plan, and which shall be the catalyst to begin or end the relevant capitation payment. Such enrollment actions shall include, but are not limited to, verifying Medicaid eligibility and placing relevant edit codes in the State's claims processing system to restrict the Participant to services of the Provider for those Capitated Services included under the Plan. Such disenrollment actions shall include, but are not limited to, removing the edit codes, which restrict the Participant to Capitated Services of the Provider.
- 1.19 Ethics Committee** shall mean the advisory body responsible for providing input on decision-making, including delivery of services, end-of-life issues and Advance Directives.
- 1.20 Grievance** shall mean an expression of dissatisfaction about any matter other than an action.
- 1.21 Governing Body** shall mean the Provider's policymaking body, which devotes resources sufficient to effectively plan, organize, administer, oversee and evaluate the operations and performance of the Plan. The Governing Body is responsible for the fiduciary obligations of the Provider and the obligations of the Provider to the Department and the Participants. The Body is composed of individuals with knowledge and experience appropriate to the Body's function.

- 1.22 Intake and Assessment Unit** shall mean that part of the Provider's operation that includes but is not limited to, identifying potential Participants for the Provider's Plan.
- 1.23 Long Term Care** shall mean social, housekeeping and support services to improve or maintain function, health, and/or activities of daily living.
- 1.24 Marketing** means any communication, from MyCare Provider to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MyCare Provider's Medicaid product, or either to not enroll in, or to disenroll from, another MyCare Provider's Medicaid product.
- 1.25 Marketing Materials** means materials that are produced in any medium, by or on behalf of MyCare Provider and can reasonably be interpreted as intended to market to potential participants
- 1.26 Medicaid** shall mean the Medical Assistance Program administered by the Department, pursuant to Title XIX of the Social Security Act.
- 1.27 Medically Necessary Services** shall mean services required to prevent, diagnose and treat health impairments or attain and maintain or regain functional capacity and are no more restrictive than the State Medicaid program.
- 1.28 MyCare Provider** shall mean shall mean the Prepaid Inpatient Health Plan, which delivers a consolidated and coordinated benefit package of health and health-related services to Participants. The range of service of the Plan is described in Article II, Section 2.1 of this Agreement.
- 1.29 MyCare Vermont** shall mean the State of Vermont's integrated long term program, under which DAIL contracts with MyCare Providers for the delivery and coordination of health care services.
- 1.30 Non-Capitated Services** shall mean those medically necessary services to which a Participant is entitled but are not included in the Capitation Payment and are billed fee-for-service under the Plan.
- 1.31 PACE** shall mean the Program of All-inclusive Care for the Elderly (PACE) in accordance with federal legislation. Section 4801 and 4802 of the Balanced Budget Act of 1997 authorized coverage of PACE under the Medicare program and establishment of PACE as a State option under Medicaid. PACE is a risk-based and community-based service program

that provides a complete package of acute and long-term care services to a frail elderly population that meets nursing facility clinical criteria.

**1.32 Participant** shall mean a person who meets the following criteria:

- A. age 18 or older, residing within *MyCare* Provider's service area;
- B. certified as eligible for Vermont's long term care waiver program (*Choices for Care*) and meets the DAIL-defined clinical threshold for the waiver's Highest Need or High Need group.
- C. determined by the *MyCare* Provider at the time of enrollment to be able to live in a community setting without the individual jeopardizing his or her health or safety; and
- D. approved for enrollment by *MyCare* Provider Interdisciplinary Care Team, applying the process and standards described in this section.

**1.33 Participant Advisory Committee** shall mean the advisory group, the membership for which is comprised of least fifty percent participants and participants' family members, responsible for representing the interests of participants and caregivers and providing advice in the areas of participant satisfaction and quality improvement.

**1.34 Participant Handbook** shall mean the manual provided to each participant in order to apprise participant of available services, program policies, and participant rights.

**1.35 Patient Pay** shall mean the total dollar amount of incurred medical expenses for which a Participant is responsible to contribute toward the monthly capitated payment as determined by the Department for Children and Families consistent with the requirements of 42 CFR 447.50 through 447.60.

**1.36 PIHP Physician** shall mean a physician participating as a member of the Team who is licensed to practice in Vermont and who has contracted with, or is employed by, the Provider to furnish services under this Agreement.

**1.37 Post Stabilization Services** shall mean covered services related to an emergency medical condition that are provided after a Participant is stabilized in order to maintain the stabilized condition, or to improve or resolve the Participant's condition.

- 1.38 Potential Enrollee** shall mean an individual who may voluntarily enroll in the Plan heretofore referred to as applicant.
- 1.39 Preparation Meeting** shall mean a discussion between the Case Manager/Social Worker and the participant for the purpose of planning the Discovery Meeting.
- 1.40 Primary Care Provider (PCP)** shall mean the individual primary care physician, nurse practitioner, or physician assistant assigned to the Participant with his/her consent to provide and coordinate the Participant's health care needs and to initiate and monitor referrals for specialized medical services when required.
- 1.41 Private Pay Participant** shall mean an individual who does not meet the Medicaid eligibility criteria but chooses to participate in the Provider's Plan and is responsible for payment of the Provider's Private Pay Premium.
- 1.42 Private Pay Premium** shall mean the monthly payment Private Pay Participants are required to pay to the Provider in order to participate in the Provider's Plan. The capitated payment is at a rate consistent with the market value of services delivered under the Plan and is fixed, regardless of changes in the Participant's health status. The Department must pre-approve the Private Pay Premium if it is different from the Medicaid Capitation Rate.
- 1.43 Professional Advisory Committee** shall mean the advisory group comprised of primary care, acute care and long-term care clinicians, which advises the *MyCare* Provider on development of program policies and ongoing review and evaluation of program performance.
- 1.44 Service Area** shall mean the Provider's geographic area within which Participants must reside in order to enroll in the Provider's Plan, as Shown in Attachment 1 to this Agreement.
- 1.45 Service Authorization** shall mean authorization of a Participant's request for the provision of a service.
- 1.46 Team** shall mean the interdisciplinary care team (ICT) composed of: the participant, or family member/caregiver designee selected by the participant; a Primary Care Provider, who may a primary care physician, nurse practitioner, or specialist physician who agrees to serve a a primary care physician for the participant and meets the DAIL

requirements for performing this role (the Primary Care Provider may be community-based clinician); a Case Manager/Masters Level Social Worker; and a Registered Nurse. Additional team members may include, but need not be limited to: Physical Therapists, Occupational Therapists; Recreational Therapists or Activities Coordinators; Dietitians; Personal Care Assistants; and Drivers or Transportation Representatives.

## **ARTICLE II: SERVICE PROVISION**

### **2.1 Functions and Duties of the Provider** The Provider shall:

- A. Carry-out its responsibilities and serve *MyCare Vermont* participants in accordance with the values and principles of person-centered care, as defined by the State. Person-centered care is customized care that is respectful of, and responsive to, an individual participant's circumstances, preferences, needs and values.

Provider acknowledges that the values and principles underlying the person-centered care approach include the following:

1. Person-Centered Care recognizes the value of each participant.
  2. Person-Centered Care maximizes the participant's independence, and creates desired community connections.
  3. The participant will participate in the Person-Centered Care process to the extent that he or she desires.
  4. Each participant has the right to express preferences and make choices and these shall be actively sought and respected.
  5. Each participant has the right to choose how supports, services and/or treatment are used to maximize his or her personal well-being.
  6. The participant has the right to request a meeting with his/her Interdisciplinary Care Team (ICT).
  7. Accommodations for communication will be made to maximize the participant's ability to express his or her needs and/or desires.
  8. A participant's cultural background and lifestyle shall be recognized and valued in the decision-making process to the extent desired by the participant.
- B. Develop a person-centered care planning process with the following attributes:
1. Collaborative decision-making;
  2. An informed and educated care team;
  3. Coordination and integration of care among providers and across all settings;
  4. Promotion of well-being including physical comfort and emotional support;
  5. Involvement throughout the process, including all ICT meetings, of the participant or a representative selected by the participant (For any participant with dementia or other organic impairments, person centered care must include spouses, guardians or other

- primary caregivers who are likely to be involved in treatment or support plan implementation.); and
6. Involvement of members of the participant's chosen support circle.

The person-centered care planning process will extend beyond the time of the individual's enrollment and will include, at a minimum, the development of an initial Individual Care Plan at time of enrollment; an updated Individual Care Plan within three months of enrollment that further incorporates person-centered care principles; and semi-annual reassessments.

- C. Furnish services through a comprehensive interdisciplinary services delivery system that addresses both health care and long term care needs. *MyCare* Provider shall establish an Interdisciplinary Care Team consisting of, at a minimum:
  1. The participant, or family member/caregiver designee selected by the participant;
  2. Primary Care Provider, who may be a primary care physician, nurse practitioner, or specialist physician who agrees to serve as a primary care physician for the participant and meets the DAIL requirements for performing this role. This individual may be a community-based primary care provider;
  3. Case Manager/Masters Level Social Worker; and
  4. Registered Nurse

When appropriate, other members shall be added to an individual participant's ICT, based on the participant's condition and/or needs. These additional team members may include, but need not be limited to: Physical Therapists, Occupational Therapists; Recreational Therapists or Activities Coordinators; Dietitians; Personal Care Assistants; and Drivers or Transportation Representatives. The composition of the ICT should be appropriate to a participant's age and physical condition.

The team members will be employed by, or staff under contract to, *MyCare* Provider. The team will operate in accordance with the *MyCare Vermont* program requirements and *MyCare* Provider's policies and procedures. It is *MyCare* Provider's responsibility to ensure participant and/or family/caregiver designee involvement with the team to the extent needed or desired by the participant.

Decisions shall be made jointly by all team members, including the participant and/or family/caregiver designee. Each team member is responsible for communicating his or her position on issues and

preferred course(s) of action. Participant participation will be considered satisfactory when the individual is participating to the degree he or she desires and at his or her comfort level. If there is disagreement between the participant/designee and the other team members, the participant/designee has a right of appeal.

Community-based primary care providers include primary care physicians, specialist physicians and Nurse Practitioners in private or group practice who treat one or more *MyCare Vermont* participants but are not directly employed by *MyCare* Provider. Physicians and Nurse Practitioners are eligible to become community-based primary care providers in *MyCare Vermont* if they are licensed in the State of Vermont specializing in family or internal medicine (general or specialty) and agree to act in accordance with the following requirements, in addition to carrying-out the general primary care provider responsibilities:

1. The provider's treatment office must be accessible and in compliance with the Americans for Disability Act standards;
2. The provider must have internet access, preferably high speed such as cable, DSL or a T-1 line;
3. The provider must agree to use an electronic centralized health record provided by *MyCare* Provider for his/her *MyCare Vermont* patient(s);
4. The provider must cooperate with, and participate in, *MyCare* Provider's care, quality and utilization management systems
5. The provider must arrange on-call coverage when he/she is not available. However, this requirement does not relieve *MyCare* Provider of its ultimate responsibility for ensuring medically necessary services are accessible in accordance with program standards.

The community-based primary care provider is not required to attend daily ICT meetings. However, in such case, the ICT must include a Nurse Practitioner. The Nurse Practitioner can serve in lieu of the Registered Nurse, or at *MyCare* Provider's option, in addition to the Registered Nurse. The Nurse Practitioner shall be responsible for updating the primary care provider regarding the substance of the daily meetings.

Employ, or contract with the following clinicians and ensure that the following services are delivered:

1. The Primary Care provider shall:
  - a. Provide initial history and physical exam;

- b. Provide periodic re-evaluation of medical status;
  - c. Provide, in the participant's residence or in an office/clinic setting, evaluation of episodic acute illness;
  - d. Provide prevention and health maintenance education to participant;
  - e. Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from hospital, rehabilitative and nursing facility settings; and
  - f. Order diagnostic or therapeutic interventions.
2. The Case Manager/Masters Level Social Worker shall:
- a. Complete basic psychosocial, environmental and economic assessments;
  - b. Provide on-going coordination of psychosocial services;
  - c. Explore financial options and eligibility for services, including employment services;
  - d. Provide information about and assist participant in maintaining and establishing community links;
  - e. Provide information about and assist participant with housing and transportation issues;
  - f. Assist in crisis intervention;
  - g. Provide assessment and coordination of mental health, alcohol and/or drug abuse services; and
  - h. Coordinate supportive counseling as appropriate.
3. The Nurse Practitioner shall:
- a. Assess physical health status and response to illness and/or disability;
  - b. Assess effectiveness of medications including intended effect, side effects, and participant knowledge and method of administration;
  - c. Provide in-home assessment to identify functional limitations and adaptations to environment;
  - d. Provide face-to-face skilled nursing services as required to manage care and maintain current knowledge of participant needs;
  - e. Delegate appropriate aspects of participant care to supportive home care service providers including Personal Care Attendants (PCAs), Homemakers, or Licensed Nursing Assistants (LNAs); and supervise and evaluate the effectiveness of care given;

- f. Provide, in conjunction with the Primary Care Provider, prevention and health maintenance education to participant;
  - g. Assess the need for and coordinate supportive home care services provided to participant;
  - h. Ensure that the supportive home care provider's written plan is reflective of participant needs, is current, and provides sufficient direction to the supportive home care provider; and
  - i. Communicate acute changes in health status to participant in a timely manner and collaborate with participant in implementing interventions.
- D. Establish, maintain, and require its medical contractors to maintain a medical record for each Participant that is consistent with current professional standards and document all care provided. At a minimum, the Participant's overall medical record shall include the following:
- 1. Participant identifying information, including communication and service accommodations in response to the participant's disability, and spiritual preference, if any;
  - 2. Documentation of contacts with participant, family members and persons giving informal support, if any;
  - 3. Participant's goals;
  - 4. A list of participant's strengths and problems;
  - 5. A summary of the participant's medical and social history prior to joining *MyCare Vermont*;
  - 6. Prescribed medications, including dosages and any known drug contraindications that are participant-specific, and any discontinued medications and the rationale for the discontinuation;
  - 7. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted;
  - 8. Multidisciplinary assessments, including diagnoses, prognoses, reassessments, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;
  - 9. Laboratory, radiology reports and reports from specialists;
  - 10. Documentation about the services being received by the participant from community agencies that are not part of the Provider Network;
  - 11. Physician orders;
  - 12. Disenrollment agreement, if applicable;
  - 13. Participant's individual Advance Directives and health care proxy, recorded and maintained in a prominent place;

14. Plan for emergency conditions and Urgent Care, including identifying information about any emergency contact persons;
15. Emergency code list;
16. Allergies and special dietary needs;
17. Activities of Daily Living (ADLs) deficits, if any; and
18. HIPAA consent forms regarding who may access participant's record.

The DAIL may periodically revise the list of required data elements and/or upgrade to newer versions of SAMS®. *MyCare Vermont* Provider will modify its reporting function in accordance with these changes.

- E. Cooperate with the DAIL in the establishment and updating of centralized, web-based electronic health records for *MyCare Vermont* participants. The records will be maintained either on the state's SAMS® Database or a DataPACE® platform, as directed by the DAIL.
- F. Ensure that the initial Individual Care Plan is developed by the ICT following individual assessments by each discipline. The ICT will take information provided from different disciplines and negotiate a single treatment plan. The Individual Care Plan must be designed to include all aspects of care, allow for on-going interdisciplinary management and reflect the current medical and social management of the participant. This plan will be in force for no more than three months and must be revised by the end of the third month of enrollment to more fully incorporate the participant's goals and desires as expressed during Discovery Meetings.
  1. The Individual Care Plan must be written from the perspective of the participant (e.g., "I will receive X hours of Personal Care Assistant services Daily to help me meet my goal of \_\_\_\_\_"). The plan must include:
    - a. Participant's goals, including therapeutic goals, and the services that will be provided to assist him/her in meeting these goals;
    - b. Level of supervision required to safely care for the prospective participant and support services that have been identified to proactively address health and safety concerns;
    - c. Measurable outcomes to provide benchmarks for measuring progress toward achievement of goals and documentation of progress made toward achieving goals (beginning with first Care Plan update);
    - d. Specific service elements scheduled each month, including

- number and frequency;
- e. Team goals involving two or more disciplines
- f. Medical diagnosis;
- g. Prescribed medications, including dosage and frequency;
- h. Individualized activity plan and specific group activities;
- i. Transportation plan;
- j. Individualized emergency care plan, as described in Article II Section 2.1 F.3, and safety precautions;
- k. Prognosis and prospective length-of-stay in *MyCare Vermont*; and
- l. Fall risk.

If indicated by the prospective participant's needs, the Individual Care Plan also must include goals for rehabilitation, therapeutic diet and dietary counseling, home care, additional assessments by medical specialists and, if applicable, the family's role and responsibility in caring for the prospective participant.

2. Once the initial Individual Care Plan is developed, the ICT will participate in an enrollment conference involving the prospective participant and other Team members. Other key staff should be included as deemed appropriate by the ICT.

The purpose of the enrollment conference will be to:

- a. Review with the prospective participant and family the Team's assessment and proposed Individual Care Plan, the family's expected benefits and costs of service;
- b. Make any necessary changes based upon request from the prospective participant and/or their family;
- c. Obtain consent to the proposed Individual Care Plan from the prospective participant and/or their family; and
- d. Execute the Enrollment Agreement, as described in Article IV Section 4.3 D.

If the applicant or his/her family member/caregiver representative agrees with the Individual Care Plan, signatures confirming the Individual Care Plan will be obtained from the applicant/representative and the primary care physician and the enrollment will be processed.

If the applicant/representative does not agree to the Individual Care Plan developed by the ICT, it will be returned to the ICT by the *Case Manager/Social Worker* for review, renegotiation, and/or compromise of the outstanding issues identified by the applicant/representative. Such review shall be conducted for the purpose of addressing the applicant's goals, desires and concerns to the fullest possible extent.

Following the ICT review, if another meeting is required, another family conference will be held to discuss the final Individual Care Plan and any modifications, and a decision to enroll will be made by the applicant/representative. If the applicant/representative chooses to enroll, the enrollment process will continue. If he/she chooses not to enroll, a referral plan will be completed and referral sources will be notified of the participant's decision not to enroll in *MyCare* Provider's plan.

3. An individualized Emergency Care Plan (ECP) will be established upon Intake at the initial Interdisciplinary Care Team conference. *MyCare* Provider will ensure that this plan:
  - a. Incorporates the expressed health care wishes of the participant with respect to Advance Directives, as conveyed by him/her or designated representative;
  - b. Identifies likely emergency conditions based on the medical conditions of the participant and the signs and symptoms associated with these conditions; and
  - c. Includes information on how to contact the appropriate 911 emergency responders.

G. Conduct a person-centered Preparation Meeting and an initial Discovery Meeting with the participant and members of the ICT within three months of enrollment. The frequency of additional Discovery Meetings shall be determined by the participant and ICT.

1. If the participant desires to actively participate in the process during the Preparation Meeting, the Social Worker/Case Manager will meet with the participant for the purpose of planning the Discovery Meeting. At the Preparation Meeting, the Social Worker/Case Manager will assist the participant in:
  - a. Setting the agenda and priorities for the Discovery Meeting;
  - b. Identifying topics he/she would like to speak about at the Discovery Meeting, including but not limited to the

- participant's goals and desires;
  - c. Identifying who to invite to the Discovery Meeting, such as Interdisciplinary Care Team members, specialists, family members and/or members of a chosen support circle;
  - d. Determining where and when the Discovery Meeting will be held; and
  - e. Selecting the person who will facilitate the Discovery Meeting.
- 2. The purpose of the Discovery Meeting will be to identify and explore the participant's goals, desires and strengths, and to build personal relationships between ICT members and the participant. *MyCare* Provider must develop or adopt a DAIL-approved person-centered planning tool to use at Discovery Meetings. *MyCare* Provider also must ensure that ICT members participate fully in the Discovery Meeting process and incorporate the outcomes of the meetings into the care planning process.
  - a. The participant and other members of the Team and the chosen support circle work collaboratively to define the participant's care plan;
  - b. The care planning process shall honor the participant's preferences, choices and abilities which were identified during the Discovery Meeting;
  - c. Development of goals for the care plan is informed and guided by the participant's strengths, goals and desires as well as by his/her medical needs;
  - d. All supports, services and treatment options to meet the expressed needs and desires of the participant are identified and discussed with the participant;
  - e. All potential sources of volunteer support are considered, including the participant, his/her family, friends, guardian and significant others;
  - f. The participant may express a need or make a request for support, services and/or treatment at any time;
  - g. Health and safety concerns are identified in partnership with the participant, and support services needed to mitigate risks are identified. All members of the ICT shall proactively anticipate potential crisis or emergency situations and develop steps to mitigate identified risks; and
  - h. Strategies, supports, services and/or treatments are selected and the care plan developed to achieve desired goals.

H. Provide each participant with ongoing opportunities to offer feedback on

his/her satisfaction with services, supports and/or treatment he or she is receiving from the ICT and individual providers, and the progress being made toward attaining his/her goals.

- I. Develop and utilize a system to routinely contact participants to determine if they are receiving person-centered care and to obtain suggestions on what improvements can be made. Contactor must take corrective steps as necessary to ensure person-centered care is being delivered when problems are brought to its attention by participants.
- J. Reassess participants at least semi-annually. In addition, the Individual Care Plan must be reviewed and updated as needed whenever the participant's condition changes significantly, as defined below, or at the request of the participant and/or family member/caregiver. The ICT may also determine for some participants that a more frequent assessment is necessary due to extreme frailty or an intervening medical and/or social problem.

A "significant change" is defined as a major decline in the participant's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, or improvement in the participant's status, that has an impact on more than one area of the participant's health status, and that requires interdisciplinary review or revision of the care plan, or both. The *Case Manager/Social Worker*, or designee, will also revise the Individual Care Plan whenever minor changes in the participant's living situation require an integrated interdisciplinary response for appropriate management.

- K. Ensure that ICT members review significant events and progress toward goals or decline in condition since the last assessment; document these on a DAIL-approved reassessment form; and incorporate changes into a revised Individual Care Plan. Decisions will be based on the participant's progress toward achievement of his/her goals; risks related to the participant's condition, particularly medical, functional and psychosocial issues; the participant's ability to manage in his/her present living situation; and the caregiver's ability to provide appropriate care.
- L. Ensure that the participant has the opportunity, to the extent possible, to explore available care options prior to making a decision about a course of care. In a medical emergency, when a participant is unable to exert his or her autonomy, the ICT shall act to respond to, and stabilize the participant's situation in a manner that is consistent with the participant's expressed values and goals. If the Team determines that an interim Care Plan should be developed, it will follow the procedures outlined in Article II, Section 2.1 F.
- M. Ensure that the ICT meets to develop and implement an Interim Individual Care Plan to address the situation if an urgent need for a change in services arises before a full reassessment can be accomplished, *MyCare* Provider will track the service intervention to ensure it is completed as expeditiously as required. The Interim Care Plan will be in force only until the ICT is able to conduct a full reassessment. Such reassessment will be performed as expeditiously as possible.
- N. Notify the participant and/his her caregiver, both verbally and in writing if during the reassessment process, the ICT determines it cannot approve the participant's or designated representative's request for care/services. The participant/caregiver also will be advised of his or her right to appeal, and the procedures for filing an appeal in accordance with Article V, Grievances and Appeals.
- O. Ensure that each participant is served by the Interdisciplinary Team. The Team shall:
  - 1. Hold daily morning meetings on regular business days, at which status updates will be provided;
  - 2. Hold regularly-scheduled weekly meetings to review assessments and update care plans;
  - 3. Be flexible in setting meeting times to accommodate participants who wish to attend.

4. Educate, empower and facilitate the participant to exercise his or her rights and responsibilities;
5. Involve the participant as an active team member and stress participant-centered collaborative goal setting;
6. Provide the supports necessary for the participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active;
7. Establish a set of guidelines or care responsibilities for the entire Team and distribute these responsibilities to all team members;
8. Provide information and support to the participant in making choices within the parameters of the program;
9. Develop, monitor and review the participant's care plan with the participant;
10. Ensure participant's goals and preferences are identified, documented in the care plan and addressed;
11. Provide case management, including assessing needs, and authorizing and coordinating services;
12. Evaluate the effectiveness of the current Individual Care Plan and implement modifications as needed in collaboration with the participant and other providers as appropriate;
13. Provide in-home assessment of safety issues, and work with the participant to manage identified risks;
14. Provide education to participants and families regarding health and social needs;
15. Identify the participant's informal support systems/networks in relationship to his or her functional and safety needs;
16. Report information to team, participant and other appropriate health care providers as needed;
17. Assess and assist the participant in identifying and addressing quality of life issues;
18. Meet documentation and reporting requirements in a timely and accurate manner;
19. Provide links/coordination/integration with care providers across settings;
20. As appropriate, represent the participant's point of view when the participant is unable to participate in decisions;
21. Provide participant with necessary equipment and supplies; and
22. Keep a record of all meetings through preparation and retention of meeting minutes.

P. Provide or arrange for the furnishing of all medically necessary Covered Services to each Participant, including emergency care and services as further described in Article II Sections 2.1 S and W, for the term of the Participant's enrollment.

- Q. Shall require its providers to ensure that in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and Shall document to the DAIL on the basis of community standards.

Appointment availability shall meet the usual and customary standards for the community, and shall, at a minimum, comply with the following:

1. Urgent care: Within twenty-four hours
2. Non-urgent, non-emergent conditions: Within 14 days
3. Preventive Care: Within 90 days.

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial participants or comparable to Medicaid fee-for-service, if the provider serves only Medicaid participants.

*MyCare* Provider must establish mechanisms to ensure that network providers comply with appointment availability standards; monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

Provider shall ensure that travel time to services does not exceed the usual and customary standards for the community.

- R. Maintain policies and procedures regarding Participant education. Participant education shall be an ongoing process that includes, but is not limited to the following:

1. orientation to Provider services (i.e., referral system, grievance procedure, after-hours call-in system, and provisions for emergency treatment);
2. restrictions against Medicaid coverage for Capitated Services received through provider(s) other than the Provider;
3. instruction in self-management of medical problems and disease prevention;
4. a written patient bill of rights; and
5. written information on advanced directives policies which will reflect any and all changes in state law no later than 90 days after the effective date of change.

The Provider shall submit its Participant education policies and procedures to the Department within 15 days of receipt of the request from the Department.

- S. Provide Capitated Services that include but are not limited to:
1. Primary care physician services, including both for physician participation in ICT activities and direct patient care (capitation covers total office visit for participants with Medicaid only and cost sharing component for participants with Medicare);
  2. Specialty physician services (capitation covers total office visit for participants with Medicaid only and cost sharing component for participants with Medicare);
  3. Adult Day Health services;
  4. Transportation to and from medically-necessary services, including non-capitated services, as well as to and from meetings with Interdisciplinary Care Team members and other *MyCare Vermont* staff;
  5. Nursing care;
  6. Social services;
  7. Physical, occupational and speech therapies;
  8. Recreational therapy;
  9. Nutritional counseling and education;
  10. Prosthetics, orthotics, medical supplies, medical appliances and durable medical equipment;
  11. Podiatry, including routine foot care;
  12. Vision care, including examinations, treatment, and corrective devices such as eyeglasses;
  13. Dental care (see the dental section for more detail);
  14. Psychiatry, including evaluation, consultation, diagnostic and treatment;
  15. Audiology, including evaluation, hearing aids, repairs and maintenance;
  16. Home care services include:
    - a. Skilled nursing services
    - b. Physical, speech, and occupational therapies
    - c. Social services, case management, and counseling
    - d. Personal care
    - e. Homemaker chore services
    - f. Home delivered meals with special diets
    - g. In-home respite care
    - h. Transportation and escort services;
  17. Long-term care facility services include:
    - a. Semi-private room and board (may require payment toward

- cost of care according to Medicaid)
    - b. Physician and nursing services
    - c. Personal care and assistance
    - e. Drugs and biologicals
    - f. Physical, speech, occupational and respiratory services
    - g. Social services
    - h. Medical supplies and appliances;
  - 18. Comfort care during difficult end of life situations;
  - 19. Dental services include:
    - a. Diagnostic services - examinations, radiographs
    - b. Preventive services - prophylaxis, oral hygiene instructions
    - c. Restorative dentistry - fillings, temporary or permanent crowns
    - d. Prosthetic appliances - complete or partial dentures
    - e. Oral surgery - extractions, removal/modification of soft and hard tissue;
  - 20. Services for hearing and speech impairments; and
  - 21. Translation services.
- T. Exercise flexibility to provide services not specified in the capitated benefit package, but deemed necessary or more appropriate to meet the participant's needs. Such "flexible" services will be funded out of *MyCare* Provider's capitation payment.
- MyCare* Provider must develop a decision methodology for use by the ICT in determining whether a participant should be offered services under this option. At a minimum, the decision methodology must include consideration of the following questions:
- 1. Participant's need, goal, or problem;
  - 2. Relationship to the participant's assessment, service plan or desired outcomes;
  - 3. Alternative methods for meeting goal or resolving problem;
  - 4. Policy guidelines for selecting from among options;
  - 5. Option preferred by participant (and/or his/her family/caregiver), following a thorough review and negotiation with the participant or his/her family/caregiver; and
  - 6. Option(s) that is/are the most effective and cost-effective in meeting the desired outcomes(s).
- U. Provide the Participant with the opportunity to seek a second opinion from a qualified health professional acceptable to the Provider at no cost to the Participant.

- V. Arrange for inpatient care to Participants in Medicaid-participating hospitals. Accommodations shall be semiprivate, unless the Team determines a Participant's medical needs dictate otherwise or unless such accommodations are not available at the time of admission.
- W. Provide for, arrange, or authorize in-area and out-of-area emergency care and post stabilization services.
1. For purposes of this Agreement, in-area or out-of-area emergency care consists of those Emergency Services defined in Article I, Section 1.16 that are provided in or enroute to a hospital or hospital emergency room, in a clinic or physician 's office, or any other site at a Provider-affiliated or non-affiliated location inside or outside the Provider's Service Area.
  2. All Capitated Services will be paid by the Provider when rendered in an in-area or out-of-area medical emergency, but only until such time as the Participant's condition permits travel to a Provider-affiliated facility following contact with the Provider for post stabilization services.
  3. The attending emergency physician, or the provider actually treating the Participant is responsible for determining when the Participant is sufficiently stabilized for transfer or discharge, and that determination is binding on the Provider.
  4. Provider may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms, and may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Participant's PCP, Provider or applicable state entity of the Participant's screening and treatment within ten calendar days of presentation for emergency services.
  5. The Provider may not deny payment for treatment obtained when a representative of the Provider instructs the Participant to seek emergency services or for treatment obtained when a Participant had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in Article I, Section 1.16 of the definition of emergency medical condition.
- X. Pay for post-stabilization care services obtained within or outside the Provider's network that are not pre-approved by a representative of the Provider, but are administered to maintain the Participant's stabilized condition if:

1. there is not response within one hour of a request to the Provider for pre-approval of further post stabilization care services.
  2. the Provider cannot be contacted.
  3. the Provider representative and the treating physician cannot reach an agreement concerning the Participant's care and the Provider's physician is not available for consultation. In this situation the Provider must give the treating physician the opportunity to consult with the Provider's physician and the treating physician may continue with care of the Participant until the Provider's physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.
- Y. Establish practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals, consider the needs of the Participants, are adopted in consultation with contractors and are reviewed and updated periodically as appropriate. Guidelines will be shared with all affected contractors and upon request, to Participants and applicant's. Decisions regarding utilization management, Participant education, coverage of services and other areas to which the guidelines apply should be consistent with the guidelines.
- Z. Ensure that the care and services set forth herein are provided and administered in accordance with accepted medical practices and professional standards. Services may only be limited on the basis of lack of medical necessity. Any decision to deny a service in an amount, duration or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Participant's condition or disease. The amount, duration or scope of a required service may not be arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition. The Provider must notify the contractor of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the contractor need not be in writing.
- Submit copies of all contracts with participating hospitals, institutions, and service providers to the Department for review and approval upon request. Submit an updated list of contracts whenever a change occurs. Provider will maintain updated list of all contracts to include contractor name, address, phone number, services provided under the contract, contract expiration date, and whether or not contract is automatically renewable.
- AA. Maintain policies and procedures to ensure effective communication and input among members of the interdisciplinary team and other providers

to continuously monitor Participant 's health status, psycho-social condition, and effectiveness of the care plan, through observation, direct provision of services, informal observation, including input from Participants and significant others. Policies and procedures must also consider processing requests for initial and continuing authorizations of services.

- BB. Maintain policies and procedures, to ensure effectiveness of interdisciplinary team, that address responsibility for scheduling and facilitating team meetings, and handling and resolving team conflicts.
- CC. Work with the Participant with respect to living conditions that directly impact the treatment of a Participant 's medical condition or health and safety issues. This may include, when appropriate, cleaning of occupied space, vector control, and installation of safety devices. Provider will conduct initial home assessment and regular follow-up assessments to evaluate appropriateness of home environment.
- DD. Provide or provide coverage of counseling or referral services as deemed medically necessary; however, the Provider is not required to do so if the Provider objects to the service on moral or religious grounds.

If the Provider elects not to provide or provide coverage of counseling or referral services because of an objection on moral or religious grounds, it must provide information about the services it does not cover to the Department with its application for a Medicaid contract and whenever it adopts the policy during the term of this contract. The information provided must also be:

1. Consistent with the provisions of 42 CFR 438.10;
  2. Provided to applicants before and during enrollment; and
  3. Provided to Participants within 90 days after adopting the policy with respect to any particular service.
- EE. Participate in efforts by the Agency of Human Services and DAIL to promote the delivery of services in a culturally competent manner to all *MyCare Vermont* participants, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
  - FF. Not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from the following actions:
    1. Advising or advocating on behalf of a participant who is his or her patient for the participant's health status, medical care, or

treatment options, including any alternative treatment that may be self-administered;

2. Providing information to the participant as necessary for the participant to decide among all relevant treatment options;
3. Advising or advocating on behalf of a participant for the risks, benefits, and consequences of treatment or non-treatment; or
4. Advising or advocating on behalf of the participant for the participant'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.

GG. Ensure that female participants have the right to choose a qualified specialist for women's health services to furnish routine or preventive health services.

HH. Ensure that participants have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers, or arrange for the ability of the participant to obtain a second opinion by enrolling a qualified provider in the program, at no cost to the participant.

## **2.2 Non-Covered Services**

A. The following exclusions apply to the capitated benefit package:

1. Any service not authorized by the Interdisciplinary Care Team, unless it is an emergency service.
2. Cosmetic surgery, unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction after mastectomy.
3. Experimental, medical, surgical, or other health procedures not generally available in the area unless authorized by the Interdisciplinary Care Team.
4. Any service rendered outside of the United States with the exception of emergencies experienced while in Canada.
5. Private room or private duty nursing while in a nursing home or hospital, unless medically necessary. Non-medical items such as radio or TV are also excluded unless authorized by the ICT.

B. The ICT, will coordinate with providers of non-capitated services, including but not limited to inpatient and outpatient hospital and behavioral health services, to ensure effective management of the participant's total health care needs. This includes assisting participants to schedule appointments with non-capitated providers and obtaining

and incorporating relevant information from non-capitated providers into the participant's Individual Care Plan. *MyCare* Provider must ensure that care coordination is performed in accordance with federal HIPAA privacy requirements.

## **2.3 Service Authorization**

### **A. Medical Necessity**

*MyCare* Provider agrees, at a minimum, to provide the services that are covered under its capitation on the basis of medical/clinical necessity. Services shall be sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished. *MyCare* Provider shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. *MyCare* Provider may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Medically-necessary care, as defined in Rule 10 of the Vermont Division of Health Care Administration, means health care services including diagnostic testing, preventive services and aftercare appropriate, in terms of type, amount, frequency, level, setting, and duration to the participant's diagnosis or condition. Medically-necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition; and 1) help restore or maintain the participant's health; 2) prevent deterioration of or palliate the participant's condition; and 3) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Ultimate authority in the determination of medical necessary lies with AHS, as the entity to which *MyCare Vermont* participants have the right to appeal. AHS will arrange for independent medical review of appeals of medical necessity decisions by *MyCare* Provider as appropriate.

Within the limits of the benefit plan, *MyCare* Provider has the responsibility for establishing procedures for referrals and when prior authorization is required.

### **B. Consumer/Surrogate-Directed Care**

The philosophy and process of person-centered planning provides the

foundation for consumer/ surrogate directed care. *MyCare* Provider must offer consumer/ surrogate directed care as a service option for all participants interested in directing their own care.

If a participant is able, willing and desires to be an employer for his/her own Personal Care, Respite or Companion services, he/she may apply to *MyCare* Provider for the consumer-directed option. Alternately, if the participant is not able or willing to be the employer, a family member or friend may apply to be the surrogate employer under the surrogate-directed option. Surrogate employers must live in close proximity to the individual and be available to perform all the responsibilities of the employer on an ongoing basis.

Whether consumer or surrogate directed, *MyCare* Provider, through the ICT, must certify that the participant or surrogate is able to serve as an employer. The Interdisciplinary Care Team must conduct a certification process for any Participant or surrogate who wishes to be an employer of services.

The Certification process shall include:

1. Assessment of the participant or surrogate-directed employer's cognitive ability to communicate effectively and perform the activities required as an employer. Cognition and communication are defined as follows:
  - a. Cognition: the ability to understand and perform the tasks required to employ a caregiver (including recruitment, hiring, scheduling, training, supervision, and termination). An individual who has cognitive impairments or dementia that prevent understanding and performance of these tasks, is not competent, or has a guardian, is not eligible to manage consumer/ surrogate directed services.
  - b. Communication: the ability to communicate effectively with his/her team members and with the caregiver(s) in performing the tasks required to employ a caregiver. An individual who cannot communicate effectively, whether through verbal communication or alternate methods, is not eligible to manage consumer/surrogate directed services. In addition, the employer must live within close proximity to the individual in order to monitor services and supervise employees adequately. Employers must demonstrate over time that they have the ability to understand program rules and to reliably perform employer responsibilities. If the

individual or surrogate is not able or willing to be the employer, the social worker will discuss other options.

2. Determination by the ICT that the participant or surrogate is able and willing to be the employer. The process includes:
  - c. The ICT Case Manager/Social Worker must assess the participant's or surrogate's ability and willingness to be an employer using the DAIL Employer Certification Form. Successful completion of this assessment process indicates the participant or surrogate is able and willing to be the employer.
  - b. The participant or surrogate must develop a plan for services using the "Personal Care Worksheet" and "Service Plan" form developed by the DAIL. If requested by the participant, the case manager/social worker will assist with completing these forms. The Personal Care Worksheet describes the specific tasks and services that shall be provided for the participant. The Service Plan identifies the overall type and amount of services for the participant. Signing of these forms by the participant or surrogate indicates he or she agrees to perform the required employer activities.

After the above certification process is complete, the ICT must meet and review the Personal Care Worksheet and Service Plan presented by the participant or surrogate. The ICT must approve, modify or deny the request. If approved, the participant or surrogate then will become the employer. It is the responsibility of *MyCare* Provider, through the ICT, to monitor the employer's ongoing ability to manage the services.

If the ICT modifies or denies the participant's request to consumer/surrogate direct care, the reasons for the denial will be communicated orally and in writing. *MyCare* Provider also will advise the participant or surrogate of the his or her right of appeal.

Once certified, *MyCare* Provider will continue to monitor the participant or surrogate's ability to:

1. Understand and follow program requirements;
2. Recruit and select qualified employee(s) who are 18 years of age or older;
3. Notify selected employee(s) of their responsibilities;

4. Enroll in an independent payroll agent approved by the *MyCare* Provider;
5. Assure that employment forms are completed and submitted to the payroll agent;
6. Train employee(s) to perform specific tasks as needed;
7. Develop a work schedule based on the approved Service Plan;
8. Maintain updated copies of approved waiver Service Plan;
9. Arrange for substitute or back-up employees as needed;
10. Develop and maintain a list of tasks for the employee(s) to perform based on the Personal Care Worksheet;
11. Authorize employee(s) timesheets (based on the approved Service Plan and actual time worked);
12. Maintain copies of all employee(s) timesheets;
13. Perform supervisory visits in order to assure that tasks are performed by the employee(s) correctly and completely;
14. Evaluate employee(s) performance;
15. Provide ongoing performance feedback to employee(s);
16. Terminate employee(s) employment when necessary;
17. Notify the payroll agent of any necessary changes;
18. Participate in the assessment and reassessment of eligibility;
19. Communicate with the Interdisciplinary Care Team on a regular basis;
20. If applicable, ensure a monthly patient share is paid to the payroll agent; and
21. Avoid conflict of interest with employees, the individual and/or other participating agencies.

If *MyCare* Provider determines that the participant or surrogate is failing to perform employer tasks, the *MyCare* Provider, through the Interdisciplinary Care Team, will address the issue through the care planning process. If *MyCare* Provider concludes that the participant/surrogate role should be modified or terminated, it will communicate the reasons both orally and in writing. *MyCare* Provider also will advise the participant or surrogate of the participant's right of appeal.

## **2.4 Administration**

### **A. Executive Management**

*MyCare* Provider must have an executive management function with clear authority over all administrative functions and must maintain sufficient administrative staff and organizational components to comply with all program standards. Staffing must be sufficient to perform

services in an appropriate and timely manner.

Minimum requirements for key staff include the following:

1. Chief Executive Officer – *MyCare* Provider shall have a Chief Executive Officer with authority over the administration of the *MyCare* Vermont line of business. The CEO shall have at least a Masters Degree in Business, Public Administration or a health-related field. He/she shall have a minimum of five years experience working at a professional level in managed care health plan administration, Medicaid program administration, or in health policy analysis and planning, at least one year of which must have been in managed care.
2. Chief Financial Officer – *MyCare* Provider shall have a Chief Financial Officer with responsibility for plan budgeting and financial management activities. The CFO shall be a Certified Public Accountant or have at least a Bachelors Degree in Business, Public Administration or related area of study. He/she shall have a minimum of five years experience in preparation of budgets and financial management working in health care administration, Medicaid program administration or grant management. The CFO also shall have experience in risk management, unless *MyCare* Provider has another qualified individual filling this position.
3. Medical Director – *MyCare* Provider shall have a Medical Director with responsibility for the plan's quality and utilization management functions. The Medical Director shall be a Vermont-licensed physician with expertise in working with geriatric populations and persons with physical disabilities.

*MyCare* Provider's Chief Executive Officer for the *MyCare Vermont* line of business must be approved by the DAIL prior to the contract taking effect. Changes in this position also must be approved by the DAIL in advance.

B. Liaison

*MyCare* Provider shall designate a representative to act as liaison between *MyCare* Provider and the DAIL for the duration of this Agreement. The Chief Executive Officer will serve as the liaison, unless an alternate is approved by the DAIL.

The representative shall be responsible for:

1. Representing *MyCare* Provider on all matters pertaining to this Agreement. Such a representative shall be authorized and empowered to represent *MyCare* Provider regarding all aspects of this Agreement;
2. Monitoring *MyCare* Provider's compliance with the terms of this Agreement;
3. Receiving and responding to all inquiries and requests made by the DAIL in the timeframes and format specified by the DAIL in this Agreement;
4. Meeting with the DAIL representative on a periodic or as-needed basis to resolve issues which may arise;
5. Coordinating requests from the DAIL including, but not be limited to, requests to participate in training programs designated by the DAIL, requests to coordinate fraud and abuse activities with the DAIL, and requests to meet with other State of Vermont agency representatives or other parties;
6. Making best efforts to resolve any issues identified either by *MyCare* Provider or the DAIL that may arise in connection with this Agreement;
7. Meeting with the DAIL at the time and place requested by the DAIL, if the DAIL determines that *MyCare* Provider is not in compliance with the requirements of this Agreement;
8. Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to prior review and approval by the DAIL are provided to the DAIL no less than 10 business days prior to execution or implementation, except where a different time frame is specified within this Agreement; and
9. Submitting any requests for documents or any other information provided to *MyCare* Provider by any individual or entity to the DAIL for its review; and submitting any proposed responses and responsive documents or other materials in connection with any such requests to DAIL.

C. Notification of Changes

The Provider shall notify the Department of all changes affecting its ability to deliver care or administer their Plan.

D. Assignment of Contract

The Provider shall not assign any right or delegate any duty or obligation hereunder; however, the Provider may meet its obligations hereunder by purchasing services from other qualified providers of such services.

1. All contracts for the purchase of services provided to its Participants are subject to the Department's approval, must be in writing, must fulfill the requirements of this Agreement and be appropriate to the service or activity delegated and must contain provisions consistent with the terms of this Agreement.
2. The Provider is prohibited from entering into capitation arrangements with contractors.
3. All contractors providing health care services on behalf of the Provider must be enrolled in the Medicaid Program if the Department has an established provider type for that provider.
4. The Provider must ensure that all contractor facilities/offices are accessible to individuals with disabilities.
5. The Provider shall oversee the performance of its contractors and shall use reasonable care in the selection, credentialing, re-credentialing, and ongoing evaluation of its contractors.

E. Provider Contracting and Credentialing

*MyCare* Provider shall have a DAIL-approved policy for credentialing all licensed providers. The policy must include, but need not be limited to, verification that all *MyCare Vermont* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *MyCare Vermont* program. Providers may not furnish services that are subject to the Vermont Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

F. Non-Discrimination

*MyCare* Provider agrees to ensure that network providers do not intentionally discriminate against *MyCare Vermont* participants or intentionally segregate participants in any way from other individuals receiving services.

1. The Provider shall provide the Department with copies of all contracts between the Provider and providers of services hereunder, within one week of the Department's request.
2. The Provider must maintain a written agreement with its contractor that specifies the activities and responsibilities delegated to the contractor and provides for revoking delegation or imposing other sanctions if the contractor's performance is inadequate.
3. Upon the Provider identifying deficiencies or areas for Improvement, the Provider and contractor must take corrective action.
4. The contract should specify that the contractor may not file an appeal with the Department in the event of non-payment by the Provider for services rendered.

G. Contractor Selection

1. *MyCare* Provider must establish and maintain a provider network with sufficient numbers of providers and in geographically accessible locations for the populations it serves, and as supported by written agreements whose language has been prior approved by the DAIL.

*MyCare* Provider's network must contain all of the provider types necessary to furnish the capitated benefit package. *MyCare* Provider's network must include primary care and specialty physicians and other providers with experience in serving and treating frail elderly and persons with disabilities, including younger adults, as well as providers capable of delivering health services in a culturally competent manner to all participants, including those with limited English proficiency and diverse cultural and ethnic backgrounds. *MyCare* Provider shall develop written policies and procedures approved by DAIL for provider selection and qualifications.

In establishing and maintaining the network, *MyCare* Provider must consider the following:

- a. Anticipated enrollment;
  - b. The expected utilization of services, taking into consideration the characteristics and health care needs of its participants, including specifically younger adults with physical disabilities;
  - c. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
  - d. The geographic location of providers and participants, considering distance, travel time, the means of transportation ordinarily used by participants, and whether the location provides physical access for participants with disabilities.
2. *MyCare* Provider's licensed and enrolled Medicaid providers must:
- a. Meet the requirements set forth in 42 CFR 431.107 regarding record keeping;
  - b. Meet *MyCare* Provider's established credentialing requirements;
  - c. Be willing to coordinate care with *MyCare* Provider, including sharing clinical information (with appropriate participant consent); and
  - d. Comply with AHS policies regarding criminal background checks.

Unless authorized by State or federal statute or regulation, *MyCare* Provider shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification. This provision does not prohibit *MyCare* Provider from limiting network participation based on quality, cost or other reasonable business purposes as permitted under federal

laws and regulations. If a provider seeks and is denied a contract, *MyCare* Provider must provide written notice of the reason(s) for its decision.

All contracts and subcontracts for services furnished pursuant to this agreement must be in writing and must provide that the DAIL and the United States Department of Health and Human Services (DHHS) may evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed, and inspect and audit any financial records of such contractor/subcontractor.

No subcontract terminates the responsibility of *MyCare* Provider to ensure that all activities under this Agreement are carried out. *MyCare* Provider agrees to make available to the DAIL and CMS, upon request, all subcontracts between *MyCare* Provider and other entities.

3. *MyCare* Provider must have a DAIL-approved policy for performing ongoing competency reviews of all employees and contract employees providing services to participants. *MyCare* Provider also must have a DAIL-approved policy for monitoring the adequacy of its network and taking prompt action to address any identified deficiencies.

*MyCare* Provider must notify the DAIL of all changes in network composition. Upon termination of any providers, *MyCare* Provider must notify the DAIL concerning the reason for termination.

*MyCare* Provider shall give written notice of termination of any contracted provider, within 15 days after receipt or issuance of the termination notice, to each participant who received services from the terminated provider.

#### H. Provider Services

*MyCare* Provider shall maintain a provider services function that operates during normal business hours. Functions shall include:

1. Assistance with development of procedures for determining participant eligibility;
2. Assistance with the submittal of claims for services rendered,

3. Assistance with preparation and submittal electronic health record data or other required submissions; and
4. Provider grievances and appeals, including appeals of participant eligibility.

I. Physician Incentive Plans

The Provider shall not enter into physician incentive plans as defined by 42 CFR 422.208(a).

J. Advance Directives

*MyCare* Provider shall comply with the requirements of 42 CFR 422.128 and 489, Subpart I related to maintaining written policies and procedures respecting Advance Directives. *MyCare* Provider shall require all *MyCare Vermont* network providers to comply with these provisions.

This requirement includes:

1. Maintaining written policies and procedures that meet requirements for Advance Directives in Subpart I of part 489;
2. Maintaining written policy and procedures concerning Advance Directives with respect to all adult individuals receiving medical care or assistance by or through *MyCare* Provider or one of its network providers;
3. Providing written description of State of Vermont law and participant's rights under State of Vermont law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Such information must reflect changes in State of Vermont law as soon as possible, but not later than 90 business days after the effective date of the State law.
4. Providing written description of policies respecting implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

The DAIL reserves the right to require Advance Directives to be scanned and incorporated in participants' electronic centralized health records.

K. Workforce Initiative to Promote Staff Retention and High Quality Performance

1. *MyCare* Provider must establish an on-going process for creating and maintaining a positive work environment for all staff. *MyCare* Provider must demonstrate through its policies, procedures and programs governing its employees and through its provider contracts that it has created a work environment that has the following characteristics:
  - a. Fosters open and clear communication within *MyCare* Provider's organization and with other providers and health care facilities. *MyCare* Provider's mission and annual goals are understood and supported by all staff involved with the participant's care. Questioning is encouraged whenever there is uncertainty or confusion about responsibilities or next steps. Different communication styles are understood and respected.
  - b. Fosters shared decision-making and a supportive environment among all staff involved with the participant's care. All staff involved with the participant's care, regardless of educational background or professional licensure, contribute to Individual Care Plans, program policies, operations and program evaluations. The contributions of all staff involved with the participant's care are recognized and respected.
  - c. Encourages the expression of different opinions and creative thinking. There is no retribution toward any staff involved with the participant's care who ask challenging questions or propose unconventional solutions.
  - d. Establishes a clear understanding of decision-making responsibilities among all staff involved with the participant's care. There are clear ground rules on how decisions are made and how policy and programs are implemented.
  - e. There is clear accountability within *MyCare* Provider organization as to who is responsible for leading initiatives to create and maintain the above-stated characteristics.
2. A workplace culture with the above-listed characteristics will be referred to as "Positive Work Culture." *MyCare* Provider must

establish an on-going process to develop a Positive Work Culture. To develop this process the *MyCare* Provider must demonstrate attention to each of the following areas of best practice:

- a. Staff recruitment
  - b. Orientation and training
  - c. Staffing levels and work hours
  - d. Professional development and advancement
  - e. Supervision training and practices
  - f. Team approaches
  - g. Staff recognition and support
3. *MyCare* Provider, with the approval of DAIL, must develop an individualized plan to address a Positive Work Culture. This Individualized Plan shall:
- a. Include Self-assessment (must include employee satisfaction survey) of challenges or barriers their organization faces with recruitment and retention of their workforce.
  - b. Identify a new Best Practice or a substantial addition and continuation of a previous Best Practice that the *MyCare* Provider will develop.
  - c. Bring together a planning team and have them become familiar with the charts and forms, either as a group or individually
  - d. Develop a Work plan for implementing change
  - e. Develop feedback loops to ensure any change implemented becomes a sustainable change in *MyCare* Provider's organization.
  - f. Develop Outcome Measures. At a minimum, DAIL requires the measurement of the following:
    - i. Employee satisfaction
    - ii. Turnover rates
    - iii. Staff position vacancy rates
    - iv. Years of service
4. *MyCare* Provider must also on a regular basis, and no less frequently than annually, reassess and identify a new Best Practice or a substantial addition and continuation of a previous Best Practice that *MyCare* Provider will develop to address Positive Work Culture.
5. On on-going basis, the *MyCare* Provider must submit to the DAIL

for approval, details regarding how it will operationally implement a Positive Work Culture using the process described above. The submission must include:

- a. Identification of who at the staff level will be responsible for providing guidance, resources, encouragement and other types of support to each of the Interdisciplinary Care Teams regarding Positive Work Culture.
- b. The content and use of *MyCare* Provider's self assessment tools that identifies potentially successes and challenges faced in the work culture.
- c. The content and use of an orientation program covering information new staff need to understand about *MyCare Vermont*, Positive Work Culture and *MyCare* Provider's other policies and procedures.
- d. Content and use of cross-disciplinary training programs regarding best practices concerning participant care.
- e. Content and use of training programs regarding communication styles, listening skills, conflict resolution and team development.
- f. Content and use of training programs for senior management on cultural competence, problem solving, communication and coaching skills.
- g. Mechanism for communicating positive feedback from participants and staff.
- h. Recognition and reward for Positive Work Culture achievement.
- i. How *MyCare* Provider will internally evaluate its successes in achieving Positive Work Culture through use of outcome measures.

### **ARTICLE III: REIMBURSEMENT PROVISIONS**

The obligations of the Department under this Agreement for any state fiscal year are subject to the appropriation, allotment, and availability of sufficient funds to discharge the Department's obligations under this Agreement which accrue in that state fiscal year, and subject to the authorization to spend such funds for the purposes of this Agreement.

#### **3.1 Capitation Rate**

- A. The Department shall pay a monthly Capitation Payment to the Provider for each Participant. Rates are calculated using an actuarially sound methodology. The rates established under this Agreement will not exceed the total per capita amount which the Department estimates would be payable for all capitated services if they were to be reimbursed under the Department's fee-for-service program.
- B. The Provider will receive payment from the Department at the current Capitation Rate, unless the Participant is required to contribute a Patient Pay towards the cost of care. For a Participant who is required to contribute a Patient Pay, the Provider will be paid by the Department for the current Capitation Rate minus the Patient Pay amount. The Provider will be responsible to collect the Patient Pay amount from the Participant.
- C. The Capitation Payment shall be accepted as payment for providing or arranging all medically necessary Capitated Services to Participants as described in Article II. The Capitation Payment includes Medicare coinsurance and deductibles for Capitated Services.
- D. The Capitation Rate shall not include any amount for recoup of losses, if any, incurred by the Provider under any previous contracts with the Department.
- E. The Provider shall seek reimbursement from Medicare for services provided to Participants with Medicare coverage through the fee-for-service program.
- F. Medicare coinsurance and deductibles for Non-Capitated Services will be paid by Medicaid through the fee-for-service program up to the Medicaid fee schedule rate.
- G. The Provider shall pay all providers and contractors for the provision of medically necessary Capitated Services to Participants. Participants may

not be held liable for the covered services provided to the Participant for which the State or the Provider did not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

- H. The Provider shall be liable for payment of all claims for Medicaid reimbursable Capitated Services provided to Participants during the period for which enrollment is effective, but the Department has not yet completed the Enrollment Process.

### **3.2 Reconciliation**

- A. Payment Adjustment Process

In the event that the Provider receives an incorrect payment from the Department, the Provider will immediately notify the Department.

- B. Rate Adjustment Process

1. Capitation Rates shall be calculated annually. The Department will make its best effort to determine the rate prior to the start of the contract year. If the Department is unable to determine the rate in time for payment to begin, payment will continue to be made at the previous year's Capitation Rate until such time as the new rate has been established.
2. If payment has been made at the previous year's Capitation Rate during any portion of the new fiscal year, an adjustment shall take place. If the new rate is greater or less than the rate used for payment, an adjustment will be made in the amount that results from the difference between the new-year rate and the old year rate.

### **3.3 Risk**

Provider assumes the total risk of providing Capitated Services included under this Agreement on the basis of the periodic Capitation Payment for each Participant. Any monies not expended by the Provider after having fulfilled the obligations under this Agreement will be retained by the Provider. Under no circumstances shall the Department be responsible for any payments other than the capitated payment rates for capitated services provided under this Agreement.

### **3.4 Risk Reserve**

The Provider agrees to maintain a risk reserve approved by the Department to be used in the event the Provider becomes insolvent. Provider must demonstrate that it has arrangements in place in the amount of at least the sum of the following to cover expenses in the event it becomes insolvent: One month 's total capitation revenue; and one month 's average payment to contractors, including providers of emergency services.

The requirement may be met by submitting one or more of the following arrangements:

- A. Insolvency insurance;
- B. An irrevocable, unconditional and automatically renewable letter of credit for the benefit of the Department, which is in place for the entire term of the Agreement;
- C. A guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Provider in the event of a default in payment resulting from bankruptcy or insolvency; or
- D. Other arrangements, satisfactory to the Department, that are sufficient to ensure payment to providers in the event of a default in payment resulting from bankruptcy or insolvency.

### **3.5 Third Party Payors**

Medicaid is the payor of last resort. If a Participant has health insurance or any of his/her care is someone else 's responsibility, those resources must be used first. It is the Provider 's responsibility to handle coordination of benefits (COB) for all Participants with health insurance, specifically, billing and collecting on applicable health insurance policies held by the Participant. It is also the Provider 's responsibility to furnish policy information or changes in policy information to the Department on any Participant who has health insurance, using a form approved by the Department. All COB collections must be reported to the Department.

The Provider shall actively pursue, collect, and retain any monies from third party payors for services to Participants covered under this Agreement except where the amount of reimbursement the Provider can reasonably expect to receive is less than the estimated cost of recovery. Records shall be maintained of all third party collections and reported to the Department. The Provider must obtain information from Participants regarding Third Party Liability (TPL)

and must seek TPL collections by all legal means available before claiming reimbursement from the Department. TPL applies to or extends to all other state and federal medical care programs, which are primary to Medicaid, and/or any other group insurance or individual health insurance.

The Contractor shall make reasonable efforts to recover the value of services rendered to Participants whenever the Participants are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, excluding instances of the tort liability of a third party. TPL monies recovered are retained by the Provider.

Collections from third party payors are the responsibility of the Provider. The Provider shall pursue collection directly from the third party payer and not from the Participant, unless the Participant has received the insurance payment from the carrier when that payment should have gone to the Provider. Access to medical services will not be restricted due to TPL collection.

## **ARTICLE IV: OUTREACH AND ENROLLMENT**

### **4.1 Outreach**

#### A. Prohibited Marketing Practices

*MyCare* Provider is prohibited from employing any of the proscribed marketing practices identified in 42 CFR 460.82(e). *MyCare* Provider is specifically prohibited from employing any of the following marketing practices:

1. Discrimination of any kind, except directing marketing to individuals who are eligible by age;
2. Any activities that could mislead or confuse potential participants or misrepresent *MyCare Vermont*, DAIL or CMS;
3. Providing gifts or payments to induce enrollment;
4. Contracting outreach efforts to individuals or organizations whose sole responsibility includes direct contact with the elderly or persons with disabilities to solicit enrollment;
5. Unsolicited door-to-door or telephone marketing.

#### B. Approval of Marketing Materials

*MyCare* Provider shall not distribute any marketing materials without first obtaining approval of such materials from the DAIL.

#### C. Employee Marketing Orientation

*MyCare* Provider must provide an orientation on allowable and prohibited marketing practices to all employees and contracted employees prior to the start of enrollment, and to all new employees and contracted employees thereafter. Employees and contract employees must sign their acknowledgement of receiving and understanding this information.

Annually thereafter, *MyCare* Provider must inform employees and contract employees again of these requirements at the time of their annual review and competency review. The signed orientation and competency checklists must be kept in employee's personnel files.

#### D. Outreach Responsibilities

MyCare Provider shall:

1. Implement its Department-approved plan for Outreach and Enrollment Activities to Medicaid Participants and potential Medicaid Participants which shall include, but not be limited to: outreach to enrollment targets; promotion of the Provider's Plan; development of a schedule for the sequence and timing of promotional and enrollment activities to include the Provider's designated service area; and the development and procurement of resources needed for implementation.
2. In conjunction with the Department, promote *MyCare Vermont* to Medicaid Participants in the Provider's Service Area and, when appropriate, in the local and/or regional offices of the Department.
3. Enroll and disenroll eligible Medicaid Participants in the *MyCare Vermont*, including completion of the Member Enrollment/Disenrollment Form.
4. Establish an Intake and Assessment Unit as defined under Article I, Section 1.22.
5. Ensure that Participants are informed at the time of enrollment about the use of services available through *MyCare Vermont* including: effective date of enrollment or disenrollment; the requirements and restrictions of enrollment; appropriate use of the referral system, after hours call-in system, and provisions for emergency treatment, including which hospitals should be used; the restriction that Participants may not seek services or items from Medicaid providers without authorization from the Team; and any Participant responsibility for payments.
6. Be knowledgeable about the policies, services, and procedures provided under this Agreement and assure that any contractors are also knowledgeable.
7. Ensure that Participants are informed of their right to terminate their enrollment voluntarily at any time.
8. Act as a liaison between the Participant and the Department's eligibility offices.
9. Ensure that all staff, including contractors who have contact with potential Participants are fully informed of the Provider's policies, including outreach, enrollment, and disenrollment policies.

## **4.2 New Enrollee Education**

*MyCare* Provider shall be responsible for educating individuals and/or designated representatives at the time of the individual's enrollment into *MyCare* Provider's plan. Initial education activities must be conducted through face-to-face meetings, although follow-up education may also be conducted via mail or telephone.

*MyCare* Provider shall provide information about the responsibilities of the participant and/or designated representative to be an active participant in his or her care management, and to:

- A. Understand the disease process, chronic illness and/or disability
- B. Realize his or her role as the Daily self-manager
- C. Engage family and caregivers in the participant's self-management

*MyCare* Provider also shall provide a participant handbook to each participant within 45 days of his or her enrollment. The handbook should be designed to assist participants in understanding all other facets pertinent to their enrollment, including:

- A. What services are covered and how to access them, including specialty referrals and emergent/urgent care;
- B. Restrictions on freedom-of-choice;
- C. Importance of coordinating Medicare and Medicaid services, in the case of participants dually-enrolled in both programs;
- D. Cost sharing;
- E. Role and responsibilities of the primary care provider (PCP);
- F. *MyCare* Provider's clinical practice guidelines;
- G. Participant rights, including appeal and Fair Hearing rights (methods for obtaining a hearing, timeframes for filing requests and resolution, representation at hearings, availability of assistance in the filing process, toll-free numbers to obtain assistance in filing, right to continuation of benefits while appealing); confidentiality rights; availability of the Office of Health Care Ombudsman; and participant-initiated disenrollment;
- H. Participant responsibilities, including making, keeping, canceling appointments with PCPs and specialists; necessity of obtaining prior authorization (PA) for certain services and proper utilization of the emergency room (ER);
- I. Advance Directives;
- J. Availability of, and how to access, oral interpreter services, translated written materials and materials in alternative formats;
- K. Information on participant cost sharing; and

- L. Information available upon request, including information on the structure of the *MyCare Vermont* program and any physician incentive plans.

*MyCare* Provider shall ensure that the participant handbook is written at an elementary reading level and submit to the DAIL for prior approval. *MyCare* Provider also shall notify its participants in writing of any change that the DAIL defines as significant to the information in the participant handbook at least 30 business days before the intended effective date of the change.

#### **4.3 Enrollment**

- A. *MyCare* Provider shall not discriminate, or use any policy or practice that has the effect of discriminating, against any individual's eligibility to enroll on the basis of race, color, religion, disability, sexual orientation or national origin. *MyCare* Provider will accept and serve all individuals eligible for *MyCare Vermont* and enrolled with *MyCare* Provider.
- B. Prior to enrollment or re-enrollment of an individual, *MyCare* Provider shall do all of the following, in accordance with *MyCare* Provider's DAIL-approved enrollment policies and procedures:
  - 1. Conduct an initial medical (history and physical) screening of the applicant.
  - 2. Conduct a comprehensive in-home assessment to evaluate appropriateness of home environment as it relates to the applicant.
  - 3. Explain the *MyCare Vermont* program to potential participants and answer any questions potential participants and their family members/caregivers may have. This includes providing the following information:
    - a. An explanation of the program and its services, to include informing the applicant/family/caregiver that *MyCare* Provider will be the sole service provider for its schedule of capitated Medicaid-covered services;
    - b. An explanation that participants are guaranteed access to all needed services, but not to a specific provider;
    - c. A copy of *MyCare* Provider's DAIL-approved Enrollment Agreement;
    - d. Enrollment and disenrollment processes;
    - e. Grievance and Appeal processes, both internal and external;
    - f. A copy of *MyCare* Provider's DAIL-approved Participant Bill of Rights;

- g. Eligibility requirements;
  - h. The DAIL-approved criteria for determining if the potential participant can be cared for safely in the community;
  - i. Assessment that care needs and health status are appropriate for enrollment into the PIHP program;
  - j. Applicable premium or Medicaid spend-down requirements; and
  - k. Anticipated effective date of enrollment.
4. Perform an Interdisciplinary Care Team evaluation of the applicant.
  5. If not already completed, arrange for an assessment by the DAIL Long Term Care Clinical Coordinator (LTCCC) to determine clinical eligibility. This determination must be made for all individuals prior to enrollment, regardless of payment source.
  6. Assist applicant in obtaining determination of financial eligibility for Medicaid. If an applicant is determined clinically eligible, but financially ineligible for Medicaid, *MyCare* Provider will notify the applicant in writing that while the applicant is ineligible for Medicaid, he or she is eligible for *MyCare Vermont* if he or she chooses to be a Private Pay Participant.
  7. Develop an initial Individual Plan of Care in accordance with the procedures described in Article II Section 2.1B, Person-Centered Care Planning.
  8. Obtain from the DAIL or its designee, final determination as to clinical and financial eligibility.
  9. Ensure that applicants complete and sign *MyCare* Provider's DAIL-approved Enrollment Agreement, as described in Article IV Section 4.3 D, Enrollment Agreement. The Enrollment form must include the names of all nursing facilities available within *MyCare* Provider's network. If applicant is legally incompetent, legal guardian or individual in charge of applicant's medical care must sign Enrollment Agreement.

*MyCare* Provider must complete all necessary enrollment forms and forward all completed enrollment forms to the DAIL no later than two business days following the effective date of enrollment.

- C. *MyCare* Provider shall comply fully with the DAIL policies for providing assistance to persons with Limited English Proficiency. *MyCare* Provider shall develop appropriate methods of communicating with its participants who do not speak English as a first language, as well as participants who are visually and hearing impaired, and accommodating participants with physical disabilities and different learning styles and

capacities. Participant materials, including the participant handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total *MyCare Vermont* enrollment.

*MyCare* Provider shall ensure in-person or telephonic interpreter services are available to any participant who requests them, regardless of the prevalence of the participant's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as written translation vendors on behalf of *MyCare* Provider and other departments under AHS umbrella, including the DAIL. *MyCare* Provider will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired participants. This requirement includes the provision of interpreters at medical sites.

D. Enrollment Agreement

Provider will develop an Enrollment Agreement and submit to the DAIL for prior approval and inclusion as Attachment 3 of this Agreement. The Enrollment Agreement must address the following:

1. Benefit services/coverage
2. Benefit exclusions and limitations
3. Process for accessing emergency services and urgently needed care
4. Eligibility/enrollment process
5. Process for accessing services outside *MyCare* Provider's service area
6. Termination of benefits due to voluntary or involuntary disenrollment
7. Participant grievance/appeal procedure
8. Participant bill of rights
9. Participant and caregiver responsibilities
10. General administrative provisions
11. Definitions
12. Financial eligibility standards
13. Nursing facility placement
14. Participant financial obligations, such as spend down requirements and copayments

The document will be reviewed with individuals at the time of their enrollment and must be signed by the individual or his/her family

member/caregiver representative prior to enrollment taking effect.

Once the participant has signed the Enrollment Agreement, Contactor will provide him/her with:

1. A copy of the Enrollment Agreement;
2. A sticker with *MyCare* Provider's emergency telephone numbers and an instruction sheet to put on or by participant's telephone telling what to do in an emergency; and
3. An identification card or sticker to be carried with participant's Medicaid and Medicare cards (if applicable) indicating that he/she is enrolled in *MyCare* Provider's *MyCare Vermont* plan.

E. Continuous Enrollment and Recertification

An individual's enrollment continues until death regardless of changes in health status unless enrollment is terminated for one of the reasons listed in Article IV Section 4.4, Disenrollment.

Recertification of level of care will be performed by DAIL on an annual basis. This annual reevaluation may be waived for those individuals for whom DAIL determines that there is no reasonable expectation of improvement or significant change in condition. In these circumstances, this waiver will be for the duration of the participant's life. Those individuals who are determined through the annual recertification process to no longer meet level of care, but in the absence of continued coverage by *MyCare* Provider, would be expected to meet level of care again within six months, may be granted continued eligibility.

#### **4.4 Disenrollment**

A. Voluntary Disenrollment

Participants may voluntarily disenroll, without cause. Enrollment requests made before the 15<sup>th</sup> day of the month will become effective on the first day of the following month. Enrollment requests made on the 15<sup>th</sup> day of the month or later will become effective on the first day of the second following month.

When a participant elects to disenroll, *MyCare* Provider will do the following:

1. The participant's case manager will complete a DAIL "Change Report" form and send copies to the DAIL and the Department of

- Children and Families. The case manager will indicate on the form the reason for termination and that it is a voluntary withdrawal.
2. The ICT will complete a discharge plan to meet the health care needs of the participant in the community. The plan will include referrals to other resources in the community to assure continuity of care. The ICT will designate a staff member to review the plan with the participant in person prior to disenrollment.
  3. *MyCare* Provider will forward medical records as requested by the participant or appropriate responsible party. In all cases of medical records release, proper authorization will be obtained in the form of a signed consent to release medical information.
  4. Each discipline will be required to document all information related to the enrollment, including the reasons for the disenrollment, and complete a discharge note. All disenrollment information will be documented in the participant's medical record and be available for review by the state and CMS.
  5. *MyCare* Provider will notify participants in writing by a formal letter of disenrollment. The letter will be in a format pre-approved by the DAIL and will include the following information:
    - a. Effective date of disenrollment;
    - b. Information regarding receipt of Medicaid long term care services outside of *MyCare Vermont*;
    - c. Statement of continued coverage until the effective date of disenrollment;
    - d. Information regarding referrals made by *MyCare* Provider to other health care providers; and
    - e. Information regarding reinstatement back into the *MyCare Vermont* program.

*MyCare* Provider will review disenrollment rates and reasons for disenrollments on a periodic basis as part of its Quality Management Program activities to determine any trends and patterns. Based on the outcomes of the studies, *MyCare* Provider will develop action plans to address any trends related to quality of care.

## B. Involuntary Disenrollment

Individuals may be involuntarily disenrolled from *MyCare* Provider's plan under the following circumstances. *MyCare* Provider shall notify DAIL promptly when it learns that a participant meets any involuntary disenrollment criteria.

1. Death;
2. Incarceration;
3. Participant fails to pay, or make satisfactory arrangements to pay, any premium due after a 30-day grace period (private-pay participants only);
4. Participant engages in disruptive or threatening behavior such that his/her behavior jeopardizes his or her health or safety, or the safety of others, subject to the provisions of Article IV Section C, Disenrollment due to Disruptive or Threatening Behavior;
5. Participant or family member/caregiver with decision-making capacity consistently refuses to comply with his/her individual Plan of Care or the terms of the *MyCare Vermont* Enrollment Agreement, subject to the provisions of Article IV Section C, Disenrollment due to Disruptive or Threatening Behavior;
6. Participant moves out of *MyCare* Provider's service area or is out of the service area for more than 30 consecutive days, unless *MyCare* Provider and the DAIL agree to a longer absence due to extenuating circumstances;
7. Participant is determined to no longer meet the state's clinical criteria for long-term care and is deemed not eligible; or *MyCare* Provider is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

## C. Disenrollment due to Disruptive or Threatening Behavior

If *MyCare* Provider proposes to disenroll an individual who is disruptive or threatening, it must document in the participant's medical record the reasons for proposing disenrollment and all efforts made to remedy the situation. *MyCare* Provider staff must undertake one-on-one discussions and/or meetings with participant and/or caregiver to encourage a change in behavior on the part of the participant. The decision to request involuntary disenrollment of an individual must be made by the entire Interdisciplinary Care Team for that individual, if efforts to resolve areas of conflict or jeopardy result in an impasse.

## D. Involuntary Disenrollment Process

*MyCare* Provider will prepare a written involuntary disenrollment report, in a format approved by the DAIL. This report will identify the reason(s) for disenrollment and describe all efforts to remedy the situation.

*MyCare* Provider will forward a copy of the involuntary disenrollment report to DAIL, which may request additional information. Once the information request from the DAIL has been satisfied, the state will review the report and notify *MyCare* Provider within ten business days of its approval or disapproval of the involuntary disenrollment.

The state has the final right of determination for all involuntary disenrollments. If the disenrollment is approved, *MyCare* Provider will follow the procedures described in Article IV Section 4.4 A, Voluntary Disenrollment, except that *MyCare* Provider must provide participants and/or family members with thirty (30) days written notice.

E. Prohibitions

*MyCare* Provider shall not disenroll any individual on the basis of an adverse change in the participant's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Upon request, information on disenrollments (by reason code) shall be available to the DAIL for audit purposes.

F. Re-enrollment

Any individual who has previously disenrolled from *MyCare Vermont* may re-enroll at any time upon meeting the eligibility criteria and paying any outstanding premium amounts (if applicable). There is no limit on the number of times an individual may re-enroll following disenrollment. An individual who wishes to be reinstated following a disenrollment must complete the intake process in its entirety, including completion of the level-of-care evaluation by the DAIL and reassessment by the Interdisciplinary Care Team prior to reinstatement.

#### **4.4 Phase-Down and Phase-Out Plan**

The Provider, if necessary, shall implement its Department-approved Phase-Down and Phase-Out Plan, which shall include but not be limited to, the following items:

- A. A description of the manner in which Participants will be referred to other sources of care.
- B. A description of the manner in which Participants will be informed of the cessation of the PIHP Agreement.
- C. The appeal process, which Participants may use during the phase-down or phase-out process.
- D. Copies of all forms and accompanying explanations to be used to notify the Participants of the phase-down or phase-out process.
- E. The case management and placement services that the Provider will provide during the phase-down or phase-out process.

## **ARTICLE V: GRIEVANCES AND APPEALS**

### **5.1 Appeal and Grievance Procedures**

Appeals and Grievances must be processed in accordance with the processes and timelines established by *Choices for Care* rules, Human Services Board statutes and rules, and federal regulatory requirements for PIHPs (42 CFR 438).

***Note – this section under development.***

## **ARTICLE VI: QUALITY MANAGEMENT AND UTILIZATION REVIEW**

### **6.1. Quality Management**

#### A. Quality Management Program

*MyCare* Provider must operate an ongoing quality Management Program (QM) which includes quality assessment and performance improvement, in accordance with federal and State requirements. *MyCare* Provider and DAIL agree to define quality services as those which: Increase the likelihood of desired health outcomes; increase the likelihood of desired independence and quality of life; are Person-Centered; and are consistent with current professional knowledge about effective care.

*MyCare* Provider shall have a Quality Management (QM) Program for doing all of the following:

1. Measuring the *MyCare* Provider's performance of its contractual responsibilities,
2. Identifying opportunities for improving performance,
3. Developing and implementing action steps to improve performance, and Measuring whether the targeted improvements have been achieved.

#### B. Written Quality Improvement Plan

*MyCare* Provider shall have on file with the DAIL, prior to the start of enrollment, an approved written plan describing the QM Program, including how *MyCare* Provider will accomplish the activities required by this section.

*MyCare* Provider shall approach all clinical, functional, personal experience and administrative aspects of quality assessment and performance improvement based on principles of Continuous Quality improvement (CQM ) and shall:

1. Rely heavily on participant input;
2. Recognize that opportunities for improvement are unlimited;
3. Be data driven;
4. Rely heavily on input from all staff of the *MyCare* Provider and its subcontractors;
5. Require measurement of effectiveness, continuing development, and implementation of improvements as appropriate;

6. Evaluate provider and *MyCare* Provider performance using objective quality indicators;
7. Support continuous ongoing measurement of clinical, functional, personal experience and administrative effectiveness and participant satisfaction;
8. Support programmatic improvements of clinical, functional, personal experience and administrative processes based on findings from ongoing measurements; and
9. Support re-measurement of effectiveness and participant satisfaction, and continued development and implementation of improvement interventions as appropriate.

The QM Program shall include annual goals for planned projects or activities, including clinical, functional, personal experience and administrative or initiatives and measurement activities. Each goal shall have associated timelines and quantitative measures for evaluation.

*MyCare* Provider shall submit a semi-annual QM Program evaluation in a format and timeframe specified by the DAIL. The evaluation shall evaluate the effectiveness of clinical, functional, personal experience and administrative QM initiatives using, in whole or in part, the quality measures defined in the Quality Program Initiatives section.

*MyCare* Provider shall include in subcontracts a requirement securing cooperation with the QM Program. The *MyCare* Provider shall keep participating physicians and other Network Providers informed about the QM Program and related activities.

#### C. QM Program Structure

*MyCare* Provider shall maintain a well-defined QM structure that includes a planned systematic approach to improving clinical, functional, personal experience and administrative processes and outcomes. *MyCare* Provider must ensure that sufficient skilled staff and resources are allocated to implement the quality management program. *MyCare* Provider will ensure that participants, Interdisciplinary Care Team members, employees and contract providers are involved in the development and implementation of all quality management activities.

*MyCare* Provider shall designate individuals to fill the following QM program-related positions:

1. *Quality Management Director:* an identified senior-level director who will oversee all quality management and performance-improvement activities. The quality management director must have expertise in the Integrated Care Model.
2. *Medical Director:* a medical director licensed by the State of Vermont with geriatric expertise and/or disability expertise and experience in community and institutional long term care, who will be responsible for establishing medical protocols and practice guidelines to support the QM program described in this section.
3. *Physician:* a qualified physician, licensed by State of Vermont in Medicine and further board certified in family practice or internal Medicine, with responsibility for establishing and monitoring the implementation and administration of geriatric and disability management protocols.
4. *Behavioral Health Clinician:* a qualified behavioral health clinician, with expertise in geriatric and disability service, who will be responsible for establishing behavioral health protocols and providing specialized support to PCPs and the ICT.

#### D. Internal Oversight of QM Program

The QM Program shall include a set of functions, roles, and responsibilities for the oversight of QM Program activities that are clearly defined and assigned to appropriate individuals, potentially including administrative staff, subcontractors, Interdisciplinary Care Team members, other clinicians, and non-clinicians.

The QM Program shall include the following standing committees:

1. *Participant Advisory Committee:* MyCare Provider must establish an advisory body that represents the interests of MyCare Vermont participants and caregivers. The Participant Advisory Committee guides key decision-making in the areas of participant satisfaction and quality improvement. This committee provides quarterly reports to the MyCare Provider's Board of Trustees overseeing the operation of MyCare Vermont. At least one member of the Committee must also be a member of the Board of Trustees.
2. *Ethics Committee:* MyCare Provider must establish an ethics committee, operating under written policies and procedures, to provide input to decision-making, including delivery of services, end-of-life issues and Advance Directives.
3. *Professional Advisory Committee:* MyCare Provider must establish a Professional Advisory Committee to advise on the development and implementation of program policies and the ongoing review and

evaluation of program performance in light of established goals and objectives. This committee provides quarterly reports to the *MyCare* Provider's Board of Trustees overseeing the operation of *MyCare Vermont*.

E. Quality Management Report

The Provider shall submit a written report of Quality Management activities including standard measures required by the State to the Governing Body, Plan Advisory Committee and DAIL on an annual basis, including topics reviewed, method of review, recommendations and evaluation of corrective actions implemented.

F. Quality Management Monitoring

The Department and their authorized representatives shall operate a Quality Management monitoring program to assure compliance with the program requirements and review program performance as it relates to Participant outcomes and consistency of quality indicators.

This Quality Management program shall consist of routine on-site compliance and quality of care reviews, and may include on-site visits of Participant's home environment. Such reviews will be performed periodically (at least annually) and may be scheduled at a time mutually agreed upon or may be unannounced. The reviews will focus on the performance of the program in the operation and delivery of services consistent within this Agreement.

Any problems identified during the review will be reported to the Provider for corrective action planning. A written corrective action plan must be submitted to the Department within 30 days of receipt of the Department's report for review and written approval. The Department approved corrective action plan shall be implemented by the Provider and will be monitored by the Department.

The Provider is also subject to an annual, external independent review of the quality outcomes and timeliness of, and access to, the services covered under this Agreement. The Provider must comply with requests from the Department for submissions of data required to complete the external independent review of quality.

G. Clinical Practice Guidelines

*MyCare* Provider shall adopt not fewer than six evidence-based clinical practice guidelines. The six evidence-based clinical practice guidelines must be distributed as follows: at least two specific quality goals in the Acute/primary care, long-term care, and behavioral health areas. Such practice guidelines shall be based on valid and reliable clinical evidence, consider the needs of participants, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate, but not less than every other year.

*MyCare* Provider shall develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QM Program. *MyCare* Provider shall coordinate the development of clinical practice guidelines with DAIL to avoid providers receiving conflicting practice guidelines from *MyCare* Provider and DAIL.

*MyCare* Provider shall disseminate the practice guidelines to all affected providers, participants and potential participants. *MyCare* Provider shall take steps to implement adoption of the guidelines, and to measure continuous Provider compliance with the guidelines.

#### H. Quality Measurement – Program Level

*MyCare* Provider shall engage in the collection of quality measurement data. Quality measures are defined to include statistical assessments of the structure and process of medical, long-term care delivery and the personal experience of the participant, as well as assessments of the impact or outcome of care on the health status and well-being of participants.

Quality measures should be selected from nationally adopted or endorsed evidence-based measurement sets wherever possible. When such measures are not available, quality measure selection should be informed by a consensus process involving providers and participants of services, in Vermont or elsewhere.

*MyCare* Provider shall assess the quality of care delivered to participants using measures and measurement methodologies, including:

1. Measurement of access to care and access to the Interdisciplinary Care Team using a participant survey;
2. Measurement of participant involvement in the interdisciplinary care team;

3. Measurement of the provision of Person-Centered Care, of participant goal attainment, and of care that is consistent with the *DDAS Desired Outcomes of Services*, using a participant survey;
4. Measurement of participant experience and level of satisfaction using periodic telephone calls to participants specifically for this purpose;
5. Measurement of program Interdisciplinary Care Team performance through review of Individual Care Plans and minutes of Team meetings, observation of Team meetings and survey of Team members;
6. Measurement of effective management of common chronic care conditions (e.g., asthma) identified by DAIL and other measures required by DAIL;
7. Measurement of effective management of: dementia; alcohol and drug abuse prevention and treatment Initiative; abuse and neglect identification measures required by the DAIL;
8. Measurement of effective provision of preventive services (e.g., periodic recommended screenings, health promotion and wellness activities) using appropriate HEDIS measures identified by the DAIL and other measures required by the DAIL;
9. Measurement of incidence and appropriate use of ambulatory care-sensitive hospitalizations, nursing facility institutionalization and emergency room visits; and
10. Measurement of the effectiveness of *MyCare* Provider and Interdisciplinary Care Team efforts to support participants in managing chronic conditions using appropriate measures required by the DAIL.

*MyCare* Provider shall use such quality measurement data in the development, assessment, and modification of its QM Program.

#### I. Annual Quality Program Initiatives

Using information obtained through the previous section, Quality Measurement Program Level, *MyCare* Provider shall annually define and develop at least two specific quality goals in the primary care, long-term care, and behavioral health areas. *MyCare* Provider must provide documentation on each project, describing:

1. The objective;
2. The expected outcomes;
3. A brief justification with background on each objective;
4. How each quality goal will be measured;
5. The target population;

6. The method of evaluating change in the quality goals;
7. Communication processes; and
8. Documentation requirements.

Quality program initiatives shall be proposed to DAIL for approval at least thirty (30) days prior to the start of each Contract Year and shall address identified opportunities for quality improvement for which a quality program initiative can positively impact care in a meaningful way for a significant percentage of participants. In selecting initiatives, Contactor may take into consideration any initiatives planned by the state's external quality review organization, as described in Article VI, Section 6.1 M, Collaboration with the EQRO.

Quality initiative evaluations shall be included within the annual QM program evaluation submitted to the DAIL.

J. Quality Measurement – ICT and Provider Profiling

*MyCare* Provider shall conduct Interdisciplinary Care Team and provider profiling activities at least annually. As part of its written QM Program description, *MyCare* Provider shall describe the methodology it uses to identify how many and which providers to profile and to identify measures to use for profiling providers and Interdisciplinary Care Teams.

The *MyCare* Provider shall develop Interdisciplinary Care Team and provider-specific reports that include a multi-dimensional assessment of an Interdisciplinary Care Team's or provider's performance using clinical, administrative, and participant experience and satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population.

*MyCare* Provider shall identify external quality benchmarks against which Interdisciplinary Care Team and provider performance can be assessed. *MyCare* Provider shall communicate the results of its profiling activities to the profiled Interdisciplinary Care Teams and providers, providing Team/provider-specific data, program-wide data, and external quality benchmark data.

K. Network Profiling

*MyCare* Provider shall use the results of its Interdisciplinary Care Team and provider profiling activities, as well as data obtained from other

sources, to identify areas of potential improvement for individual Teams and providers. *MyCare* Provider shall establish Team-specific and provider-specific quality improvement goals for priority areas in which an Interdisciplinary Care Team or provider does not meet established *MyCare* Provider quality performance standards or did not meet prior year improvement goals. *MyCare* Provider shall establish such improvement goals with active input and involvement by the affected Teams and providers.

*MyCare* Provider shall, at least annually, measure and report to DAIL on the progress of individual Interdisciplinary Care Teams and individual providers towards goal achievement. DAIL reserves the right to require more frequent reporting.

L. Collaboration with the DAIL Division of Disability and Aging Services

The DAIL Division of Disability and Aging Services (DDAS) maintains a Quality Management Plan addressing quality assurance and improvement on a statewide basis. The DDAS Quality Management Unit performs ongoing assessment of the quality of certain long-term care services provided to Vermonters served by DAIL, including services delivered by Home Health providers, Area Agencies on Aging, and Adult Day Services providers. *MyCare* Provider agrees to comply with the Quality Management Plan of the DAIL, Division of Disability and Aging Services.

M. Collaboration with the EQRO

*MyCare* Provider will collaborate with the Agency of Human Services external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to participants and to identify opportunities for *MyCare* Provider improvement. *MyCare* Provider shall work collaboratively with the DAIL and the EQRO to define annually perform quality measurement activity.

N. Outcomes of the Quality Management Program:

*MyCare* Provider and the DAIL agree that the DAIL will use the measures listed below to evaluate and measure the success of the QM program. The outcomes of a Quality Management Program are met when *MyCare* Provider:

1. Demonstrates that it has an internal quality improvement system described in an annual report to the DAIL;
2. Provides documentation that it has reviewed and if appropriate, taken steps for improving the quality of services provided by subcontractors as reported in the annual delegation of authority report to the DAIL;
3. Provides documentation that it has reviewed and if appropriate, taken steps for improving, access to health care in an annual report to the DAIL;
4. Provides documentation of the results of physician credentialing in an annual report to the DAIL;
5. Provides the results of member satisfaction survey indicating overall Satisfaction of at least eighty (80) percent in an annual report to the DAIL;
6. Achieves demonstrable improvement in significant aspects of clinical, functional, personal experience areas that can be expected to have a favorable effect on health outcomes and participant satisfaction, as evidenced in the two annual project reports to the DAIL; and
7. Demonstrates improvement in the support provided to participants in achieving their desired outcomes.

O. Utilization Management Plan

*MyCare* Provider shall develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must conform to all applicable Federal and State regulations.

*MyCare* Provider 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 participant.

P. State of Vermont and Federal Reviews

*MyCare* Provider must make available to the State of Vermont and/or outside reviewers, on a periodic basis, medical, financial and other records for review of quality of care and access issues. This requirement is in addition to *MyCare* Provider's activities with regard to the State's EQRO, as described in Article VI Section 6.1M, Collaboration with the EQRO.

CMS also may designate an outside review agency to conduct an evaluation of the *Choices for Care Waiver* and its progress toward achieving program goals. *MyCare* Provider must agree to make available to the CMS outside review agency medical and other records (subject to confidentiality constraints) for review as requested.

## **ARTICLE VII: RECORD RETENTION, AUDIT, AND INSPECTION**

### **7.1 Records**

#### A. Records Retention

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

#### B. Enrollee Records

*MyCare* Provider shall ensure that each participant has a clinical care / treatment record. *MyCare* Provider shall ensure compliance with all State and Federal legal requirements as they pertain to medical records and in particular, to confidentiality of records. At a minimum, all records shall:

1. Be maintained in a manner that is current, detailed, and organized such that it permits effective patient care and quality review as documented in the Minimum Standards and Clinical Care Audit;
2. Include sufficient information to identify the patient, date of encounter and pertinent information which documents the type and frequency of services provided;
3. Include an annual review of treatment and service plan determinations (as appropriate and applicable); and
4. Describe the participant's diagnosis and appropriateness of the treatments/services, the course and results of the treatment/services, and shall illustrate how the provider facilitates continuity and coordination of care as evidenced by:
  - a. As appropriate, presence of a comprehensive semi-annual health evaluation;
  - b. Functional assessment completed biennially (if appropriate); History and Physical;
  - c. Annual service or as necessary and participant preference, if applicable;
  - d. Quarterly updates to the service plan, if applicable;
  - e. Monthly evaluative summary of treatment and service needs, if applicable;

- f. As appropriate, medication evaluation, prescription and management of drug therapies.

Audit expenses incurred by the Provider's staff shall be borne by the Provider, while the cost of state and federal audit personnel will be the responsibility of the state and federal government respectively. The Provider agrees to maintain all records in accordance with the laws of the State and the United States Government, and their administrative rules, regulations, and guidelines and in a manner conducive to review and analysis.

## **ARTICLE VIII: CONFIDENTIALITY**

*MyCare* Provider agrees that all information, records, and data collected in connection with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a)(7) of the Social Security Act, *MyCare* Provider agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and participants to purposes directly connected with the administration of the plan. In addition, *MyCare* Provider agrees to guard the confidentiality of participant information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to participant identifying information shall be limited by *MyCare* Provider to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, DAIL, the United States DHHS, and other individuals or entities as may be required by the State of Vermont.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. DAIL shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by participants or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated either by State and/or Federal laws and regulations.

## **ARTICLE IX: TERMS AND CONDITIONS**

### **9.1 Compliance**

*MyCare* Provider must also meet the requirements of all applicable Federal and State laws and regulations, including Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

### **9.2 Prohibited Affiliations**

*MyCare* Provider shall not knowingly have a relationship with either of the following:

- A. 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.
- B. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

For purposes of this Agreement, a relationship is defined as a director or officer of *MyCare* Provider or a person with an employment, consulting or other arrangement with *MyCare* Provider.

### **9.3 Representation and Warranties of the Provider**

- A. The Provider represents and warrants to the Department that, to the best of its knowledge, it and its contractors has complied with and is complying with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to its property and the conduct of its operations, and there are no violations of any statute, order, rule, or regulation existing or threatened.
- B. If, at any time during the term of this Agreement, the Provider, or its contractors, incur loss of clinical licensure(s), accreditation(s), or state approval(s), such loss shall be reported to the Department no later than

the next business day following the discovery of such loss. Such loss may be grounds for termination of this Agreement under the provisions of Article XI, Section 11.1.

#### **9.4 Information Sharing**

Subject to all applicable federal and state laws, the Provider, during the course of the Participant's enrollment or upon termination of enrollment, whether voluntary or involuntary, shall arrange for the transfer of medical information regarding such terminated Participant to any subsequent provider of medical services to such Participant, as may be directed by the Department, the Participant, regulatory agencies of the State, or the United States Government.

#### **9.5 Other Contracts**

Nothing contained in this Agreement shall be construed to prevent the Provider from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder. However, the Provider shall submit to the Department a complete list of such plans and services, including rates, upon request. Nothing in this Agreement shall be construed to prevent the Department from contracting with other comprehensive health care plans in the same enrollment area.

#### **9.6 Entire Agreement**

This Agreement, including all Attachments and Appendices, constitutes the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Agreement shall prevail notwithstanding any variances with terms and conditions of any written or verbal communication subsequently occurring, except as provided in Article XII, Section 12.2 herein. The MyCare Provider Agreement (including attachments), the Request for Proposals, and Provider's submission in response to the Request for Proposals are incorporated by reference and made part of this Agreement. In the event of any conflict in terms or requirements, the MyCare Agreement shall take precedence, followed by the Request for Proposals.

## **9.7 Section Heads**

The headings of the sections of this Agreement are for convenience only and will not affect the construction hereof.

## **9.8 Administrative Procedures Not Covered**

Administrative procedures not provided for in this Agreement will be set forth when necessary, in separate memoranda in accordance with Article XII, Section 12.2 herein.

## **9.9 Effect of Invalidity of Clauses**

If any clause or provision of this Agreement is in conflict with any state or federal law or regulation, that clause or provision shall be null and void, and any such invalidity shall not affect the validity of the remainder of this Agreement.

**9.10** *MyCare* Provider understands that it is the state's ultimate objective to apply for a federal waiver permitting capitation of Medicare-reimbursable services furnished to *MyCare Vermont* participants, regardless of participant age. Once such approval has been granted, the state reserves the right to require *MyCare* Provider to accept Medicare capitation, under an agreement with the federal government, as a condition for continued participation in the program.

## **9.11 Independent Contractors**

The Provider, its employees, contractors, or any other of its agents shall act in an independent capacity and not as officers or employees of DAIL or the State of Vermont in performance of this Agreement.

## **9.12 Subrogation**

The Department shall be subrogated and succeed to any right of recovery of a Participant against any person or organization, for any services, supplies, or both, provided under this Agreement up to the amount of the benefits provided hereunder. The Department may ask the Participant to pay over to the Department all such amounts recovered by suit, settlement, or otherwise, from any third person or his/her insurers to the extent of the benefits provided hereunder.

The Provider shall make no claim for recovery of the value of Covered Services rendered to a Participant when such recovery would result from an action

involving the tort liability of a third party or casualty liability insurance, including Workers' Compensation awards. The Provider shall identify and notify the Department of cases in which an action by the Participant involving the tort or Workers' Compensation liability of a third party could result in recovery by the Participant of funds to which the Department has lien rights. Such cases shall be referred to the Department within 10 working days of discovery. To assist the Department in exercising its responsibility for such recoveries, the Provider shall meet the following requirements:

- A. The Provider shall use its best efforts to notify the Department of any Covered Service that is delivered as a result of an accident or illness from which the Department may be eligible to make a claim for recovery.
- B. If the Department requests payment information and/or copies of paid invoices/claims for Covered Services to an individual Participant, the Provider shall deliver the requested information within 30 calendar days of the request. The value of the Covered Services shall be the amount that the Department would have paid for the services if billed fee-for-service.
- C. Information to be delivered shall contain the following data items:
  - 1. Participant name
  - 2. Participant social security number
  - 3. Participant Medicaid Identification Number
  - 4. Participant date of birth
  - 5. (Sub)contractor name
  - 6. Provider name (if different from contractor)
  - 7. Date(s) of service
  - 8. Diagnosis code and/or description of illness/injury
  - 9. Procedure code and/or description of services rendered
  - 10. Amount billed to the Provider by the contractor or non-11. Provider affiliated provider (if applicable)
  - 11. Amount paid by other health insurance to the Provider, subcontractor, or non-Provider affiliated provider
  - 12. Amount date paid by the Provider to the subcontractor or non-Provider-affiliated provider and date of payment
  - 13. Date of denial and reason (if applicable)
  - 14. National Drug Code (NDC) (if applicable)
  - 15. Name of insurance carrier (if applicable)
  - 16. Participant policy number (if applicable)
- D. The Provider shall identify to the Department the name, address, and telephone number of the person responsible for receiving and complying with requests for information under this Section.

If the Provider receives any requests by subpoena from attorneys, insurers or beneficiaries for copies of bills, the Provider shall provide the Department with a copy of any document released as a result of such requests, and shall provide the name, address, and telephone number of the requesting party.

***Note – Please see Attachment 5 “Customary State Contract Provisions” and Attachment 7 “Agency of Human Services Customary Contract Provisions”.***

## **ARTICLE X: REPORTS**

### **10.1 Reporting Requirements**

A. *MyCare* Provider shall maintain a management information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The system must collect data on participant and provider characteristics, as specified by the DAIL, and on services as set forth under Article VI Section 6.1 J, Quality Management Program. All collected data must be available to DAIL and the CMS upon request.

B. Quarterly Reports

*MyCare* Provider agrees to electronically transmit data elements as required by the DAIL in the format and frequency specified by the Department. Data either will be submitted using the Vermont SAMS® data base or DataPACE®. Provider agrees to participate both financially and programmatically in any data collection or survey activities the DAIL requests, including purchase of software at the DAIL's location.

*MyCare* Provider shall submit quarterly reports, in the DAIL-specified formats, documenting *MyCare Vermont* enrollment, revenue, expense and utilization. Report formats are included in Attachment 4 of the Agreement. Quarterly reports are due thirty days after the quarter's end.

The DAIL reserves the right to require monthly or quarterly submission of encounter data if *MyCare* Provider's summary reports are determined to be incomplete or inaccurate, or if encounter-level reporting is mandated by CMS.

C. Ad Hoc Reports

*MyCare* Provider agrees to provide any additional information that the Department needs as determined necessary by the Department or to substantiate the above reports, or monitor effectiveness of program.

## **10.2 Completion of MDS**

At the DAIL's discretion, *MyCare* Provider agrees to complete a Resident Assessment Minimum Data Set (MDS) or other assessment instrument as determined by the Department, and transmit the information to the Department or its designee in an electronic format designated by the Department. The assessment will be completed on a regular basis (as determined by the Department) for each Participant for the purpose of comparing the *MyCare Vermont* population to the nursing facility and waiver population. Provider agrees to purchase the software required to transmit the data and to attend any training needed in order to complete this requirement.

## **10.3 Consumer Satisfaction Surveys**

The Provider agrees to regularly evaluate their Participants' satisfaction with services and agrees to cooperate and facilitate implementation of consumer satisfaction surveys (from Participant or caregiver) the Department determines necessary in order to evaluate services provided under this Agreement.

## **10.4 Network Reporting**

The DAIL shall provide report formats and variable definitions for *MyCare* Provider to use in providing network capacity data to demonstrate that it offers an appropriate range of covered services adequate for the anticipated number of participants for the service area; and that it maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of participants in the service area.

Network capacity documentation shall be submitted annually and at any time there has been a significant change in *MyCare* Provider's operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

Reports are due within 45 days following the end of the reporting period.

## **10.5 Data Validation**

*MyCare* Provider must have DAIL-approved policies and procedures for verifying that services documented on quarterly reports were actually provided. Biennially, DAIL or its designee will request encounter data for a sample of participants and will perform medical record reviews for purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

DAIL, the U.S. Department of Health and Human Services and the U.S. Government Accountability Office shall have the right to inspect and audit any of *MyCare* Provider's financial records.

### **10.6 Fraud and Abuse**

*MyCare* Provider must have both administrative and management procedures, and a mandatory compliance plan, to guard against fraud and abuse. The procedures and compliance plan must include the following:

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

*MyCare* Provider must further require any employees, contractors, and grantees that provide goods or services for *MyCare Vermont* to furnish, upon reasonable request, to DAIL, the Vermont Attorney General, and the United States DHHS, any record, document, or other information necessary for a review, audit, or investigation of program fraud or abuse, and shall establish procedures to report all suspected fraud and abuse to DAIL and the Vermont Attorney General.

For each case of suspected fraud and abuse reported, *MyCare* Provider shall supply (as applicable) the name and identification number; source of the complaint or issue; type of provider; nature of the complaint or issue; the approximate dollars involved; and the legal and administrative disposition of the case. *MyCare* Provider must provide access to both original documents and provide free copies of requested documents on a reasonable basis. Such access may not be limited by confidentiality provisions of the plan or its sub-contractors.

### **10.7 Medical Personnel**

The Provider shall supply to the Department, within ten working days of request, a list of all its medical personnel and all providers of health care with whom regular referral arrangements exist.

## **ARTICLE XI: TERMINATION OF AGREEMENT**

### **11.1 Failure to Conform**

In the event of the Provider's failure to conform to requirements set forth in Article IX, the Department may terminate this Agreement upon 30 calendar days written notice, unless within such 30-day period, the failure to conform is cured.

### **11.2 Termination Without Notice**

The Department may terminate this Agreement immediately upon any of the following events:

- A. The Provider's (1) application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property; (2) admission in writing that it is unable to pay its debts as they mature; (3) assignment for the benefit of creditors; or (4) commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Provider in any such proceedings.
- B. Commencement of an involuntary proceeding against the Provider under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within 60 days.
- C. The Provider incurs loss of any of the following: (1) licensure at any of the Provider's facilities; (2) any federally required certification(s); or (3) state or federal approvals of the Provider.
- D. Cessation of state or federal funding of Title XIX programs, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases.

### **11.3 Termination With Notice**

Either party may terminate this Agreement upon any of the following events:

- A. Breach by a party of any duty or obligation hereunder which breach continues unremedied for 30 calendar days after written notice thereof by the other party.

- B. Written notice by one party to the other that this Agreement will terminate within 120 calendar days of such notice.

#### **11.4 Termination Upon Commencement of Risk Based Contract**

This Agreement will terminate the day before the effective date of the Agreement between the Provider and the Department if any such Agreement is entered into by the parties to move to dual capitation as approved by the Centers for Medicare and Medicaid Services.

#### **11.5 Continuance of Obligations**

Notwithstanding the termination of this Agreement, the obligations of the parties there under with regard to any Participants at the time of such termination will continue in effect until other placements are found. Upon termination of this Agreement for any reason, all finished or unfinished documents, data, studies and reports prepared by the Provider pursuant to this Agreement shall become the property of the Department.

#### **11.6 Responsibilities**

In the event that this Agreement is terminated or is not renewed for any reason: (1) the Provider shall be responsible for notifying all Participants covered under this Agreement of the date of termination and the process by which those Participants will continue to receive medical care; (2) any payments advanced to the Provider for coverage of Participants for periods after the effective date of termination shall be promptly returned to the Department; and (3) the Provider agrees to promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

## **ARTICLE XII: EFFECTIVE TERM, RENEGOTIATION, AND MODIFICATION**

### **12.1 Agreement Review and Renewal**

This Agreement represents a comprehensive understanding of each party's responsibilities as pertinent to the *MyCare Vermont* program. This Agreement shall be effective for the period from \_\_\_\_\_ to \_\_\_\_\_. This Agreement shall be amended as necessary, subject to the mutual consent of both parties. In the event that a new agreement is not executed prior to the expiration date of the Agreement, the pending Agreement shall remain in effect until a successor Agreement is signed, if mutually agreed upon by both parties.

### **12.2 Amendments**

The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual consent, the parties may amend this Agreement where such amendment does not violate state or federal laws, regulations, or waiver requirements, provided that such amendment is in writing, signed by both parties, and attached hereto.

### **12.3 Sanctions**

The Department may apply sanctions to the Provider for violations of the terms of this Agreement or applicable state and federal law and regulations. Any sanctions initiated by the Department for non-compliance by the Provider shall be in accordance with current policies and procedures.

The following penalties may be applied at the discretion of the Department for contract violations as determined by the Department:

- A. A warning that future contract violations will result in actions such as those as stated in B. and C. of this paragraph.
- B. Withholding all or part of the capitation payment.
- C. Suspension of new enrollment or restriction of current enrollment.
- D. Fines/penalties consistent with those applied to nursing facilities in the State.

**12.4 Notices**

Notices to the parties as to any matter there under will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

For the Provider:

---

---

---

---

For the Department:

---

---

---

---

ATTACHMENT 5  
CUSTOMARY STATE CONTRACT PROVISIONS

1. **Entire Agreement:** This Contract represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.
2. **Applicable Law:** This Contract will be governed by the laws of the State of Vermont.
3. **Appropriations:** If this Contract extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Contract, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriations authority.
4. **No Employee Benefits for Contractors:** The Contractor understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers' compensation or other benefits or services available to State employees, nor will the State withhold any state or federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Contract. The Contractor understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Contractor, and information as to Contract income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.
5. **Independence, Liability:** The Contractor will act in an independent capacity and not as officers or employees of the State. The Contractor shall indemnify, defend, and hold harmless the State and its officers and employees from liability and any claims, suits, judgments, and damages arising as a result of the Contractor's acts and/or omissions in the performance of this Contract. The Contractor shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this Contract.
6. **Insurance:** Before commencing work on this Contract the Contractor must provide certificates of insurance to show that the following

minimum coverage is in effect. The Contractor must notify the State no more than 10 days after receiving cancellation notice of any required insurance policy. It is the responsibility of the Contractor to maintain current certificates of insurance on file with the State through the term of the Contract. Failure to maintain the required insurance shall constitute a material breach of this Contract.

**Workers' Compensation:** With respect to all operations performed, the Contractor shall carry workers' compensation insurance in accordance with the laws of the State of Vermont.

**General Liability and Property Damage:** With respect to all operations performed under the Contract, the Contractor shall carry general liability insurance having all major divisions of coverage including, but not limited to:

- Premises - Operations
- Products and Completed Operations
- Personal Injury Liability
- Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

- \$1,000,000 Per Occurrence
- \$1,000,000 General Aggregate
- \$1,000,000 Products/Completed Operations Aggregate
- \$ 50,000 Fire/Legal Liability

**Automotive Liability:** The Contractor shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Contract. Limits of coverage shall not be less than: \$1,000,000 combined single limit.

**Professional Liability:** Before commencing work on this Contract and throughout the term of this Contract, the Contractor shall procure and maintain professional liability insurance for any and all services performed under this Contract, with minimum coverage of \$ N/A per occurrence.

No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Contractor for the Contractor's operations. These are solely minimums that have been established to protect the interests of the State.

7. **Reliance by the State on Representations:** All payments by the State under this Contract will be made in reliance upon the accuracy of all prior representations by the Contractor, including but not limited to bills, invoices, progress reports and other proofs of work.
8. **Records Available for Audit:** The Contractor will maintain all books, documents, payroll, papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the Contract and for three years thereafter for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this Contract.
9. **Fair Employment Practices and Americans with Disabilities Act:** Contractor agrees to comply with the requirement of Title 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Contractor shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Contractor under this Contract. Contractor further agrees to include this provision in all subContracts.
10. **Set Off:** The State may set off any sums which the Contractor owes the State against any sums due the Contractor under this Contract; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.
11. **Taxes Due to the State:**
  - a. Contractor understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.

- b. Contractor certifies under the pains and penalties of perjury that, as of the date the Contract is signed, the Contractor is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.
  - c. Contractor understands that final payment under this Contract may be withheld if the Commissioner of Taxes determines that the Contractor is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.
  - d. Contractor also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Contractor has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Contractor has no further legal recourse to contest the amounts due.
12. **Child Support:** (Applicable if the Contractor is a natural person, not a corporation or partnership.) Contractor states that, as of the date the Contract is signed, he/she:
- a. is not under any obligation to pay child support; or
  - b. is under such an obligation and is in good standing with respect to that obligation; or
  - c. has agreed to a payment plan with the Vermont Office of Child Support and is in full compliance with that plan. Contractor makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Contractor is a resident of Vermont, Contractor makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.
13. **Subcontractors:** Contractor shall not assign or subContract the performance of this agreement or any portion thereof to any other Contractor without the prior written approval of the State. Contractor also agrees to include in all subContract agreements a tax certification in accordance with paragraph 11 above.

Notwithstanding the foregoing, the State agrees that the Contractor may assign this Contract, including all of the Contractor's rights and obligations hereunder, to any successor in interest to the Contractor arising out of the sale of or reorganization of the Contractor.

14.

**No Gifts or Gratuities:** Contractor shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Contract.

15. **Copies:** All written reports prepared under this Contract will be printed using both sides of the paper.
16. **Certification Regarding Debarment:** Contractor certifies under pains and penalties of perjury that, as of the date that this Contract is signed, neither Contractor nor Contractor's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in federal programs or programs supported in whole or in part by federal funds.

ATTACHMENT 6  
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“Agreement”) is entered into by and between **the State of Vermont Agency of Human Services operating by and through its Department, Office, or Division of (\_\_\_\_\_Insert Department, Office, or Division) (“Covered Entity”)** and **(\_\_\_\_\_Insert Name of the Contractor) (“Business Associate”)** as of **(\_\_\_\_\_Insert Date)** (“Effective Date”). This Agreement supplements and is made a part of the Contract to which it is an attachment.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) including the Standards for the Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (“Privacy Rule”) and the Security Standards at 45 CFR Parts 160 and 164 (“Security Rule”).

The parties agree as follows:

1. **Definitions:** All capitalized terms in this Agreement have the meanings identified in this Agreement, 45 CFR Part 160, or 45 CFR Part 164.

The term “Services” includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR 160.103 under the definition of Business Associate.

The term “Individual” includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g). All references to “PHI” mean Protected Health Information. All references to “Electronic PHI” mean Electronic Protected Health Information.

2. **Permitted and Required Uses/Disclosures of PHI:**

- 2.1. Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services provided that any use or disclosure would not violate the minimum necessary policies and procedures of Covered Entity. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

- 2.2. Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents (including subcontractors) in accordance with Sections 6 and 14 or (b) as otherwise permitted by Section 3.
3. **Business Activities:** Business Associate may use PHI received in its capacity as a “Business Associate” to Covered Entity if necessary for Business Associate’s proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as “Business Associate” to Covered Entity for Business Associate’s proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if (a) Business Associate obtains reasonable written assurances via a written Contract from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person and (b) the person promptly notifies Business Associate (who in turn will promptly notify Covered Entity) in writing of any instances of which it is aware in which the confidentiality of the PHI has been breached. Uses and disclosures of PHI for the purposes identified in this Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.
4. **Safeguards:** Business Associate shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.
5. **Reporting:** Business Associate shall report in writing to Covered Entity any use or disclosure of PHI in violation of this Agreement by Business Associate or its agents including its subcontractors. Business Associate shall provide this written report promptly after it becomes aware of such use or disclosure. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate the impermissible use or disclosure. Consistent with 45 CFR 164.502(j)(1) Business Associate may use PHI to report violations of law to federal and state authorities.
6. **Agreements by Third Parties:** Business Associate shall ensure that any agent (including a subcontractor) to whom it provides PHI received from

Covered Entity or created or received by Business Associate on behalf of Covered Entity agrees in a written Contract to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. For example, the written Contract must include those restrictions and conditions set forth in Section 12.

Business Associate must enter into the written Contract before any use or disclosure of PHI by such agent. The written Contract must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the Contract concerning the use or disclosure of PHI. Business Associate shall provide a copy of the written Contract to Covered Entity upon request. Business Associate may not make any disclosure of PHI to any agent without the prior written consent of Covered Entity.

7. **Access to PHI:** Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.
8. **Amendment of PHI:** Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.
9. **Accounting of Disclosures:** Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

10. **Books and Records:** Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity (without regard to the attorney-client or other applicable legal privileges) upon Covered Entity's request in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

11. **Termination:**

11.1. This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 15.11.

11.2. If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate this Contract without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate this Contract without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under this Contract, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

12.

**Return/Destruction of PHI:**

- 12.1. Business Associate in connection with the expiration or termination of this Contract shall return or destroy all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this Contract that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.
- 12.2. Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible for so long as Business Associate maintains such PHI.
13. **Notice/Training:** Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in information security awareness training regarding the use, confidentiality, and security of PHI.
14. **Security Rule Obligations:** The following provisions of this Section 14 apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.
- 14.1. Business Associate shall implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.
- 14.2. Business Associate shall ensure that any agent (including a

subcontractor) to whom it provides Electronic PHI agrees in a written Contract to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written Contract before any use or disclosure of Electronic PHI by such agent. The written Contract must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the Contract concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written Contract to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any agent without the prior written consent of Covered Entity.

14.3. Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an agent, including a subcontract). Business Associate shall provide this written report promptly after it becomes aware of any such Security Incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

14.4. Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

15. **Miscellaneous:**

15.1. In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract, the terms of this Agreement shall govern with respect to its subject matter. Otherwise the terms of the Contract continue in effect.

15.2. Any reference to “promptly” in this Agreement shall mean no more than seven (7) business days after the circumstance or event at issue has transpired. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended or renumbered.

15.3. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of a use or disclosure of PHI in violation of any provision of this Agreement.

15.4. Business Associate shall cooperate with Covered Entity to amend this

Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

- 15.5. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.
- 15.6. In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule) in construing the meaning and effect of this Agreement.
- 15.7. This Agreement may be amended or modified, and any right under this Agreement may be waived, only by a writing signed by an authorized representative of each party.
- 15.8. Nothing express or implied in this Agreement is intended to confer upon any person other than the parties hereto any rights, remedies, obligations or liabilities whatsoever. Notwithstanding the foregoing, the Covered Entity in this Agreement is the Agency of Human Services operating by and through its Department, Office, or Division of **(\_\_\_\_ Insert name of Department, Office, or Division)**. Covered Entity and Business Associate agree that the term “Covered Entity” as used in this Agreement also means any other Department, Division or Office of the Agency of Human Services to the extent that such other Department, Division, or Office has a relationship with Business Associate that pursuant to the Privacy or Security Rules would require entry into an agreement of this type.
- 15.9. As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.
- 15.10. Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity under this Grant even if some of that information relates to specific services for which Business Associate may not be a “Business Associate” of Covered Entity under the Privacy Rule.
- 15.11. The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity

determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 12.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 9 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

- 15.12. This Agreement constitutes the entire agreement of the parties with respect to its subject matter, superseding all prior oral and written agreements between the parties in such respect.

## ATTACHMENT 7

### AGENCY OF HUMAN SERVICES CUSTOMARY CONTRACT PROVISIONS

1. **Agency of Human Services – Field Services Directors** will share oversight with the department (or office) that is a party to the contract for provider performance using outcomes, processes, terms and conditions agreed to under this contract.
2. **2-1-1 Data Base:** The contractor will ensure that relevant descriptive information regarding its agency, programs and/or contact information is contained in Vermont's 211 database and is accurate and up to date.
3. **Medicaid Program Contractors:**

**Inspection of Records.** Any Contracts accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid program must fulfill state and federal legal requirements to enable the Agency of Human Services (AHS), the United States Department of Health and Human Services (DHHS) and the Government Accounting Office (GAO) to:

Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and

Inspect and audit any financial records of such Contractor or Subcontractor.

**Subcontracting for Medicaid Services:** Having a Subcontract does not terminate the Contractor, receiving funds under Vermont's Medicaid program, from its responsibility to ensure that all activities under this agreement are carried out. Subcontracts must specify the activities and reporting responsibilities of the Contractor or Subcontractor and provide for revoking delegation or imposing other sanctions if the Contractor or Subcontractor's performance is inadequate. The Contractor agrees to make available upon request to the Agency of Human Services; the Office of Vermont Health Access; the Department of Disabilities, Aging and Independent Living; and the Center for Medicare and Medicaid Services (CMS) all Contracts and Subcontracts between the Contractor and service providers.

**Medicaid Notification of Termination Requirements:** Any Contractor accessing payments for services under the Global Commitment to Health Waiver and Medicaid programs who terminates their practice will follow the Office of Vermont Health Access, Managed Care Organization enrollee

notification requirements.

Encounter Data: Any Contractor accessing payments for services through the Global Commitment to Health Waiver and Vermont Medicaid programs must provide encounter data to the Agency of Human Services and/or its departments and ensure that it can be linked to enrollee eligibility files maintained by the State.

4. **Non-discrimination Based on National Origin as evidenced by Limited English Proficiency:** The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that Contractors and Subcontractors receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the Contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.
5. **Voter Registration:** When designated by the Secretary of State, the Contractor agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.
6. **Drug Free Workplace Act:** The Contractor will assure a drug-free workplace in accordance with 45 CFR Part 76.
7. **Privacy and Security Standards:**

Protected Health Information: The Contractor shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Contract. The Contractor shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPPA) and its federal regulations.

Substance Abuse Treatment Information: The confidentiality of any alcohol and drug abuse treatment information acquired by or provided to the Contractor or Subcontractor shall be maintained in compliance with any applicable state or federal laws or regulations and specifically set out in 42 CFR Part 2.

Other Confidential Consumer Information: The Contractor agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The Contractor agrees to comply with any applicable Vermont

State Statute, including but not limited to 12 VSA §1612 and any applicable Board of Health confidentiality regulations. The Contractor shall ensure that all of its employees and Subcontractors performing services under this agreement understand the sensitive nature of the information that they may have access to and sign an affirmation of understanding regarding the information's confidential and non-public nature.

Social Security numbers: The Contractor agrees to comply with all applicable Vermont State Statutes to assure protection and security of personal information, including protection from identity theft as outlined in Title 9, Vermont Statutes Annotated, Ch. 62.

8. **Abuse Registry:** The Contractor agrees not to employ any individual, use any volunteer, or otherwise provide reimbursement to any individual who provides care, custody, treatment, services, or supervision to children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Contractor will check the Adult Abuse Registry in the Department of Disabilities, Aging and Independent Living. Unless the Contractor holds a valid child care license or registration from the Division of Child Development, Department for Children and Families, the Contractor shall also check the Central Child Abuse Registry. (See 33 V.S.A. §4919 & 33 V.S.A. §6911).
9. **Child Abuse Reporting:** Notwithstanding the provision of 33 V.S.A. §4913(a) any agent or employee of the Contractor who has reasonable cause to believe that a child has been abused or neglected as defined in Chapter 49 of Title 33 V.S.A. shall report the suspected abuse or neglect to the Commissioner of the Department for Children and Families within one working day. The report shall contain the information required by 33 V.S.A. §4914.
10. **Work Product Ownership:** All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the Contract - including, but not limited to, all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio, pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, regardless of the state of completion, which are prepared for or are a result of the services required under this Contract shall be and remain the property of the State of Vermont and shall be delivered to the State of Vermont upon 30 days notice by the State. With respect to software computer programs and / or source codes developed for the State, the work shall be considered "work for hire," i.e., the State, not the Contractor or Subcontractor, shall have full and complete ownership of all software computer programs and/or source codes developed.
11. **Software Development:** Without exception or alternate options, it is the

State's policy that any application software which is purchased to support a business, operational or service delivery, activity of state government must include the licensing or ownership of the source code. The source code must be delivered to, and reside in, the state agency or department that supports and/or maintains the application and must be available for modification and/or maintenance by state personnel at the sole discretion and option of the State. Source code held in escrow by a third party does not meet the requirement of this policy.

12. **Intellectual Property Ownership:** All work products and items delivered or produced under this agreement will be the exclusive property of the State of Vermont. This includes, but is not limited to, software, documentation, and development materials. The Contractor shall not sell or copyright a work product or item produced under this Contract without explicit permission from the State. The Contractor shall not make information entered in the application available for uses by any other party than the State of Vermont without prior authorization by the State.
13. **Lobbying:** No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.
14. **Non-discrimination:** The Contractor will prohibit discrimination on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, or on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. No person shall on the grounds of sex (including, in the case of a woman, on the grounds that the woman is pregnant) or on the grounds of religion, be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by state and/or federal funds.
- 15.

**Environmental Tobacco Smoke:** Public Law 103-227, also known as the Pro-children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or Contracted for by an entity and used routinely or regularly for the provision of health, child care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, Contract, loan or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds.

The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

Contractors are prohibited from promoting the use of tobacco products for all clients. Facilities supported by state and federal funds are prohibited from making tobacco products available to minors.