8.5.3 Elements That Shall Not Be Included in Provider Agreements

1) No terms of the Contractor's contract with providers are valid which terminate legal liability of the Contractor in the Medicaid CCC Plus Contract.
2) The Contractor shall not require as a condition of participation/contracting in the CCC Plus program, that providers:
   a. Shall not contract with other CCC Plus program Contractors or DMAS' other managed care program Contractors;
   b. Enrolled in the Contractor's CCC Plus program network (even if for enhanced services, i.e., dental) must also participate in the Contractor's other lines of business (e.g., commercial managed care network). However, this provision would not preclude a Contractor from requiring their other managed care (commercial, Medicare, etc.) network providers to participate in their CCC Plus program provider network; and,
   c. Must, as a condition of participation/contracting, abide by terms that limit the provider's participation with other CCC Plus program Contractors.
3) In accordance with VA Code § 32.1-4, contractual indemnification with a state or local government entity is an abrogation of sovereign immunity; therefore, the Contractor's agreements with any state or local government provider shall not contain an indemnity clause.

8.5.4 Elements That Shall Be Required in Provider Agreements

The Contract between the Contractor and its intended network providers shall comply with all applicable provisions of the health plan's CCC Plus Contract with the Department of Medical Assistance Services. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract).

8.5.4.1 Elements Required in All Provider Agreements

1) Provider shall have a National Provider Identifier (NPI) number.
2) Provider shall meet the Contractor's standards for licensure, certification, and credentialing, and these shall be included in the Contractor's provider network contracts.
3) Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-

171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL #06-010.

4) Provider shall maintain records for ten (10) years from the close of the provider contract. For children under age 21 enrolled in the CCC Plus Waiver, the Contractor shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12VAC30-120-1730.
5) Provider shall provide copies of Member records and access to its premises to representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit.
6) Provider shall maintain and provide a copy of the Member's medical records, in accordance with 42 CFR § 438.208(b)(5), to Members and their authorized representatives as required by the Contractor and within no more than 10 business days of the Member's request.
7) Provider shall disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 CFR § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
8) Provider shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of its employees/contractors have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CCC Plus Members.
9) Provider shall submit utilization data for Members enrolled with the Contractor in the format specified by the Contractor, consistent with Contractor obligations to the Department as related to quality improvement and other assurance programs as required in this contract.
10) Provider shall comply with corrective action plans initiated by the Contractor.
11) Contractor shall clearly specify referral approval requirements to its providers and in any sub-subcontracts.
12) In accordance with 42 CFR § 447.15, the provider shall accept Contractor payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member's period of Contractor enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a CCC Plus recipient for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where the provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions.

13) Should an audit by the Contractor or an authorized state or federal official result in disallowance of amounts previously paid to the provider, the provider will reimburse the Contractor upon demand. The provider shall not bill the Member in these instances.
14) Any conflict in the interpretation of the Contractor's policies and MCO Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals. Provider shall comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
15) Provider agreements shall include claim processing and payment provisions as described in Section 12.4, *Provider Payment System*.

8.5.4.2 Special Provisions For Certain Provider Agreements

1) LTSS, ARTS, CMHRS and Early Intervention provider agreements shall include provisions requiring the use of the DMAS established billing codes as described in the CCC Plus Coverage Chart.
2) LTSS Providers agreements shall include provisions for compliance with the CMS HCBS Settings Rule detailed in 42 CFR § 441.301(c)(4)(5).
3) Nursing Facility, LTSS, ARTS, and Early Intervention provider agreements shall include special claim processing and payment provisions as described in Section 12.4, *Provider Payment System.*
4) Provider agreements with private providers of Community Mental Health Rehabilitative Services- the CMHRS providers are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.
5) Provider agreements with Virginia Community Services Boards (CSBs) shall include provisions that allow the CSB to bill under the facility NPI for qualifying practitioners in accordance with DMAS guidelines. Such guidelines apply to:
    a. Psychiatric services - CSBs can provide outpatient services as described under the Psychiatric Services Manual, Chapter 2, where qualifying providers are not required to operate under the physician-directed model for all services. CSBs can also bill as a mental health clinic for physician-directed services. The requirements for physician-directed services are described in the Mental Health Clinic manual, Chapter 2.
    b. Community Mental Health Rehabilitative Services- the CSBs are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.