COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MEDALLION 3.0
MANAGED CARE CONTRACT

JULY 1, 2017- DECEMBER 31, 2018

VIRGINIA

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1. Definitions and Acronyms

1.1 1.1 DEFINITIONS

"Abuse" Provider practices that are inconsistent with sound fiscal, business, or medical practices, that result in unnecessary cost to the Medicaid program; or reimbursement for services that are not medically necessary; or fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program.

"Access" As defined in 42 C.F.R. § 438.320, access as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services)
"Accreditation" The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by an industry recognized accrediting agency, such as NCQA. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

Adverse Benefit Determination" Consistent with 42 C.F.R. § 438.400, adverse benefit determination refers to the denial or limited authorization of a requested service; the failure to take action or timely take action on a request for service; the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a covered service (except where the provider's claim is denied for technical reasons including but not limited to service authorization rules, referral rules, late filing, invalid codes, etc.); failure to provide services within the timeframes required in this Contract; or, for a resident of a rural exception area with only one Contactor, the denial of a member's request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) (described in Section 7.1 of this Contract) to obtain services outside of the network; or the denial of a member's request to dispute a financial liability.

"Actuarially Sound Capitation Rates" As defined in 42 C.F.R. § 438.4(a), Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph 438.4(b) of this section.

"Actuary" an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board; also refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates

"Administrative Dismissal" A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights, but does not require the submission of a case summary or any further informal appeal proceedings.

"Adoption Assistance" A social services program, under Title XX of the Social Security Act, that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the Commonwealth of Virginia.

"Ameliorate" Necessary to improve or to prevent the condition from getting worse, with regard to EPSDT services.

"Annually" For the purposes of contract reporting requirements, annually shall be defined as 11:59PM on September 30th immediately following the effective Contract date and/or effective Contract renewal date, unless otherwise specified in the Contract.

"Appeal" In accordance with 42 C.F.R. § 438.400, a member appeal is defined as a request for review of a Contractor's internal appeal decision to uphold the contractor's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the contractor's one step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370_For providers, an appeal includes two different levels, informal and formal, and any reconsideration decision rendered by the Contractor may be appealed by the provider to the Department's Appeals Division after the provider has exhausted the Contractor's reconsideration process. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in § 2.2-4000 *et. seq*. and 12 VAC 30-20-500 *et. seq.*

"Assessment" The Contractor's appraisal and evaluation of its members to determine level of health and necessary interventions as may be appropriate. A successful assessment is considered a contact made by the health plan which assesses all health care needs, interventions received, and any additional services or referral needs. The health plan must submit the assessment procedures plan and a copy of the assessment tool annually to the Department.

"Audit" A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures.

"Balanced Budget Act" Refers to the Balanced Budget Act (BBA) of 1997; final rule issued June 14, 2002; effective August 13, 2002. The BBA is the comprehensive revision to Federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Part 438 et seq.

"**Behavioral Health Services Administrator (BHSA)"** An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. The BHSA is responsible for administering the Department's behavioral health benefits on a statewide basis for Title XIX Medicaid members and Title XXI FAMIS members, to include care coordination, provider management, and reimbursement of such behavioral health services for: 1) the full spectrum of behavioral health services for individuals who are not currently enrolled in one of the

Department's MCO Programs/contracts; and, 2) the subset of community mental health rehabilitation services that are carved out of the Department's contracts with MCOs.

"Behavioral Health and Substance Abuse Treatment Services (BHS)" An array of therapeutic and rehabilitation services provided in inpatient and outpatient psychiatric and community mental health settings to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance abuse disorder. Under this contract, the Department categorizes BHS as traditional and non-traditional services.

> ***"Traditional Behavioral Health & Substance Abuse Treatment Services"*** are defined as inpatient and outpatient behavioral health and substance abuse treatment services, including care coordination services that are covered by the Contractor under the terms of this contract.
>
> ***"Non-Traditional Behavioral Health & Substance Abuse Treatment Services"*** are defined as the subset of community mental health and rehabilitation services that are covered by the Department or its designee in accordance with the Department's established criteria and guidelines.

"Behavioral Therapy Services" Systematic interventions provided by licensed practitioners within the scope of practice, as defined under state law or regulations, and covered as remedial care under 42 C.F.R. § 440.130(d) to individuals younger than 21 years of age in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis (ABA). Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. Behavior Therapy Services are available to qualified individuals through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

"Benchmarking" A process through which standards and thresholds are developed through comparisons with others, standards, and best practices. In terms of quality benchmarking, the goal of a performance improvement system is to develop an assessment process that incorporates four basic comparisons: with self, with others, with standards, and with best practices.

"Budget Neutral" A standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

"Business Associate" Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program. A Business Associate includes, but is not limited to, those applicable parties referenced in 45 C.F.R, §160.103.

"Business Days" Means Monday through Friday, 8:30 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.

"Capitation Payment" A payment the Department makes periodically to a Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee.

"Capitation Rate" The monthly amount, payable to the Contractor, per member, for all expenses incurred by the Contractor in the provision of contract services as defined herein.

"Care Coordination" The process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

"Carved-Out Service(s)" The subset of Medicaid covered services for which the Contractor will not be responsible under this Contract.

"Case Management" The process of identifying patient needs and developing and implementing a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

"Centers for Medicare and Medicaid Services" or "CMS" The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.

"Childhood Obesity" In accordance with The Center for Health and Health Care in Schools, Childhood Obesity is defined as an age-specific Body Mass Index (BMI) that is greater than the ninety-fifth (95th) percentile. Children are considered at risk if their BMI-for-age is greater than the eighty-fifth (85th) percentile but less than the ninety-fifth (95th) percentile.

"Children With Special Health Care Needs" or "CSHCN" or "Children and Youth With Special Health Care Needs" or "CYSHCN" Children and youth with special needs have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in the eligibility category of SSI, foster care, and adoption assistance or children participating under the Health and Acute Program (HAP). CYSHCN shall include members with childhood obesity.

"**Choice Counseling"** The provision of information and services designed to assist members in making enrollment decisions. It includes answering questions and identifying factors to consider when choosing among MCOs. Choice Counseling does not include making recommendations for or against enrollment into a specific MCO.

"Claim" An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-04 (or subsequent iterations of these forms).

"Clean Claim" A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act.

"Client" or "Member" or "Participant" An individual having current Medicaid eligibility who shall be authorized by the Department to participate in the program.

"Cold-call Marketing" Any unsolicited personal contact with a potential member by an employee, affiliated provider, or contractor of the entity for the purpose of influencing enrollment with such entity.

"Complaint" A grievance.

"Comprehensive Risk Contract" a risk contract between the Department and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.
(2) Rural health clinic services.
(3) Federally Qualified Health Center (FQHC) services.
(4) Other laboratory and X-ray services.
(5) Nursing facility (NF) services.
(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.
(7) Family planning services.
(8) Physician services.
(9) Home health services.

"Consumer Assessment of Healthcare Providers and Systems" or "CAHPS®" A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Health Care Policy and Research, the Research Triangle Institute, and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans.

"Contract" This signed and executed document.

"Contract Modifications" or "Contract Amendment" Any changes, modifications, or amendments to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

"Contractor" Any entity that contracts with the Department, under the State Plan and in return for payment: to processes claims, pays for or provides medical services, or enhances the Department's capability for effective administration of the program.

"Coordination of Benefits" or "COB" A method of integrating benefits payable under more than one form of health insurance coverage so that the covered member's benefits from all sources do not exceed 100 percent of the allowable medical expenses. COB rules also establish

which plan is primary (pays first) and which plan is secondary; recognizing that Medicaid is the payor of last resort.

"Cost Avoidance" The application of a range of tools to identify and prevent inappropriate or medically unnecessary charges before they are actually paid. This may include service authorization, second surgical opinions, medical necessity review, and other pre-and post-payment / service reviews.

"Cost Sharing" Co-payments paid by the member in order to receive medical services.

"Credibility Adjustment" As defined in 42 C.F.R. § 438.8, an adjustment to the Medical Loss Ration (MLR) for a partially credible MCO to account for a difference between the actual and target MLRs that may be due to random statistical variation.

"Cultural Competency" The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

"Data Analysis" Tool for identifying potential payment errors and trends in utilization, referral patterns, formulary changes, and other indicators of potential fraud, waste, or abuse. Data analysis compares claim information and other related data to identify potential errors and /or potential fraud by claim, individually or in the aggregate. Data analysis is an integrated, on-going component of fraud detection and prevention activity.

"Days" Business days, unless otherwise specified.

"Department" also referred to as "DMAS" The Virginia Department of Medical Assistance Services.

"Disease Management" System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

"Disenrollment" The process of changing enrollment from one MCO plan to another MCO.

"Drug Efficacy Study Implementation" or "DESI" Designation indicating drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness.

"Durable Medical Equipment" or "DME" medical equipment, supplies, and appliances suitable for use in the home consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations.

"Early Intervention" or "EI" Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are

provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EI services are distinguished from similar rehabilitative services available through EPSDT to individuals aged three and older in that EI services are specifically directed towards children from birth to age three. EI services are not medically indicated for individuals aged three and above. In Virginia, the EI services program is called the "Infant and Toddler Connection of Virginia" and is managed by the Department of Behavioral Health and Developmental Services (DBHDS).

"Early Periodic Screening, Diagnosis, and Treatment" or "EPSDT" The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program benefit for individuals under the age of 21 and provides coverage for children with a comprehensive set of screenings, interventions, and other support services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT member to correct, ameliorate, or prevent the condition from worsening or prevent the development of additional health problems even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See also, 42 C.F.R. § 441 Subpart B (Sections 50-62).

"Elderly Or Disabled With Consumer Direction Waiver " or "EDCD" The CMS-approved 1915(c) waiver that covers a range of community support services offered to individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.

"Emergency Custody Order" An order, pursuant to §§ 37.2-800 through 37.2-847 (adults) and §§ 16.1-340 through 16.1-361 (minors) of the *Code of Virginia* , issued by a magistrate that requires any person in the magistrate's judicial district who is incapable of volunteering or unwilling to volunteer for treatment, or in the case of a minor pursuant to §16.1-340, to be taken into custody and transported for an evaluation in order to assess the need for temporary detention order and to assess the need for hospitalization or treatment.

"Emergency Medical Condition" A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

"Emergency Services" Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; Serious impairment to bodily functions; or, Serious dysfunction of any bodily organ or part. [42 C.F.R §438.114 (a)(i-iii)]

"Encounter" Any covered or enhanced service received by a Member through the Contractor or its subcontractor.

"Encounter Submission Calendar" The Department's schedule for the Contractor to submit encounters.

"Encryption" A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties.

"Enhanced Services" Services offered by the Contractor to members in addition to services covered by this Contract. The Department will not pay for enhanced services.

"Enrollee" A Medicaid beneficiary who is currently enrolled in an MCO.

"Enrollee Encounter Data" Information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO.

"Enrollment" The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a member to an MCO by the Department in accordance with the terms of this Contract.

"Enrollment Area" The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate as a Contractor and in which service capability exists as defined by the Commonwealth.

"Enrollment Broker" An independent broker who enrolls members in the Contractor's health plan and who is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to: member education and enrollment, assistance with and tracking of member's grievance resolution, and may include member marketing and outreach.

"Enrollment Period" The time that a member is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in Section 5 of this Contract and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

"Enrollment Report" The method by which the Department notifies the Contractor of members assigned to its health plan, as described in the Managed Care Technical Manual.

"Every Reasonable Effort" This is Contractor initiated action to promote EPSDT related screenings, laboratory tests, immunizations, follow-up treatment or other services. Every

reasonable effort shall include at a minimum a telephone call or mailed reminder either prior to the due date of each visit or upon learning that a visit has been missed and scheduling appointments for members. In the case of being notified of a missed appointment, a telephone call or mailed reminder for the missed appointment is required. If there is no response, a personal visit to urge the parent or guardian to take the child to his or her EPSDT appointment is required.

"Excluded Entity" Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Section 13.3 of this Contract.

"Exclusion from Managed Care/Exclusion from Medallion 3.0" The removal of a member from the Medallion 3.0 Program on a temporary or permanent basis.

"Expedited Appeal" The process by which an MCO must respond to an appeal by a member if a denial of care decision by an MCO may jeopardize life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor must respond as expeditiously as the member's health condition requires, not to exceed the latter of three (3) business days from the initial receipt of the appeal, or three (3) business days from receipt of written certification from the MCO or treating medical professional that the member's health condition requires expedited handling of the appeal.

"External Quality Review" or "EQR" Analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to Medicaid members, as defined in 42 C.F.R. § 438.320.

"External Quality Review Organization" or "EQRO" An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs external quality review, and other EQR related activities as set forth in 42 C.F.R. § 438.358, or both.

"Family Planning" Those necessary services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility.

"FAMIS MOMS Members" Members who are uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level (plus a 5% disregard), and who are assigned and enrolled in the aid category of 05. Covered services for FAMIS MOMs are the same as the covered services for Medallion 3.0 members. Per 12 VAC 30-141, FAMIS MOMS are not subject to exemption from MCO participation (e.g., for being hospitalized at the time of MCO enrollment). Other MCO exemptions are specific to the Medicaid Medallion 3.0 program.

"Federally Qualified Health Centers" or "FQHCs" Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

"Federally Qualified HMO" An HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

"Fee-for-Service" The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract.

"Financial Relationship" As defined in 42 C.F.R. § 438.320, a financial relationship is (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or (2) A compensation arrangement with an entity.
"**Firewall"** Software or hardware-based security system that controls the incoming and outgoing network traffic based on an applied rule set. A firewall establishes a barrier between a trusted, secure internal network and another network (e.g. the internet) that is not assumed to be secure and trusted. Firewall also includes physical security measures that establish barriers between staff, the public, work areas, and data to ensure information is not shared inappropriately or in violation of any applicable State or Federal laws and regulations.

"Flesch Readability Formula" The formula by which readability of documents is tested as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).

"**Formulary**" A list of drugs that the MCO has approved. Prescribing some of the drugs may require service authorization.

"Foster Care" Pursuant to 45 C.F.R. §1355.20, a "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility." Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is predicated upon the child being placed outside of the home and with an individual who has "placement and care" responsibility for the child. The term "placement and care" means that the Local Department of Social Services (LDSS) is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. Pursuant to the Affordable Care Act, Virginia must provide Medicaid coverage to additional foster care individuals (formerly Title IV-E or non-Title IV-E) when the following conditions occur: the individual was under the responsibility of a Virginia-based foster care agency and receiving Medicaid until discharged from foster care upon turning twenty- one (21) years, the individual is not eligible for Medicaid in another mandatory Medicaid covered group, and the individual is under age 26 years.

"Fraud" Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. Fraud also includes any act that constitutes fraud under applicable Federal or State law.

"Full Credibility" As defined in 42 C.F.R. § 438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ratio (MLR) with a

minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR

"Generally Accepted Accounting Principles" or "GAAP" Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board.

"Grievance" In accordance with 42 C.F.R. § 438.400, grievance is an expression of dissatisfaction about any matter other than an "adverse benefit determination" Grievance is also used to refer to the overall system that includes grievances, internal appeals, and reconsiderations handled at the Contractor level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to: the quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights.)

"Guardian" An adult who is legally responsible for the care and management of a minor child or another adult.

"Health and Acute Care Program" or "HAP" A Medicaid Medallion 3.0 program that includes members receiving services concurrently under both the 1915(b) managed care waiver and 1915(c) home and community-based waivers. The purpose of this program is to ensure that all Medallion 3.0-eligible members receiving services through the Elderly or Disabled with Consumer Direction (EDCD) waiver, as well as members who become eligible for a Home and Community Based Services (HCBS) waiver while enrolled in a Medallion 3.0 MCO are treated as members with special health care needs. Members will receive medical acute and primary care services through Medallion 3.0 MCOs, while long-term care waiver services will be paid under the Department's Fee-for-Service System. Members enrolled in the HCBS Technology Assisted waiver are excluded from this program and will remain in the Department's Fee-For-Service system for both medical and waiver services. Individuals participating in the HAP program will transition from the Medallion 3.0 to the CCC Plus program during the CCC Plus regional launch. See section 7.7.E.IV of this Contract.

"Health Care Services" All Medicaid services provided by an MCO under contract with the Department.
"**Health Care Home (Formally Patient Centered Medical Home)"** A patient centered health care delivery system option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions to support the "whole-person" across the lifespan.

"Health Insurance Portability & Accountability Act of 1996" or "HIPAA" Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

"Health Insuring Organization (HIO)" A county operated entity, that in exchange for capitation payments, covers services for beneficiaries

(1) Through payments to, or arrangements with, providers;
(2) Under a comprehensive risk contract with the State; and
(3) Meets the following criteria -
(i) First became operational prior to January 1, 1986; or
(ii) Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and section 205 of the Medicare Improvements for Patients and Providers Act of 2008).

"Home and Community-Based Care Services" or "HCBS" Medicaid community-based care programs operating in the Commonwealth under the authority of §1915(c) of the Social Security Act, 42 U.S.C. §1396 n (c) including, but not limited to, the waivers for Elderly or Disabled with Consumer Direction (EDCD), Individuals with Intellectual Disability/Community Living, Alzheimer's, Technology Assisted, Individual and Family Developmental Disabilities Support (DD)/Family and Individual Supports, and Day Support/Building Independence.

"Hospital" A facility that meets the requirements of 42 C.F.R. § 482, as amended.

"Indian" An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

"Indian Health Care Provider" A health care program, including providers of contract health services (CHS), operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"Individualized Education Program" or "IEP" Means a written statement for a child with a disability that is developed, reviewed, and revised in a team meeting in accordance with (34 C.F.R. §300.22). The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child's educational needs.

"Individualized Family Service Plan" or "IFSP" Individualized family service plan (IFSP) means a comprehensive and regularly updated statement specific to the child being treated containing, but not necessarily limited to: treatment or training needs, measurable outcomes expected to be achieved, services to be provided with the recommended frequency to achieve the outcomes, and estimated timetable for achieving the outcomes. The IFSP is developed by a multidisciplinary team which includes the family, under the auspices of the local lead agency.

"Individuals with Disabilities Education Act Early Intervention Services" or "IDEA-EIS" A program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § 303.12) administered by the Virginia Department of Behavioral Health and Developmental Services. Early Intervention services include services that are designated to meet the developmental needs of an infant or

toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development.

"Informational Materials" Written communications from the Contractor to members that educates and informs about services, policies, procedures, or programs specifically related to Medicaid.

"Initial Implementation" The first time a program or a program change is instituted in a geographical area by the Department.

"Inquiry" An oral or written communication usually received by a Member Services Department or telephone helpline representative made by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirements or materials received, etc.; 2) provision of information regarding a change in the member's status such as address, family composition, etc.; or 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

"Institution for Mental Disease", or "IMD" A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental disease. An IMD may be private or state-run.

> **"State Institution for Mental Disease"** or **"State-run IMD" or "State Mental Hospital"** A hospital, psychiatric institute, or other institution operated by the Department of Behavioral Health and Developmental Services (DBHDS) that provides care and treatment for persons with mental illness.

"Intensive Outpatient Services" Services shall include the major psychiatric, psychological, and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for members are provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to provide a minimum of 4 hours and a maximum of 19 hours of skilled treatment services per week.

"Intermediate Care Facility for Individuals with Intellectual Disabilities" Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) is a facility, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to intellectually disabled individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide

health or rehabilitative services, and provide active treatment to clients toward the achievement of a more independent level of functioning.

"Internal Appeal" In accordance with 42 C.F.R. § 438.400, an internal appeal is defined as a request to the Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of a Contractor's adverse benefit determination. The internal appeal is the only level of appeal with the Contractor and must be exhausted by a member or deemed exhausted according to 42 CFR § 438.408(c)(3) before the member may initiate a state fair hearing.

"Laboratory" Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 C.F.R. §§ 493.2 and 493.3, as amended.

"Limited English Proficient (LEP)" In accordance with 42 C.F.R. § 438.10, potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

"List of Excluded Individuals and Entities" or "LEIE" When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG website and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

"Long-Stay Hospital" or "LSH" Hospitals that provide a slightly higher level of care than Nursing Facilities. The Department recognizes two facilities that qualify the individual for exemption as Long-Stay Hospitals: Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).

"Local Education Agency" A local school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or the Virginia School for the Deaf and the Blind at Staunton. Neither state operated programs nor the Virginia School for the Deaf nor the Blind at Staunton are considered a school division as that term is used in these regulations. (§ 22.1-346(C) of the *Code of Virginia* ; 34 C.F.R. § 300.28)

"Local Lead Agency" Local lead agency means an agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local Early Intervention system, as described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the *Code of Virginia* .

"Long-Term Acute Care Hospitals" or "LTAC" A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in treating patients with serious and often complex medical conditions. The Department recognizes these facilities as Acute Care Facilities.

"Managed Care Organization" or "MCO" An organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 C.F.R. § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Medallion 3.0 members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 C.F.R. § 438.116.

"Managed Care Program" As defined in 42 C.F.R. § 438.2, a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

"Managed Care Technical Manual" or "MCTM" A document developed by the Department that provides the technical specifications for the submission of encounters and other contract deliverables, including monthly, quarterly, annual, and other required reports from MCOs. In addition, it supplies technical information on enrollment and payment files, Department-generated files, and Departmental processes such as the processing of incarcerated members and the reconciliation of payments for newborn members.

"Managing Employee" In accordance with 42 C.F.R. 455 Subpart B, means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

"Marketing" Any communication, from an MCO to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll

in that particular MCO's Medicaid product, or either to not enroll in or to disenroll from another MCO's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

"Marketing Materials" Any materials that are produced in any medium, by or on behalf of an MCO, are used by the MCO to communicate with individuals, members, or prospective members, and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity.

"Marketing Services" Any communication, services rendered, or activities conducted by the Contractor or its subcontractors to its prospective members for the purpose of education or providing information that can reasonably be interpreted as intended to influence the member to enroll in that particular MCO's Medicare and Medicaid products.

"Material adjustment" As defined in 42 C.F.R. § 438.2, an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.
"Medallion 3.0" A statewide mandatory Medicaid program which utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver.

"(Medallion 3.0) Carved-Out Services" The subset of Medicaid covered services which the Contractor shall not be responsible for covering under the program.

"(Medallion 3.0) Covered Services" The subset of Medicaid covered services which the Contractor shall be responsible for covering under the program.

"Medallion Care System Partnership" or "MCSP" An arrangement, such as a health care home, with the goal of improving health outcomes for Medicaid members whereby the Managed Care Organizations form partnerships and contractual arrangements tied to gain and/or risk sharing, performance-based incentives, and other Commonwealth-approved quality metrics and financial performance in an effort to increase participation of integrated provider health care delivery systems.

"Medicaid Covered Services" Services as defined in the Virginia State Plan for Medical Assistance or State regulations.

"Medicaid Non-Covered Services" Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or State regulations.

"Medicaid Fraud Control Unit" The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the *Code of Virginia* § 32.1-320, as amended.

"Medicaid Management Information System" or "MMIS" The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

"Medicaid Member" Any individual enrolled in the Virginia Medicaid program.

"Medicaid Works" also known as " Medicaid Buy-In program" Medicaid Works allows working people with disabilities whose income is no greater than 80% Federal Poverty Level (FPL) to pay a premium to participate in the Medicaid program. Certain services will be provided through a State Plan Amendment/ Fee-for-Service Medicaid and are carved-out of this Contract.

"Medical Loss Ratio (MLR) Reporting Year" As defined in 42 C.F.R. § 438.8, a period of 12 months consistent with the rating period selected by the Department.

"Medical Necessity" or "Medically Necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines.

"Medically Needy" Individuals who meet Medicaid covered group requirements, but have excess income. A medically needy determination requires a resource test and includes pregnant women, children under the age of 18, foster care and adoption assistance, and those in ICF/IIDs up to age 21, ABD up to age 21. Parents and caretaker relatives do not qualify under medically needy. Medically needy individuals are excluded from managed care enrollment.

Effective September 2012, these members would gradually be put in appropriate non-medically needy aid categories unless they are spend-down. As a result, these individuals may qualify for managed care enrollment.

"Medicare Exclusions Database" or "MED" CMS maintains the MED as a way of providing exclusion information to its stakeholders, including State Medicaid agencies and Medicare contractors. Office of Inspector General (OIG) sends monthly updates of the LEIE to CMS. CMS uses the OIG updates to populate the MED (formerly Publication 69). Unlike the LEIE and the SAM, the MED includes unique identifiers (e.g., SSNs, EINs, NPIs), but is available only to certain users to protect sensitive information.

"Member" A person eligible for Medicaid who is enrolled with an MCO Contractor to receive services under the provisions of this Contract.

"Member Handbook" Document required by the Contract to be provided by the MCO to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, member eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, member

services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

"Member Months" As defined in 42 C.F.R. § 438.8, the number of months an enrollee or a group of enrollees is covered by an over a specified time period, such as a year.

"Monthly" For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

"National Practitioner Data Bank" or "NPDB" The NPDB, maintained by the Health Resources and Services Administration, is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. OIG reports exclusions to the NPDB monthly. Although the NPDB includes unique identifiers, to protect sensitive information it is available only to registered users whose identities have been verified.

"National Provider Identifier" or "NPI" NPI is a national health identifier for all typical health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire.

"Network Provider" Any provider, group of providers, or entity that has a network provider agreement with a MCO or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP

"Newborn Guarantee Coverage Period" The time period between the date of birth of a child whose mother is a Medicaid member with the Contractor until the last day of the third calendar month including the month of birth, unless otherwise specified by the Department. For example, a baby born any day in February will be enrolled with the Contractor until April 30.

"No credibility" As defined in 42 C.F.R. § 438.8, a standard for which the experience of an MCO is determined to be insufficient for the calculation of a Medical Loss Ration (MLR). An MCO that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements.

"Non-claims Costs" As defined in 42 C.F.R. § 438.8, expenses for administrative services that are not: Incurred claims (as defined in 42 C.F.R. §438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 C.F.R. §438.8(e)(3)); or licensing and regulatory fees, or Federal and State taxes (as defined in 42 C.F.R. §438.8 (f)(2) of this section)

"Non-participating Provider" A health care entity or health care professional not in the Contractor's participating provider network.

"Non-risk Contract" A contract between the Departtment and a PIHP or PAHP under which the contractor

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 C.F.R § 447.362; and
(2) May be reimbursed by the Department at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

"Open Enrollment" The time frame in which members are allowed to change from one MCO to another, without cause, at least once every 12 months per 42 C.F.R. § 438.56 (c)(2) and (f)(1). For Medallion 3.0 members, open enrollment timeframes are based upon the Department's regional open enrollment effective date, per Attachment VI of this contract. Within sixty (60) days prior to the open enrollment effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within sixty (60) days of the open enrollment period shall remain in his or her current health plan selection until their next open enrollment effective date.

"Outcomes" As defined in 42 C.F.R § 438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

"Out-of-Network Coverage" Coverage provided outside of the established MCO network; medical care rendered to a member by a provider not affiliated with the Contractor or contracted with the Contractor.

"Overpayment" As defined in 42 C.F.R § 438.2, any payment made to a network provider by a MCO to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO by a State to which the MCO is not entitled to under Title XIX of the Act.

"PACE" The Program of All-inclusive Care for the Elderly. PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute, and long-term care services) to their members without limit as to duration or dollars.

"Partial credibility" As defined in 42 C.F.R. §438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ration (MLR) but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

"Party in Interest" Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or member of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a

beneficial interest of more than five (5) percent of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual.

"Performance Incentive Award" A program instituted by the Department that rewards or penalizes managed care organizations with possible incentive payments based upon the quality of care received by Virginia's Medicaid/CHIP members.

"Person with Ownership or Control Interest" In accordance with 42 C.F.R. 455 Subpart B, means a person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor's capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor.

"Physician Incentive Plan" Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan member.

"Plan First" The Medicaid fee-for-service family planning program. The purpose of this program is to reduce unplanned pregnancies, increase spacing between births, reduce infant mortality rates, and reduce the rates of abortions due to unintended pregnancies. Men and women not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS, who have income less than or equal to 200 percent of the federal poverty level (plus a 5% disregard) and meet citizenship and identity requirements may be eligible for Plan First.

"Post-Payment" Subjecting claims for services to evaluation after the claim has been adjudicated. This activity may result in claim reversal or partial reversal, and claim payment recovery.

"Pre-Payment" A review process conducted before a claim is paid to ensure the appropriate code was billed, the documentation supports the claim submitted, and/or the service was medically necessary.

"Prevalent Non-English Language" A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

"Post Stabilization Services" Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

"Potential Enrollee" As defined in 42 C.F.R. § 438.2, a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, , but is not yet an enrollee of a specific MCO, entity.

"Potential Member" A Medicaid member who is subject to mandatory enrollment in a given managed care program. [42 C.F.R. § 438.10(a)]

"Prepaid Ambulatory Health Plan (PAHP)" An entity that:

(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

"Prepaid Inpatient Health Plan (PIHP)" An entity that -

(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.
(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

"Previously Authorized" As described in 42 C.F.R. § 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example. If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the MCO authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the MCO. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended, or reduced.

"Primary Care" As defined in 42 C.F.R. § 438.2, all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the Department, to the extent the furnishing of those services is legally authorized in the State.

"Primary Care Case Management" means a system under which:

(1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or
(2) A PCCM entity contracts with the State to provide a defined set of functions.

"Primary Care Case Management Entity (PCCM entity)" An organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
(4) Provision of payments to FFS providers on behalf of the State.
(5) Provision of enrollee outreach and education activities.
(6) Operation of a customer service call center.
(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
(9) Coordination with behavioral health systems/providers
(10) Coordination with long-term services and supports systems/providers.

"Primary Care Case Manager (PCCM)" A physician, a physician group practice or, at State option, any of the following:
(1) A physician assistant.
(2) A nurse practitioner.
(3) A certified nurse-midwife.

"Primary Care Provider" or "PCP" A practitioner who provides preventive and primary medical care for eligible members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

"Prospective Risk Adjustment" A methodology to account for anticipated variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from historical experience of the contracted MCOs, PIHPs, or PAHPs and applied to rates for the rating period for which the certification is submitted.

"Protected Health Information" or "PHI" Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.

"Provider" As defined in 42 C.F.R. § 438.2 , any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.

"Quality" As defined in 42 C.F.R. § 438.320, as it pertains to external quality review, the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through: (1) Its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidenced-based-knowledge. (3) Interventions for performance improvement.

"Quality Compass", or "NCQA Quality Compass" NCQA's comprehensive national database of health plans' HEDIS and CAHPS results, containing plan-specific, comparative and descriptive information on the performance of hundreds of managed care organizations. The database allows benefit managers, health plans, consultants, the media, and others to conduct a detailed market analysis by providing comprehensive information about health plan quality and performance.

"Quality Improvement Program " or "QIP" A quality improvement program with structure and processes and related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, plans, and/or members.

"Quarterly" For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each calendar quarter.

"Quarters" Calendar quarters starting on January 1, April 1, July 1, and October 1.

"Rate Cell" As defined in 42 C.F.R. § 438.2, a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

"Rating Period" A period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by § 438.7(a).

"Readily Accessible" Electronic information and services which comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

"Reconsideration" A reconsideration is a provider's request for review of an adverse benefit determination as defined in this Contract. The Contractor's reconsideration decision is a pre-requisite to a provider's filing of an appeal to the Department's Appeals Division.

"Residential Treatment Facilities (Level C)" A facility as defined in 12 VAC 30-130-860, as amended.

"Retrospective Risk Adjustment" A methodology to account for variation in risk levels among contracted MCOs that is derived from experience concurrent with the rating period of the contracted MCOs subject to the adjustment and calculated at the expiration of the rating period.

"Risk Adjustment" A methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs contracted with the State.

"Rural Area" A census designated area outside of a metropolitan statistical area.

"Rural Exception" A rural area as designated in the 1915(b) managed care waiver, pursuant to 1935(a)(3)(B) of the Social Security Act and 42 C.F.R. § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying members are mandated to enroll in the one available contracted MCO.

"Rural Health Clinic" A facility as defined in 42 C.F.R. § 491.2, as amended.

"School Health Services" Medical and/or mental health services identified through the child's individualized education program (IEP). These services include physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, nursing services, medical assessments, audiology services, personal care services, medical evaluation services, and IEP-related transportation on specially adapted school buses. School health services that are rendered in a public school setting or on school property, (including Head Start Services) and are included on the child's IEP are carved out of this contract and are reimbursed directly by the Department. (Reference Section 7.5.A for coverage guidelines.)

"Screening" Comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by the Department and as required by the Screenings and Assessments provisions of this Contract.

"Sentinel Event" An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "Sentinel" because they signal the need for immediate investigation and response.

"Service authorization (SA) Program" also known as "Service Authorization (SA)" The Department's service authorization program for fee-for-service Medicaid and for carved-out services.

"Service Authorization Request" A managed care member's request for the provision of a service.

"State Fair Hearing" The Department's evidentiary hearing process for member appeals. Any internal appeal decision rendered by the Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

"State Plan for Medical Assistance" or "State Plan" - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining Federal financial participation. The

Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-325, as amended.

"State Plan Substituted Services" (In Lieu of Services) – Alternative services that are not (or services provided in a setting that is not) included in the state plan and/or not normally covered by this Contract, but are medically appropriate, cost effective substitutes for state plan services that are included within this Contract (An example of this type of services is a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). The Contractor shall not, however, require a Member to use a state plan substituted service/"in lieu of service" as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner. For individuals 21 through 64 years of age, an Institution for Mental Disease (IMD) may be an "in lieu of" service; however, a member's stay in an IMD shall be limited to **no more than** fifteen (15) calendar days in any calendar month. Reference 42 CFR §§ 438.3 and 438.6(e).

"Subcontract" A written contract between the Contractor and a third party, under which the third party performs any one or more of the Contractor's obligations or functional responsibilities under this Contract.

"Subcontractor" An individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with Contractor.

"Substance Abuse" The use of drugs, without a compelling medical reason, or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the member. This care and treatment may include counseling, rehabilitation, medical, or psychiatric care.

"Successor Law or Regulation" That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this Contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation.

"System for Award Management" or "SAM" or formerly "EPLS" The General Services Administration (GSA) maintains the SAM, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the SAM on parties they have debarred or suspended as described above; Office of Inspector General (OIG) sends

monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the SAM. The SAM does not include any unique identifiers; it provides only the name and address of excluded entities. If SAM users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.

"Telemedicine" The real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services.

"Temporary Detention Order" or "TDO" An emergency custody order issued following sworn petition to any magistrate that authorized law enforcement to take a person into custody and transport that person to a facility designed on the order to be evaluated, where such person is believed to be mentally ill and in need of hospitalization or treatment pursuant to 42 C.F.R. § 441.150 and *Code of Virginia* §§ 16.1-340 and 340.1, *et. seq*.(minors) and §§ 37.2-808 through 810, *et. seq*. (adults).

"Third-Party Liability" The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan.

"Threshold" A pre-established level of performance that, when it is not attained, results in initiating further in-depth review to determine if a problem or opportunity for improvement exists. Failure of Contractor to meet any threshold in the Contract may result in compliance actions. Failure of Contractor to meet specified thresholds may result in loss of performance incentive awards.

"Transmit" Send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

"Urban Area" Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

"Urgent Medical Condition" A medical (physical, mental, or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson that possesses an average knowledge of health and medicine to result in:

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily function;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Utilization Management" The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

"Validation" As defined in 42 C.F.R. § 438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

"Value-Added Network" or "VAN" A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.

"Waste" The rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally not considered criminally negligent actions but rather misuse of resources.

1.2 1.2 ACRONYMS

AA -- Adoption Assistance
ABD -- Aged, Blind, and Disabled Population
ACIP -- Advisory Committee on Immunization Practice
ADHD – Attention-Deficit/Hyperactivity Disorder
ANSI -- American National Standards Institute
APIN -- Administrative Provider Identification Number
AHRQ – Agency for Healthcare Research and Quality
ARTS-- Addiction and Recovery Treatment Services
ASP -- Application Service Provider

BAA – Business Associate Agreement
BBA -- Balanced Budget Act of 1997
BHSA – Behavioral Health Services Administrator
BMI -- Body Mass Index
BOI -- Bureau of Insurance of the Virginia State Corporation Commission

CAD -- Coronary Artery Disease
CAHPS® -- Consumer Assessment of Healthcare Providers and Systems
CAP -- Corrective Action Plan
C.F.R. -- Code of Federal Regulations
CHF -- Congestive Heart Failure
CHIPRA -- Children's Health Insurance Program Reauthorization Act
CMS -- Centers for Medicare and Medicaid Services
CMS 1500 –Standard Professional Paper Claim Form
CMHRS – Community Mental Health Rehabilitative Services
COB -- Coordination of Benefits
COPD -- Chronic Obstructive Pulmonary Disease
CORFs -- Comprehensive Outpatient Rehabilitation Facilities
CPT -- Current Procedural Terminology
CSB -- Community Service Board
CSHCN -- Children with Special Health Care Needs

CY – Calendar Year
CYSHCN – Children and Youth with Special Health Care Needs

DBA -- Dental Benefits Administrator
DBHDS -- Department of Behavioral Health and Developmental Services
DD -- Individual and Family Developmental Disabilities Support/ Family and Individual Supports
DESI -- Drug Efficacy Study Implementation
DHHS -- Department of Health and Human Services
DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DRG -- Diagnosis Related Grouping
DSP -- Data Security Plan
DSS -- Department of Social Services

EDCD -- Elderly or Disabled with Consumer Direction
EI -- Early Intervention
EN -- Enteral Nutrition
EOC -- Evidence of Coverage
EPA -- Environmental Protection Agency
EPSDT -- Early Periodic Screening, Diagnosis, and Treatment
EQR -- External Quality Review
EQRO -- External Quality Review Organization
ER -- Emergency Room

FAMIS -- Family Access to Medical Insurance Security
FAMIS Plus -- Another name for Children's Medicaid
FIPS -- Federal Information Processing Standards
FOIA -- Freedom of Information Act
FQHC -- Federally Qualified Health Centers
FTE -- Full-Time Equivalent
FTP -- File Transfer Protocol
FY-- Fiscal Year

GAAP -- Generally Accepted Accounting Principles

HAP – Health and Acute Care Program
HCBS -- Home and Community-Based Care Services
HEDIS -- Healthcare Effectiveness Data and Information Set
HIPAA -- Health Insurance Portability and Accountability Act of 1996
HIV/AIDS -- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

IBNR -- Incurred But Not Reported
ICF/IID-- Intermediate Care Facility/Individuals with Intellectual Disabilities
IHCP—Indian Health Care Provider
ID – Identification

IDEA -- Individuals with Disabilities Education Act.
IDEA – EIS -- Individuals with Disabilities Education Act - Early Intervention Services
IEP -- Individual Education Plan
IFSP -- Individual Family Service Plan
IMD – Institution of Mental Disease

LARC-- Long Acting Reversible Contraception
LCSW -- Licensed Clinical Social Worker
LDSS—Local Department of Social Services
LEIE -- Listing of Excluded Individuals and Entities
LIFC - - Low Income Families and Children
LSH -- Long-Stay Hospital
LTAC -- Long-Term Acute Care

MCHIP -- Managed Care Health Insurance Plans
MCSP -- Medallion Care System Partnership
MCO -- Managed Care Organization
MED -- Medicare Exclusions List
MMIS -- Medicaid Management Information System (also known as VAMMIS)
MCTM – Managed Care Technical Manual

NCPDP -- National Council for Prescription Drug Programs
NCQA -- National Committee for Quality Assurance
NPDB – National Practitioner Data Bank
NPI -- National Provider Identifier
NQTL-- Nonquantitative Treatment Limitations

OB/GYN -- Obstetrician and Gynecologist
OIG –Office of Inspector General
OSR – Operational Systems Review
OT -- Occupational Therapy

PA -- Prior Authorization (also known as Service Authorization)
PACE -- Program of All-inclusive Care for the Elderly
Part C -- Part C of the Individuals with Disability and Education Act (also known as Early Intervention)
PCP -- Primary Care Provider
PDN – Private Duty Nursing
PHI -- Protected Health Information
PIP -- Physician Incentive Plan
PIRS -- Patient Intensity Rating Survey
PMP – Prescription Monitoring Program
PMV - Performance Measure Validation
POC -- Plan of Care
PSA -- Prostate Specific Antigen
PT -- Physical Therapy

QI -- Quality Improvement
QIP -- Quality Improvement Program

RFP -- Request For Proposal
RHC -- Rural Health Clinics
RN -- Registered Nurse
RTF -- Residential Treatment Facility

SA - Service Authorization (formally known as Prior Authorization)
SAM – System for Award Management (formally known as Excluded Parties List System)
SLP -- Speech-Language Pathology
SPO -- State Plan Options
SSI -- Social Security Income
SSN -- Social Security Number

TB -- Tuberculosis
TDO -- Temporary Detention Order
TPL -- Third-Party Liability
TPN -- Total Parenteral Nutrition
Title XIX -- Medicaid
Title XXI -- CHIP
TTY/TDD -- Teletype/Telecommunication Device for the Deaf

UM -- Utilization Management
U.S.C. -- United States Code

VAC -- Virginia Administrative Code
VAMMIS -- Virginia Medicaid Management Information System
VAN --Value Added Network
VPN -- Virtual Private Network
VVFC – Virginia Vaccines for Children Program

WIC -- Special Supplemental Nutrition Program for Women, Infants, and Children."

XYZ -- Any Named Entity

2. Requirements for Operations

2.1 LICENSURE

The Contractor shall obtain and retain at all times during the period of this Contract a valid license issued with "Health Maintenance Organization" Lines of Authority by the State Corporation Commission and comply with all terms and conditions set forth in the *Code of Virginia* §§ 38.2-4300 through 38.2-4323, 14 VAC 5-211-10 et seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.

2.2 CERTIFICATION

Pursuant to § 32.1-137.1 through § 32-137.6 *Code of Virginia* , and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner of the Office of Licensure and Certification.

2.3 ACCREDITATION

As specified in 42 C.F.R. § 438.332, the Contractor must obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA). The Contractor must report to the Department any deficiencies noted by NCQA within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest. Denial or revocation of NCQA accreditation status or a status of "Provisional" may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA.

Under 42 C.F.R. § 438.332(b)(1)-(3), the Contractor shall give NCQA permission to annually provide the Department with a copy of its most recent accreditation review, including:

- Accreditation status, survey type, and level (as applicable);
- Recommended actions or improvements, corrective action plans, and summaries of findings; and
- The expiration date of the accreditation.

Any new plan that has been approved by the Department and is seeking NCQA accreditation for its Virginia Medicaid line of business must agree to, adhere to, and meet a timeline of milestones set by the Department as a condition of operation. The Contractor must adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and CAHPS survey.

2.3.A Milestones for New Managed Care Organizations

New Health Plans must also adhere to the following timeline of milestones for NCQA Accreditation set forth by the Department and provide documentation upon completion of each milestone:

2.3.A.I EQRO Comprehensive onsite review at least annually, at dates to be determined by the Department**.**

2.3.A.II Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to Virginia Medicaid/CHIP members).

2.3.A.III Obtain NCQA accreditation status of at least Accredited within 36 months of the onset of delivering care to members.

2.3.B Mergers and Acquisitions

MCOs must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify the Department of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to a change in accreditation status, loss of accreditation, etc.).

2.4 READINESS REVIEW

The Department and/or its duly authorized representative may conduct readiness review(s) which will include a minimum of one site visit. This review may be conducted prior to enrollment of any members in the MCO, prior to the renewal of the Contract, and shall commence within thirty (30) calendar days of the execution of this Contract. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled members.

The review will document the status of the MCO with respect to meeting program standards set forth in the BBA, federal regulations, and this Contract, as well as any goals established by the Department. The readiness review activities will be conducted by the Department's External Quality Review Organization (EQRO), and/or by a multidisciplinary team appointed by the Department. The scope of the readiness review(s) will include, but not be limited to; review and/or verification of: network provider composition and access; staffing; content of provider agreements; policies and procedures consistent with the Medallion 3.0 contractual standards; pregnancy and complex care management programs; EPSDT plan; financial solvency; and information systems performance and interfacing capabilities. In the event of Medicaid Expansion, the Contractor must agree to meet any expansion criteria as may be required by the Department. The readiness review(s) may assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

The Department will provide the Contractor with a summary of the findings, as well as areas requiring remedial action.

2.5 BASE OF OPERATIONS

The Contractor shall have a dedicated Virginia Medicaid Project Executive located in an operations/business office within the Commonwealth of Virginia. The Virginia Medicaid Project

Executive shall be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia business, claim payment, and provider relations/contracting. The Project Executive shall be able to make decisions about managed care policy and program issues and shall represent the Contractor at the Department's meetings. Additionally, the Virginia Medicaid Project Executive must be solely responsible to the Contractor (not to a third party administrator) and attend all required meetings as well as comply with all requirements of this Contract in that capacity. The Virginia-based location must include a designee who can respond to issues involving systems and reporting, appeals, quality improvement, member services, EPSDT services management, pharmacy management, medical management, and case management. The Virginia office shall include a Virginia licensed and Virginia based medical director and dedicated staff able to perform member advocacy and provider network development. Provider relations staff shall be located within the geographic region where the Contractor operates. Member Services staff must assist members in writing complaints and are responsible for monitoring the complaint through the Contractor's complaint process. The Department does not require claims utilization management, customer service, pharmacy management, or member services to be physically located in Virginia.

The Contractor is required to ensure that any and all staff members dedicated to the Virginia Medicaid line of business who communicate via email with the Department and/or via email regarding Virginia Medicaid to other external parties (providers, members, etc.) perform these communications using an email address that is comprised of a domain address that clearly represents the entity contracted with the Commonwealth to provide health care services. Contractors with multiple email addresses must "link" accounts together to provide the Department with a single identifying email address. Contractors may also contact the Department to request a variance of this provision. Variances will be granted only when the Contractor provides a digital communication plan or process to the Department outlining how the Contractor will ensure it is clear to all Department staff which entity the Contractor's employees represent.

See Section 14 "Terms & Conditions" in its entirety, with particularly emphasis on Sections 14.6 "Changes in Key Staff Positions & Organization", 14.7 "Conflict of Interest", and 14.20 "Meetings" for additional personnel-related and business arrangement conditions of doing business with the Department.

3. Access to Care & Network Standards

The Contractor is required to establish a network of providers. The Contractor must establish, maintain, and monitor its network in accordance with this Contract and any and all applicable Medicaid Rules and Regulations at the State or Federal level. The Contractor may terminate, suspend, sanction, and/or educate providers according to the terms described in its agreements with its network providers, including but not limited to "for cause" terminations, such as access, program integrity, or quality of care issues, as well as "not-for-cause" or "at-will" terminations under authority granted by Section 14 of this Contract. The Contractor is not required to offer providers appeal rights except as specified in Section 10.2 in cases of denied authorization/reimbursement and/or reduced reimbursement. The Contractor is permitted to offer additional types of provider appeal rights at the MCO-level of review only. Network providers may not appeal termination decisions to the Department. The Contractor is required to report on all terminations and credentialing failures to the Department as specified in the MCTM

3.1 PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion, impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and members, including but not limited to the proposed provider's past performance. The Contractor shall submit any new network provider agreement at least thirty (30) days prior to the effective date for review, and upon request thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of members is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

The Department will review each type of agreement for services before contract signing. The Contractor shall submit each type of agreement for services with this Contract in Section 3.7 and the Attachments. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in all network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract):

- (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid Contract) with the Department of Medical Assistance Services.

- No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract.
- 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.

Refer to Attachment III "Network Provider Agreement Requirements" for more information.

3.2 NETWORK PROVIDER COMPOSITION

3.2.A Network Establishment & Maintenance

The Contractor shall be solely responsible for arranging for and administering covered services to enrolled members and must ensure that its delivery system will provide available, accessible and adequate numbers of facilities, locations, and personnel for the provision of covered services. In establishing and maintaining the network, the Contractor shall consider all of the following:

- The anticipated Medicaid enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid population to be served;
- The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted services;
- The numbers of network providers not accepting new Medicaid members;
- The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by Medicaid members; and
- Whether the location provides physical access for members with disabilities.

The Contractor shall include in its network or otherwise arrange care by providers specializing in early childhood, youth and geriatric services. The Contractor must develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions, and facilities that are needed to assure that the members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient behavioral health services and supports needed.

3.2.B Notification to the Department

The Contractor shall notify the Department within thirty (30) business days of any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms and not otherwise addressed in Attachment III, Section C, that could reduce member access to care. The Contractor shall notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems. This written notice must occur in advance of the formal notification of hospital's termination from the Contractor's network.

3.2.C Admission Privileges

Any physician who provides inpatient services to the Contractor's members shall have admitting and treatment privileges in a minimum of one general acute care hospital.

3.2.D Complete Provider File for Enrollment Broker

The Contractor shall submit, to the Department for the Enrollment Broker, a complete network provider file at thirty (30) days prior to the effective date of the initial Contract. A full file for the Enrollment Broker will be submitted to the Department each week. Details on the quality measures and details on the reporting structure and template can be found in the MCTM.

3.2.E Complete Provider File to Department

The Contractor shall submit to the Department a complete provider file quarterly, or on a more frequent basis, as requested by the Department. The Managed Care Technical Manual details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department.

3.2.F Network Sufficiency Determined by the Department

Network provider composition standards set forth in this Section are not the minimum standards for network development for entry into new or existing managed markets, or program expansions to include additional population groups. New population group expansions will be set forth by the Department as part of the program development cycle. These standards shall be considered as operational guidelines. The Department shall be the sole determiner of Contractor network sufficiency. Additional network and expansion requirements are set forth in Attachment X, DMAS Managed Care Expansion Requirements. Attachment X details notification and expansion requirements required by the Department to assure that appropriate IT, network development, budget, and personnel resources are available for introducing managed care into new areas.

3.2.G GeoAccess Provider File to Department

The Contractor shall submit to the Department a complete provider file using GeoAccess or similar software quarterly, or on a more frequent basis as requested by the Department. The Managed Care Technical Manual details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department

3.3 PROVIDER ENROLLMENT INTO MEDICAID

The Contractor will make its best effort as part of its credentialing process, to encourage all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), to apply for enrollment in the Medicaid program. The Contractor shall be required to have an NPI or an Administrative Provider Identification Number (APIN).

3.4 NETWORK PROVIDER LICENSING AND CERTIFICATION STANDARDS

Each Contractor must have the ability to determine whether physicians and other health care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services contracted for under this Contract. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or

employment contracts**.** The Contractor shall be able demonstrate upon request by the Department that its network providers are credentialed as required under 42 C.F.R. § 438.214.

3.4.A Credentialing/Recredentialing Policies and Procedures

The Contractor shall have the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the Contractor or its subcontractor(s) are qualified to perform their medical or clinical services. In accordance with 42 C.F.R. §438.214(b) the Contractor shall have written policies and procedures for the credentialing process that aligns with the uniform credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract. See Section 3.16 "Subcontractor Management & Monitoring' for additional requirements unrelated to credentialing. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The Contractor shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers), this includes program integrity-related and adverse actions (See the Managed Care Technical Manual). The Contractor shall require its providers and subcontractors to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455 Subpart B and Sections 13 and 14 of this Contract.

3.4.B Provider Selection

In accordance with 42 C.F.R. §§438.12 and 438.214, the Contractor shall implement written policies and procedures for selection and retention of network providers. The Contractor shall submit its policies and procedures in accordance with the Managed Care Technical Manual. The Contractor must give written notice of the reason for its decision when it declines to include an individual or groups of providers in its provider network. In all contracts with network providers, the Contractor must use a documented process and follow the Department's uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorder.

In all contracts with network providers, the Contractor's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

3.5 MEMBER-TO-PCP RATIOS

As a means of measuring accessibility, the Contractor must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid members, and there must be one (1) FTE PCP with pediatric training and/or experience for every 1,500

members under the age of eighteen (18). No PCP may be assigned members in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

Each contract between the Contractor and any of its network providers who are willing to act as a PCP must indicate the number of open panel slots available to the Contractor for members under this Contract.

This standard refers to the total members under enrollment by the Contractor as identified in this Contract. If necessary to meet or maintain appointment availability standards set forth in this Contract, the Contractor shall decrease the number of members assigned to a PCP. When specialists act as PCPs, the duties they perform must be within the scope of their specialist's license.

3.6 CHOICE OF PRIMARY CARE PHYSICIAN (PCP)

The Contractor must have written policies and procedures for assigning each of its members to a PCP. (See below.) Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department. These policies and procedures shall include the features listed below:

3.6.A Providers Qualifying as PCPs:

Providers qualifying as PCPs include the following:

- Pediatricians;
- Family and General Practitioners;
- Internists;
- Obstetrician/Gynecologists;
- Specialists who perform primary care functions within certain provider classes, care settings, or facilities including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or
- Indian Health Providers, (as defined in this Contract), if participating in the network as a primary care provider with the capacity to provide such services.
- Other providers approved by the Department.

3.6.B Specialists as PCPs

Members enrolled under the HAP program criteria, with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children for whom the PCP is a specialist receive EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

3.6.C Member Choice of PCP

In accordance with 42 C.F.R. §§438.3(l), the Contractor shall offer each member covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the

extent that open panel slots are available pursuant to travel time and distance standards described in Section 3.11. See also Section 5.13 "Rural Exception."

3.6.D Default Assignment of PCP

If the member does not request an available PCP prior to the twenty-fifth (25th) day of the month prior to the enrollment effective date, then the Contractor may assign the new member to a PCP within its network, taking into consideration such known factors as current provider relationships (as indicated on the enrollment broker's Health Status Survey Questionnaire), language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor then must notify the member in writing, on or before the first effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

3.6.E Timing of PCP Assignment

The member must have an assigned PCP from the date of enrollment with the plan.

3.6.F Change in PCP

The Contractor must allow members to select or be assigned to a new PCP when requested by the member, when the Contractor has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When a member changes his or her PCP, the Contractor must make the member's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

3.7 NETWORK PROVIDER CLASSES

The following provider classes will be utilized for the Department's network analysis. The Contractor will provide its Medallion 3.0 membership with sufficient access to the following provider classes, but is not required to contract with each subtype so long as the members have access to these categories. Health care provider taxonomy codes for these provider classes are provided in the MCTM and will be used to assess network adequacy.

Acute Care Hospital	Otolaryngology
Allergy & Immunology	Pain Medicine
Anesthesiology	Pathology
Behavioral Health and Social Service Providers	Pediatrics
Clinical Medical Laboratory	Pharmacy
Colon and Rectal Surgery	Physician Assistants and Advanced Practice Nursing Providers
Community Service Boards	Physical Medicine and Rehabilitation
Dermatology	Plastic Surgery
Durable Medical Equipment	Preventive Medicine
Emergency Medicine	Prosthetic Supplier
End- Stage Renal Disease Facility Family Medicine	Psychiatry & Neurology
Federally-Qualified Health Centers (FQHC)	Radiology

General Practice	Respiratory, Developmental, Rehabilitative and Restorative Service Providers
Health Department	Rural Health Care Clinic (RHC)
Home Health	Skilled Nursing Facility
Hospitalist	Substance Abuse Treatment
Internal Medicine	Surgery
Medical Genetics	Thoracic Surgery
Neurological Surgery	Transplant Surgery
Nuclear Medicine	Transportation
Obstetrics & Gynecology	Urgent Care Center
Ophthalmology	Urology
Oral Surgery	
Orthopedic Surgery	

3.8 INPATIENT HOSPITAL ACCESS

The Contractor shall maintain in its network a sufficient number of inpatient hospital facilities, which is adequate to provide covered services to its members. The Contractor shall notify the Department within fifteen (15) calendar days of any changes to its contracts with hospitals if those changes impact the scope of covered services, the number of members covered and/or the units of service covered**.**

3.9 POLICY OF NONDISCRIMINATION

The Contractor shall ensure that its providers provide contract services to members under this Contract in the same manner as they provide those services to all non-Medicaid members, including those with limited English proficiency or physical or mental disabilities. Additionally, in accordance with 42 C.F.R. § 438.206, the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

3.10 NETWORK ADEQUACY STANDARDS

In accordance with 42 C.F.R.§438.206, the Contractor must maintain and monitor a network of appropriate providers, supported by written agreements. The Contractor and its network providers must meet the Department's standards for timely access to care and services, taking into account the urgency for the need of services. The Contractor's network providers must offer hours of operation that are no less than the hours offered to commercial members or are comparable to fee-for-service, if the provider serves only Medicaid members.

3.11 TWENTY FOUR-HOUR COVERAGE

The Contractor shall maintain adequate provider network coverage to serve the entire eligible populations in geographically accessible locations within the region twenty-four (24) hours per

day, seven (7) days a week. The Contractor shall make arrangements to refer members seeking care after regular business hours to a covering physician or shall direct the member to go to the emergency room when a covering physician is not available. Such referrals may be made via a recorded message.

In accordance with the *Code of Virginia* § 38.2 - 4312.3, as amended, the Contractor shall maintain after-hours telephone service, staffed by appropriate medical personnel, which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying member enrollment with the Contractor.

3.12 TRAVEL TIME AND DISTANCE STANDARD

Pursuant to NCQA's Network Adequacy-Related Standards, the Contractor must ensure that the travel time or travel distance requirements listed below in Section 3.12.A and 3.12.B are met.

3.12.A Travel Time Standard

The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any member in urban areas unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than sixty (60) minutes travel time from any member in rural areas unless the Contractor has a Department-approved alternative time standard. The Contractor shall ensure that obstetrical services are available within no more than forty-five (45) minutes travel time from any pregnant member in rural areas unless the Contractor has a Department approved alternative time standard.

3.12.B Travel Distance Standard

The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. The Contractor must ensure that a member is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, or other necessary providers, unless the member so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the Contractor, and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area such as treatment of cancer, burns, or cardiac diseases.

3.13 APPOINTMENT STANDARDS

3.13.A Appointment Standards and Member's Health Condition

The Contractor must arrange to provide care as expeditiously as the member's health condition requires and according to each of the following appointment standards:

3.13.A.I Emergency Services

Appointments for emergency services shall be made available immediately upon the member's request.

3.13.A.II Urgent Medical Conditions

Appointments for an urgent medical condition shall be made within twenty-four (24) hours of the member's request.

3.13.A.III Routine Primary Care Services

Appointments for routine, primary care services shall be made within thirty (30) calendar days of the member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.

3.13.B Maternity Care Appointment Standards

For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant members as follows:

3.13.B.I First trimester

Appointments shall be scheduled within fourteen (14) calendar days of request

3.13.B.II Second trimester

Appointments shall be scheduled within seven (7) calendar days of request

3.13.B.III Third trimester

Appointments shall be scheduled within five (5) business days of request

3.13.B.IV High Risk Pregnancies

Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

3.14 EMERGENCY SERVICES COVERAGE

The Contractor shall ensure that all emergency covered services are available twenty-four (24) hours a day, seven (7) days a week, either in the Contractor's own facilities or through arrangements with other subcontractors. The Contractor must designate emergency sites that are as conveniently located as possible for after-hours emergency care.

The Contractor shall negotiate provider agreements with emergency care providers to ensure prompt and appropriate payment for emergency services. Such network provider agreements shall provide a process for determining a true and actual emergency.

3.15 MEDICAL HELP LINE ACCESS STANDARDS

The Contractor must provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist members. The Contractor must have mechanisms in place to promote the Medical Helpline to its Medicaid members. Mechanisms must include ways to distribute periodic reminders of the Helpline and cannot be exclusive to information only being provided in the Member Handbook.

3.16 ASSURANCES THAT ACCESS STANDARDS ARE BEING MET

The Contractor must establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to the Department that these access standards have been met.

3.17 SUBCONTRACTOR MANAGEMENT & MONITORING

The Contractor may enter into subcontracts for the provision or administration of any or all covered services or enhanced services. Subcontracting does not relieve the Contractor of its responsibilities to the Department or members under this Contract. The Department shall hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor's actions and/or providers shall also be considered providers of the Contractor. [42 C.F.R. §§ 438.230(b)(1) and 438.3(k)]

The Contractor must ensure that subcontractors and providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. The Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs. See also Section 3.4.A "Credentialing/Recredentialing Policies and Procedures," Section 13.3 "Prohibited Actions," and Section 14.6 "Changes in Key Staff Positions and Organization."

3.17.A Delegation and Monitoring Requirements

In accordance with 42 C.F.R. §§ 438.230 and 438.3(k), all subcontracts entered into pursuant to this Contract shall meet the following delegation and monitoring requirements and are subject to audit by the Department:

3.17.A.I Delegation Requirements

3.17.A.I.a All subcontracts shall be in writing;

3.17.A.I.b Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations including applicable sub-regulatory guidance and contract provisions;

3.17.A.I.c Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor;

3.17.A.I.d Subcontracts shall provide that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract;

3.17.A.I.e Subcontracts shall specify that if the Department, CMS, or the DHHS Inspector General determine that there is reasonable possibility of fraud or similar risk, the Department, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time;

3.17.A.I.f Subcontracts shall state that the right to audit by the Department, CMS, the DHHS Inspector General, the Comptroller General

or their designees will exist through ten (10) years of the final date of the contract period or from the date of completion of any audit, whichever is later;

3.17.A.I.g Subcontracts shall clearly state that the subcontractor must comply with member privacy protections described in HIPAA regulations and in Title 45 C.F.R. parts 160 and 164, subparts A and E; and

3.17.A.I.h Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate and ensure all information necessary for the reimbursement of any outstanding Medicaid claims is supplied promptly.

3.17.A.II Monitoring Requirements

3.17.A.II.a The Contractor shall perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements.

3.17.A.II.b The Contractor shall perform a formal performance review of all subcontractors at least annually.

3.17.A.II.c The Contractor shall monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, member and provider identification numbers, dates of service, diagnosis and procedure codes, etc.

3.17.A.II.d The Contractor shall monitor the subcontractor's provider enrollment, credentialing, and recredentialing policies and procedures to assure compliance with Federal disclosure requirements described in Section 13.3 of this Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally-funded health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federally-related health care programs as described in Section 13 and Section 4.6 of this Contract.

3.17.A.II.e As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement and shall require the subcontractor to take appropriate corrective action.

3.17.B Review Requirements for Subcontractors

All subcontracts must ensure the level and quality of care required under this Contract. Subcontracts with the Contractor for delegated administrative and medical services in the areas of care management, planning, finance, reporting systems, administration, quality assessment, credentialing/recredentialing, utilization management, member services, claims processing, or provider services must be submitted to the Department at least thirty (30) calendar days prior to their effective date. This includes subcontracts for

transportation, vision, behavioral health, prescription drugs, or other providers of service. The Contractor shall submit a list of all such subcontractors and the services each provides annually to the Department, or upon request, making note of any changes to subcontracts or subcontractors. See the Managed Care Technical Manual for details.

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this Contract. Subcontracts which require the subcontractor to be responsible for the provision of covered services must include the terms set forth in the Managed Care Technical Manual and for the purposes of this Contract, that the subcontractor shall be considered both a subcontractor and network provider. Contractor shall adhere to subcontractor specific restrictions found herein Sections 13 and 14. Please note that use of a Third Party Administrator triggers additional requirements under Section 14.7.A.

4. Provider Relations

4.1 PROVIDER ENROLLMENT

4.1.A Adequate Resources

The Contractor shall provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The Contractor shall give each network provider explicit instructions about the Contractor's provider enrollment process, including enrollment forms, brochures, enrollment packets, provider manuals, and participating provider agreements. The Contractor shall provide this information to potential network providers upon request. The Contractor's network provider agreement shall comply with the terms set forth in Attachment III.

4.1.B Commercial Network Requirement Prohibited

The Contractor shall not require as a condition of participation/contracting with physicians, etc. in their Medicaid network to also participate in the Contractor's commercial managed care network. However, this provision would not preclude a Contractor from requiring their commercial network providers to participate in their Medicaid provider network.

4.1.C Panel Participation Prohibited

The Contractor shall not require as a condition of participation/contracting with physicians, etc. in the Medicaid network a provider's terms of panel participation with other MCOs.

4.1.D Out-of-State Providers

A Contractor licensed in Virginia may include, in its provider network, providers which are located across State boundaries, as long as all such providers are necessary for the delivery of services to members in a particular locality. The Contractor may also utilize non-participating in-state and out-of-state providers who are not enrolled as Virginia Medicaid providers; however, the Contractor must make a best effort to have all network participating providers in Virginia apply to be a Medicaid provider.

4.2 ANTI-DISCRIMINATION

Pursuant to Section 1932 (b)(7) of the SSA, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Additionally, consistent with 42 C.F.R. § 438.214(c), provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include an individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. [42 C.F.R. § 438.12(a)(1)]

This section shall not be construed to prohibit the Contractor from including providers only to the extent necessary to meet the needs of the organization's members; or from using different

reimbursement amounts; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor. [42 C.F.R. § 438.12(b)]

4.3 PROVIDER EDUCATION

The Contractor shall ensure that all providers receive proper education and training regarding the Medallion 3.0 managed care program to comply with this Contract and all applicable Federal and State requirements. The Contractor shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

- All Medallion 3.0 covered services, carved-out and enhanced services, policies, procedures, and any modifications to these items;
- Eligibility standards, eligibility verification, and benefits;
- The role of the enrollment broker regarding enrollment and disenrollment;
- Special needs of members in general that may affect access to and delivery of services, to include, at a minimum, transportation needs;
- The rights and responsibilities of the enrolled;
- Grievance and appeals procedures;
- Procedures for reporting fraud, waste, and abuse;
- References to Medicaid manuals, memoranda, and other related documents;
- Payment policies and procedures;
- Billing instructions which are in compliance with the Department's encounter data submission requirements; and,
- Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

4.4 PROVIDER PAYMENT

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. §§ 447.45, 447.46, 438.60, and Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered members who are enrolled with the Contractor. 42 C.F.R. § 447.45 defines timely processing of claims as:

- Adjudication (pay or deny) of ninety percent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all Virginia Medicaid clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. § 447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

The Contractor shall notify the Department forty-five (45) days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims

processing operations. Any expenses incurred by the Department or its contractors to adapt to the Contractor's claims processing operational changes (including, but not limited to costs for site visits) shall be borne by the Contractor.

The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least sixty (60%) percent of claims received from providers are submitted electronically.

The Contractor must pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the *Code of Virginia.* Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid services/providers and as identified by the Department, and these rate adjustments are incorporated into the Medallion 3.0 capitation payment rates during the Contract period, where required by the Department and/or regulation, the Contractor is required to increase its reimbursement to providers at the same percentage as Medicaid's increase as reflected in the revised fee-for- service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Department shall make every reasonable effort to provide at least thirty (30) days advance notice of such increases. The Contractor shall provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format. A copy of such notification shall be provided to the Department sixty (60) days before the Contractor's mailing of such notice.

Under 1932 (b) of the SSA the Contractor must establish an internal grievance procedure by which providers under contract may challenge the Contractor's decisions including, but not limited to, the denial of payment for services.

4.4.A Payment for Indian Health Care Providers

The Contractor shall reimburse both network and non-network Indian Health Care Providers who provide covered services to Indian Members a negotiated rate which shall be no lower than the Department's fee-for-service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the covered service by a non-Indian Health Care Provider.

The Contractor shall reimburse non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Member at a rate equal to the rate that the

Contractor would pay to a network FQHC that is not an Indian Health Care Provider. [42 C.F.R. § 438.14 (c)(1)-(2)]

Under 42 C.F.R. § 438.14 (c)(2), when an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Contractor, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in absence of a published encounter rate, the amount it would receive if the services where provided under the Department's fee-for-service payment methodology.

In accordance with 42 C.F.R. § 438.14 (b)(2)(iii), the Contractor shall meet the requirements of fee-for-service timely payment for all Indian Tribe, Tribal Organization, or Urban Indian Organization providers in its network, including:

- Adjudication (pay or deny) of ninety percent (90%) of all clean claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. § 447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

4.5 PROVIDER DISENROLLMENT

The Contractor must have in place written policies and procedures which are filed at the time of the initial contract signature with the Department related to provider disenrollment. These policies and procedures shall include, but are not limited to, the following:

- Procedures to provide a good faith effort to give written notice of termination of a contracted provider within fifteen (15) days after receipt or issuance of the termination notice to each member who received care on a regular basis from the terminated provider. [42 C.F.R. § 438.10(f)(1)]
- Procedures to provide a good faith effort to transition PCP panel members to new PCPs at least thirty (30) calendar days prior to the effective date of provider disenrollment;
- Procedures for the reassessment of the provider network to ensure it meets access standards established in its Contract;
- Procedures for notifying the Department within the time frames set forth in this Contract; and
- Procedures for temporary coverage in the case of unexpected PCP absence (e.g., due to death or illness).

4.6 INELIGIBLE PROVIDERS OR ADMINISTRATIVE ENTITIES

See Section 13.3, entitled "Prohibited Actions."

4.7 PHYSICIAN INCENTIVE PLAN

The Contractor may, at its discretion, operate a Physician Incentive Plan (PIP) only if:

- No single physician is put at financial risk for the costs of treating a Member that are outside the physician's direct control;
- No specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Member; and,
- The applicable stop/loss protection, Member survey, and disclosure requirements of 42 C.F.R. § 417 are met.

The Contractor shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R.§§ 422.208 and 422.210.

In accordance with 42 C.F.R. § 438.6 (b), all incentive and withhold arrangements are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the Department's quality strategy. Performance for all incentive and withhold arrangements is measured during the rating period under which the incentive or withhold arrangement is applied. Further, all incentive and withhold arrangements must:

- Be for a fixed amount of time;
- Not be renewed automatically;,
- Be made available to both public and private contractors under the same terms of performance.
- Does not condition MCO participation in the withhold arrangement on the MCO entering into or adhering to intergovernmental transfer agreements

The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Department that results from the Contractor's or any of its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 C.F.R.§§ 417, 434 and 1003; however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Members in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of the Department, that it has made a good faith effort to comply with the cited requirements.
The Contractor shall report annually, and upon request, whether services not furnished by physician/group are covered by PIP or incentive arrangement that includes withhold, bonus, capitation, and percent of withhold or bonus, if applicable. The report shall also include the requirements in section 42 C.F.R. § 438.6, the percentage of the Contractor's network providers participating in a physician incentive plan, value-based purchasing arrangements, and/or gain sharing arrangements.

4.8 PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS

Under Section 1932(b)(3)(A), Section 4704 (a)(3) of Public Law 105-33, and 42 C.F.R. § 438.102(a)(i-iv), the Contractor must not prohibit or restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, regardless of whether benefits for such are provided under the Contract, regarding:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment;
  The member'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.

In accordance with 42 C.F.R. § 438.102(d), the Contractor may be subject to intermediate sanctions if there is any violation of 42 C.F.R. § 438.102(a)(1).

4.9 PROVIDER INQUIRY PERFORMANCE STANDARDS & REPORT

The Contractor shall answer telephonic provider inquiries, including requests for referrals and prior-authorizations with a monthly average speed of answer (ASA) of less than three (3) minutes. Provider call abandonment rates shall average less than five percent (5%) each month. Upon request, the Contractor will provide a report of these measures to include total call volume, wait time in seconds, and abandonment percentage rate to the Department.

The Contractor shall record one hundred (100%) of incoming calls to its member and provider helplines using up-to-date call recording technology. Call recordings must be searchable by provider NPI, API, Member ID Number # (if available) and date and time of the call. Recordings will be made available to the Department upon request, and stored for a period of no less than fifteen (15) months from the time of the call.

The Contractor shall report call center statistics for the Provider & Member Inquiry lines to the Department on a monthly basis, as described in the MCTM.

4.10 PROVIDER ADVISORY COMMITTEE

In accordance with NCQA requirements, the Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve members. At least two (2) providers on the committee shall maintain practices that predominantly serve Medicaid members and other indigent populations, in addition to at least one (1) other participating provider on the committee who has experience and expertise in serving members with special needs. The committee shall meet at least quarterly. The committee's input and recommendations shall be employed to inform and direct Contractor quality management and activities, as well as policy and operations changes. The Department may conduct on-site reviews of the membership of this committee, as well as the committee's activities throughout the year.

4.11 PROVIDER SATISFACTION SURVEY

The Contractor shall conduct a provider satisfaction survey every other year. The survey shall include a statistically valid sample of its participating Medicaid providers. The Contractor shall submit a copy of the survey instrument and methodology to the Department. The Contractor shall communicate the findings of the survey to the Department in writing within one hundred twenty (120) days after conducting the survey. The written report shall also include identification of any corrective measures that need to be taken by the Contractor as a result of the findings, a time frame in which such corrective action will be taken by the Contractor and recommended changes as needed for subsequent use. Results of the survey shall be submitted biennially.

4.12 CONTRACTOR REFERRAL RESPONSIBILITIES

4.12.A Referral requirements

In addition to the referral requirements set forth elsewhere in this Contract, the Contractor shall:

- Establish referral mechanisms to link members with providers and programs not covered through Medallion 3.0 or Medicaid.
- Maintain a current list of providers, agencies, and programs and provide that list to members who have needs for those programs; and
- Refer members to the Department for carved-out and excluded services pursuant to Section 7.5 of this Contract.
- Refer members to the Department who are transitioning to residential treatment.

4.12.B Availability of Other Programs and Services

The Contractor shall advise members of the availability of services offered by the following programs, if appropriate to address the needs of the member. The Contractor will coordinate with and refer members to the following programs:

- Part C of IDEA - The Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § 303.12) is administered by the Virginia Department of Behavioral Health and Developmental Services. Early Intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The Contractor shall refer members who are potentially eligible or qualify for Early Intervention Services to local interagency councils. The Contractor shall maintain a listing of local interagency councils and shall make that listing available to all qualified members.
- WIC Programs - Section 1902(a)(11)(C) of the Social Security Act, as amended, requires the State Plan to provide for the coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and is administered by the Virginia Department of Health (VDH). The Contractor shall provide for the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by providers working within Medallion 3.0 managed care plans to the WIC Program.

- The Contractor is not responsible for covering WIC-specialized infant supplemental nutrition. The Contractor shall refer members who are potentially eligible for WIC to the Virginia Department of Health (VDH) who shall bill The Department for services provided.
- Head Start - The Head Start program is authorized under the Head Start Act, 42 U.S.C. § 9831 et seq., as amended.
- Service authorization (SA) - The Contractor shall refer providers, on behalf of members, to the Department's SA contractor, and/or BHSA, as needed.
- Lead Environmental Investigation - The Contractor shall refer members who require a lead environmental investigation to the local health department for assistance.

For all referrals that require the sharing of the member's medical information, the Contractor shall ensure that its network providers obtain necessary written and signed informed consent from the member prior to release of the member's medical information. All requests for medical information shall be consistent with the confidentiality requirements of 42 C.F.R. § Part 431, Subpart F.

5. ELIGIBILITY, ENROLLMENT & GENERAL RESPONSIBILITIES

5.1 ELIGIBILITY AND ENROLLMENT

5.1.A Eligibility

The Department shall have sole responsibility for determining the eligibility of a member for Medicaid-funded services. The Department shall have sole responsibility for determining enrollment in the Contractor's plan.

5.1.B Enrollment

The Department shall have sole authority and responsibility for enrollment into the Medallion 3.0 program and for excluding members from Medallion 3.0, including those members meeting the criteria in Section 5.2 below. The Contractor shall promptly notify the Department upon learning that a member meets one or more of these exclusion criteria. There shall be no retroactive enrollment in managed care. The only exception will be babies born to MCO-enrolled mothers when the child's eligibility is added back to their date of birth.

In conducting any enrollment-related activities permitted by this Contract or otherwise approved by the Department, the Contractor shall assure that member enrollment is voluntary and without regard to health status, physical or mental condition or handicap, age, sex, national origin, race, or creed. Members shall be enrolled in the order that the members apply to the Enrollment Broker, up to the limits (if any) specified in this Contract. The Contractor shall notify the member of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the member handbook. Upon disenrollment from the plan, the Contractor shall notify the member through a disenrollment notice that coverage in the Contractor's plan will no longer be effective. The disenrollment notice should identify the effective date of disenrollment and, whenever possible, should be mailed prior to the member's actual date of disenrollment. The Contractor shall not discriminate against, or use any policy or practice that has the effect of discriminating against, individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability as specified in 42 C.F.R.§ 438.3 (d)(4).

The Contractor shall be responsible for keeping its network of providers informed of the enrollment status of each member. The Contractor shall be able to report and ensure enrollment to network providers through electronic means.

The Department may establish alternate or contingent enrollment strategies as allowed by federal waiver requirements which support transition of enrollment for new and existing populations and health plans into and from managed care.

5.1.B.I Indian Health Provider Services

The Contractor must permit any member who is identified as an Indian to receive health care services from a participating Indian Health Provider, to choose covered services from that Indian Health Provider (as defined in this Contract), and if that Indian Health

Provider participates in the network as a primary care provider, to choose that Indian Health Provider as his/her PCP, as long as the provider has capacity to provide the services as described in Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111–5) and Section 1932(d)(3) of the Social Security Act and 42 C.F.R §438.14(b)(3) The Contractor must also permit an out-of-network IHCP to refer an Indian member to a network provider under 42 C.F.R §438.14(b)(6).

The Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under the contract from such providers for Indian members as required in 42 C.F.R. §§438.14(b)(1) and 438.14(b)(5).

The Contractor is required to pay IHCPs, whether participating or not, for covered services provided to Indian members, who are eligible to receive services at a negotiated rate between the Contractor and IHCP or, in absence of a negotiated rate, at a rate not less than the level and amount the Contractor would make to a participating provider that is not an IHCP as specified in 42 C.F.R. §438.14(b)(2)(i)-(ii).

5.1.C Member Selection of MCO

5.1.C.I At the time a member is enrolled

At the time a member is enrolled, a new VAMMIS generated letter will be sent to individuals stating that the individual will likely be managed care eligible and that the individual may pre-select an MCO.

5.1.C.II At the time a member is assigned

At the time a member is assigned, an assignment letter will be generated by VAMMIS, either confirming the pre-selected MCO from 5.1.C.I or assigning the member to an MCO for enrollment (See 5.1.D, below). At that time, the member may call the enrollment broker to change or select a different MCO.

5.1.C.III After assignment

After this period, a member can disenroll from the assigned MCO and select another MCO within the first ninety (90) days of enrollment without cause.

5.1.D Assignment to MCOs

In accordance with 12 VAC 30-120-370 and 42 C.F.R. §438.3(d)(1) , the Department will assign members to MCOs using an assignment system.

The following assignment process is to be followed during routine business months. The Department reserves the right to revise this process, as needed. Members will be assigned to MCOs through system algorithms, congruent with State conflict of interest safeguards described in 1932(d)(3) of the Social Security Act, based upon the client's history with a contracted MCO as follows:

5.1.D.I All eligible members, except those meeting one of the exclusions of **Section 5.2 shall be enrolled in Medallion 3.0.**

5.1.D.II Once members are enrolled in Medicaid, they will receive a letter indicating their eligibility for managed care and the effective date of enrollment. The letter will also

include the enrollment broker phone number, a link to the Medallion 3.0 website, and instructions to contact the toll-free managed care helpline number to select an available MCO, or for assistance with questions. Members are encouraged to exercise their selection choice.

5.1.D.III Members shall be assigned to an MCO as follows:

5.1.D.III.a Members that have a previous enrollment history with a currently contracted MCO will be assigned to that MCO.

5.1.D.III.b Members not assigned pursuant to subsection 1 above will be assigned to the MCO of another family member, if applicable.

5.1.D.III.c All other members will be randomly assigned to an MCO in approximately equal numbers by MCO in each locality.

5.1.D.III.d Pursuant to 1932 (a)(4), the member can choose to change from the MCO to which they were assigned during the first 90 days of enrollment.

5.1.D.III.e Members whose eligibility changes from CHIP to Medicaid shall remain enrolled in the MCO without disruption when eligibility changes are made on the same day. Impacted members who are hospitalized during this transition will remain enrolled with the MCO.

5.2 EXCLUSIONS FROM MEDALLION 3.0 PARTICIPATION

The Contractor shall cover all Medicaid eligible members, with the exception of excluded members as defined in 12 VAC 30-120-370 B.

The Department shall exclude members who meet at least one of the exclusion criteria listed below:

5.2.A Inpatient Members in Long-Stay Hospitals

Members who are approved by the Department as inpatients in long-stay hospitals (the Department recognizes two facilities as long-stay hospitals: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]), nursing facilities, or intermediate care facilities for the intellectually disabled.

5.2.B Spend Down

Members who are placed on spend-down.

5.2.C Home and Community-based Waivers

Members who are participating in Federal Waiver Programs for home-based and community based Medicaid coverage prior to managed care enrollment. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver, if determined to be Medallion 3.0 managed care eligible, shall not be excluded.

5.2.D Outside Area of Residence

Members, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those members placed there for medically necessary services funded by the Contractor or other MCO.

5.2.E Hospice

Members who receive hospice services in accordance with Department criteria.

5.2.F Third Party Liability

Members with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program, except as set forth in this Contract. (Veteran's Affairs (VA) benefits are not considered "other insurance" and do not qualify as an exclusion from Managed Care). [42 C.F.R. §§ 43 Sub D and 447.20]

5.2.G Newly Eligible Members in Third Trimester who Request Exclusion

Newly eligible members who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician, certified nurse midwife, or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests under this paragraph shall be made by the member, MCO, or obstetrical provider.

5.2.H Residential Level C Programs

Members under age twenty-one (21) who are approved for DMAS residential facility Level C programs as defined in 12VAC 30-130-860.

5.2.I Limited Life Expectancy

Members who have been assigned to the Contractor but whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion 3.0. Requests must be made during the assignment period.

5.2.J Inpatient Members in Hospitals

Members who are inpatients in hospitals, other than those listed in 5.2.A and above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within thirty (30) calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage. (See also Section 5.9 "Delay of Enrollment due to Hospitalization").

5.2.K Part C of Individuals with Disabilities Education Act

Certain members between birth and age three (3) certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et. seq.), who are granted an exception by the Department. Please note this Section is also listed as a carve-out under Section 7.5.A.XIV, since the member remains enrolled in the MCO.

5.2.L Birth Injury Fund

Members who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund.

5.2.M Limited eligibility Period

Members who have an eligibility period that is less than three (3) months

5.2.N FAMIS

Members who are enrolled in the Commonwealth's Title XXI SCHIP program.

5.2.O Retroactive Eligibility

Members who have an eligibility period that is only retroactive.

Members enrolled with a MCO that subsequently meets one or more of these criteria during MCO enrollment shall be excluded from MCO participation as appropriate by the Department, with the exception of those who subsequently become members in the federal long-term waiver programs, as otherwise defined elsewhere in this section, for home and community-based Medicaid coverage (Individual and Family Development Disabilities

Supports/Family and Individual Supports, Individuals with Intellectual Disability/Community Living, Elderly or Disabled with Consumer Direction, Day Support/Building Independence, Alzheimer's, or as may be amended from time to time). Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver, if determined to be Medallion 3.0 managed care eligible, shall not be excluded at any time except at the Department's discretion. All members addressed in this paragraph shall receive acute and primary medical services via the MCO and shall receive home and community-based waiver services and related transportation to waiver services via the fee-for-service program.

The Department shall, upon new State or Federal regulations or Department policy, exclude other members as appropriate.

5.3 ASSIGNMENT

The Contractor will accept assignment for any eligible member as specified in 42 C.F.R§ 438.3 (d)(1).

5.4 AUTOMATIC RE-ENROLLMENT

In accordance with 42 C.F.R §438.56(g), members who have been previously enrolled with the Contractor who regain eligibility for Medallion 3.0 enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment and who do not select another MCO will be reassigned to the Contractor, as appropriate, (provided sufficient member slots are available under this Contract) and without going through the selection or assignment process.

5.5 ENROLLMENT PERIOD & EFFECTIVE TIME

5.5.A Enrollment Period

For the initial ninety (90) calendar days following the effective date of enrollment, the member will be permitted to disenroll from one health plan and enroll in another health plan without cause. This ninety (90) day time frame during which a member may disenroll without cause applies to the member's initial period of enrollment and to any subsequent enrollment periods when they enroll in a new MCO.

If the member does not disenroll during the ninety (90) day period, he/she may not disenroll without cause for the remainder of the enrollment period.

Following their initial ninety (90) day enrollment period, members , except those classified as Foster Care children shall be restricted to their health plan selection until the open enrollment period for their locality, unless disenrolled under one of the conditions described in Section 5.2 and pursuant with Section 1932 (a)(4)(A) of Title XIX.

In addition, within sixty (60) days prior to the open enrollment effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO will have an additional thirty (30) days from the effective date of enrollment to choose an MCO. After

this total ninety (90) day period, the member shall remain in his or her current health care selection.

The member may disenroll from any contracted health plan to another at any time, for cause, as defined by the Department. See Section 5.10 "Disenrollment and Health Plan Election Changes" for details.

5.5.B Enrollment Effective Time

All enrollments are effective 12:00 A.M. on the first day of the first month in which they appear on the enrollment report, except for newborns, whose coverage begins at birth.

All disenrollments are effective 11:59 P. M. on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month

5.6 OPEN ENROLLMENT

Members will be notified of their ability to change plans at the end of their enrollment period at least sixty (60) days before the end of that period. Those members who do not choose a new MCO will have an additional thirty (30) days from the effective date of enrollment to choose an MCO. Enrollment selections will be effective no later than the first day of the second month following the month in which the member makes the request for the change in plans. MCOs that have contractual enrollment limits shall be able to retain existing members who select them and shall be able to participate in open enrollment until contractual limits are met. See Attachment VI for current open enrollment information by region and city/county.

5.7 ENROLLMENT PROCESS FOR NEWBORNS

The Contractor is responsible for the entire birth month plus two (2) additional consecutive month period for all MCO Newborns regardless of whether the newborn receives a Medicaid ID number, unless the MCO Newborn's enrollment is changed during the "birth month plus two (2)" period by the parent or legal guardian electing to change health plans. In such cases, the former MCO is not responsible once the MCO Newborn is enrolled into the MCO selected by the parent or legal guardian.

Any newborn whose mother is an enrolled FAMIS MOMS member in the Contractor's plan on the newborn's date of birth shall be deemed a member of that Contractor's plan for up to three (3) calendar months (birth month plus two (2) months) and shall hereafter be referred to as an MCO Newborn.

The obligation of the MCO to cover the MCO Newborn for the "birth month plus two (2)" period is not contingent on the mother's continued enrollment in the MCO; the MCO must cover the MCO Newborn even if the mother does not remain enrolled after the MCO Newborn's date of birth.

If this Contract is terminated in whole or in part by the Contractor, the Contractor shall continue coverage for the MCO Newborn until the child is enrolled with another MCO in the Department's MMIS, or until the end of the "birth month plus two" period, whichever is earlier.

Any medically necessary claims for an MCO Newborn may not be denied by the MCO for any reason during the "birth month plus two (2)" period, including- but not limited to, lack of service authorizations for newborn services, timely filing issues as a result of delayed or incorrect enrollment of the newborn, medically necessary services received out of MCOs service area, or medically necessary services received from out-of-network providers.

The Contractor is required to reimburse provider(s) if treating the MCO Newborn in the hospital and/or performing follow-up appointments during the "birth month plus two (2)" period, even if that provider is not in the MCO network. In the absence of a provider agreement otherwise, an MCO must reimburse the non-network provider at the Medicaid rate in place at the time the services were rendered.

The Contractor may not deny payment to a provider as a result of enrollment errors or because payment is not reflected on the Contractor's 820 Payment Report.

The Department shall reimburse the Contractor appropriate capitation payment for MCO Newborns for the entire "birth month plus two (2)" period. Any payment for MCO Newborns that is not reflected on the Contractor's 820 Payment Report shall be handled via the reconciliation process as outlined in Section 12 and the Managed Care Technical Manual. All charges for MCO Newborns are the responsibility of the Contractor in all cases.

The Contractor is responsible for advising the parent or guardian of the newborn that Medicaid eligibility rules ensure continuous eligibility for the child up to twelve (12) months following birth; however, to receive coverage, the local DSS office must be notified of the birth. The Contractor shall have written policies and procedures governing the identification of MCO Newborns by their network providers. The Contractor should also encourage contracted hospitals to submit newborns via the streamlined online enrollment process.

The Contractor must report all live births to the Department monthly using the specified format and parameters as documented in the Managed Care Technical Manual.

5.8 ENROLLMENT PROCESS FOR FOSTER CARE & ADOPTION ASSISTANCE CHILDREN

The Contractor shall cover services for managed care enrolled foster care & adoption assistance children (designation codes 076 and 072, respectively).

- For decisions regarding the foster care child's medical care, the MCO shall work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child's medical care, the MCO shall work directly with the adoptive parent.
- The social worker will be responsible for all changes to MCO enrollment for foster care children. The adoptive parent will be responsible for all changes to MCO enrollment for

adoption assistance children. An enrollment change can be requested at any time that the child is placed in an area not serviced by the plan of enrollment.

- Coverage shall not be limited to emergency services and must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area.
- If the MCO has found that the foster care child has been placed in an area other than the one where the MCO participates, the MCO may contact the social worker to request a change of health plan be initiated.
- The MCO must work with DSS and the foster parent(s) in all areas of care coordination.
- For decisions regarding the medical care of former foster care or Fostering Futures members (AC 070), the Contractor shall work directly with the former foster care members.
- The former foster care or Fostering Futures members (AC 070) shall be responsible for all changes regarding their MCO enrollment.
- Foster care children are not restricted to their health plan selection following the initial ninety (90) day enrollment period, as stated in Section 5.5.A.
- Regardless of the reasons described above, if a child moves out of the service area, the child remains the responsibility of the health plan for all contractual covered services until disenrollment occurs.

Additional information pertaining to requirements for Foster Care and Adoption Assistance individuals can be located in Section 7.1.O.III.

5.9 DELAY OF ENROLLMENT DUE TO HOSPITALIZATION

Members who are inpatients in hospitals, other than those listed in Section 5.2 of this Contract, at the scheduled time of Managed Care enrollment or who are scheduled for inpatient hospital stay or surgery within thirty (30) calendar days of the enrollment effective date are restricted from enrollment with the MCO until the first day of the month following discharge, as set forth in 12 VAC 30-120-370 B. This does not pertain to newborns that are enrolled as described in Section 5.7 “Enrollment Process for Newborns”.

A member who is discharged from one hospital and admitted to another hospital within twenty-four (24) hours (facility to facility transfers) for continued treatment of the same diagnosis shall not be considered discharged under this section.

5.10 DISENROLLMENT AND HEALTH PLAN ELECTION CHANGES

Enrollment in Medallion 3.0 is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. The Department reserves the right to exclude from participation in the Medallion 3.0 managed care program any member who has been consistently noncompliant, as determined by the Department, with the policies and procedures of managed care or who is threatening to providers, MCOs, or the Department. There must be sufficient documentation from various providers, the MCO, and the Department of these noncompliance issues and any attempts at resolution. Recipients excluded from Medallion 3.0 through this provision may appeal the decision to the Department. Disenrollment from managed

care by the Department shall be in accordance with 42 C.F.R. § 438.56(b)(2)&(3). As specified in 42 C.F.R. § 438.56(b)(2), the Contractor may not request disenrollment because of: an adverse change in the member's health status; the member's utilization of medical services; the member's diminished mental capacity; or the member's uncooperative or disruptive behavior resulting from his or her special needs.
Members shall have the right to disenroll from the Contractor's plan to another Plan pursuant to 42 C.F.R. § 438.56, as amended, or § 1903 (m)(2) A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements. During the first ninety (90) calendar days following the effective date of enrollment, a member may elect to change health plans for any reason. Any such change of plan shall be effective no later than the first day of the second month after the month in which the member requests disenrollment.

Consistent with § 1932(a)(4) of the Social Security Act, as amended (42 U.S.C. § 1396u-2), the Department must permit a member to disenroll at any time for cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 C.F.R. § 438.56(d)(2) and 12 VAC 30-120-370. The Department will respond to "cause" requests, in writing, within fifteen (15) business days of the Department's receipt of the request. In accordance with 42 C.F.R. §§ 438.56(e)(1)-(2) and 438.3 (q) , if the Department fails to make a determination by the first day of the second month following the month in which the member files the request, the disenrollment request shall be considered approved and effective on the date of approval.

In accordance with 42 C.F.R.§§ 438.3(q)(5);438.56 (c)(l); and 438.56 (c)(2), a member has the right to disenroll from the Contractor's plan without cause once every twelve (12) months, without cause upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period, without cause when the Department imposes intermediate sanctions on the Contractor, if the member moves out of the services area, if the Contractor does not cover the services the member seeks, because of moral or religious objections, and if the enrollee needs related services to be performed at the same time, not all related services are available within the provider network and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk..

Upon disenrollment, the Contractor shall notify each member in writing of their disenrollment and the effective date of disenrollment. Upon receipt of an inquiry, the Contractor should provide instructions for the disenrolled member to contact the Department of Social Services (DSS) with any questions regarding Medicaid eligibility. With respect to the disenrollment of newborns, the Contractor should inform mother/parent/guardian that in order to continue the newborn's eligibility, the mother/parent/guardian must go to DSS to obtain a Medicaid identification number for the newborn.

Provision of an enhanced service that is a service qualifying for an exclusion from Medallion 3.0 Managed Care shall not be the sole basis for disenrollment or exclusion from Medallion 3.0. In order to be excluded from Medallion 3.0, individuals must meet the Department's criteria for receiving that service.

5.11 LOSS OF ELIGIBILITY

The member will lose managed care eligibility upon occurrence of any of the following events:

- Death of the member;
- Cessation of Medicaid eligibility;
- Members that meet at least one (1) of the exclusion criteria listed in Section 5.2 of this Contract. The Department shall determine if the member meets the criteria for exclusion;
- Transfer to a Medicaid eligibility category not included in this Contract; or
- Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

The Department will determine the need for status change disenrollment based on input and supporting documentation from the Contractor and/or other source(s).

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or loss of eligibility, except for specially manufactured DME that was prior-authorized by the Contractor and certain payments using DRG Methodology, as detailed in Section 12.7. However, in cases where disenrollment is anticipated, secondary to the member's participation in the Technology Assisted home and community based care waiver, nursing facility, hospice, or other exclusionary program, the Contractor is responsible for the authorization and provision of all services covered under this Contract until notified of the disenrollment by the Department.

In certain instances a member may be excluded from participation effective with retroactive dates of coverage. The Contractor is not liable for services rendered outside of the member's dates of enrollment with the Contractor. Providers may submit claims to the Department for services rendered during this retroactive period. Reimbursement by the Department for services rendered during this retroactive period is contingent upon the members meeting eligibility and coverage criteria requirements.

The Contractor shall be entitled to a capitation payment for the member based on the recoupment/reconciliation procedures in Section 12 and the Managed Care Technical Manual. The Contractor shall not be entitled to payment during any month subsequent to status change determination. Capitation payments already paid by the Department for months beyond the month in which the event occurred shall be repaid to the Department in accordance with the provisions of this Contract.

5.12 INFORMING THE DEPARTMENT OF POTENTIAL INELIGIBILITY

The Department will share with the Contractor data that its agents have regarding reasons for enrollment and disenrollment (via the *Plan Change Report*) at least on a monthly basis.
When a member for who services have been authorized, but not provided as of the effective date of exclusion or disenrollment is excluded or disenrolled from the Contractor's plan and from Medallion 3.0, the Contractor shall provide to the Department or the relevant PCP the history for that member upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

5.13 RURAL EXCEPTION

A Rural Exception occurs where a single MCO operates under the Federal Rural Exception guidelines and where qualifying members are enrolled with that contracted MCO. The single Contractor shall adhere to all contract requirements as described within this Contract.

The following differences apply in any locality where there is a Rural Exception:

5.13.A Enrollment:

Members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines shall be enrolled, and remain enrolled with the contracted MCO unless disenrolled under one of the conditions described in Section 5.2 "Exclusions from Managed Care" and pursuant with Section 1932 (a)(4)(a) of Title XIX.

5.13.B Member Choice of PCP:

Members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines must be permitted to choose or change from at least two (2) PCP providers (see Section 3.6.A).

5.13.C Out-of-Network Services:

In addition to the requirements found in Section 7.1.K, for members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, per 42 C.F.R. § 438.52(b)(2)(B), the Contractor shall provide out-of-network coverage in all of the following circumstances:

5.13.C.I Out of Network

Where a provider is not a part of the Contractor's network, but is the main source of a service to the member, provided that:

5.13.C.I.a The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type;

5.13.C.I.b If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider within sixty (60) days (after being given the opportunity to select a provider who participates);

5.13.C.II Separately Services

The member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

5.13.D Assignment:

Once members are enrolled in Medicaid, they will receive a letter indicating that they may be assigned to a contracted MCO. Members who reside in a locality where a single MCO operates under the Federal Rural Exception guidelines shall be provided an advanced notice that (s)he will be enrolled in the contracted MCO

6. Member Outreach and Marketing Services

6.1 MARKETING PLAN

For the purposes of this Contract, Marketing Materials and Services as defined shall apply to members who may or may not be currently enrolled with the Contractor. All Contractors may utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf.

Marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the Anti-Kickback Statute and the, Civil Monetary Penalty law which prohibits inducements to beneficiaries. An organization may be subject to sanctions if it offers or gives something of value to a member that the organization knows or should know is likely to influence the member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to members.

The Contractor shall:

6.1.A Have Adequate Written Descriptions to Members

Offer its plan to members and provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for members to make an informed decision about enrollment.

6.1.B Submit an Annual Marketing Plan

Submit to the Department a complete marketing plan on or before September 30th each year, and thirty (30) calendar days prior to implementation. This is provided to the Department for informational purposes. Any changes to the marketing plan must be submitted to the Department for approval prior to use. The Department will review individual marketing materials and services as they are submitted (prior to their planned use), and approve, deny, or ask for modifications within the timeframes outlined below.

6.1.C Submit Marketing and Informational Materials to the Department

Submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Department will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Department. [42 C.F.R. § 438.104(b)]

6.1.D Distribute Marketing Materials

Distribute marketing materials to the Contractor's entire eligible population on a city or countywide basis, and also through the Contractor's website. The Department must approve a request for a smaller distribution area. The Contractor may distribute marketing materials to Medicaid members where the member is enrolled with the Contractor's (or the Contractor's affiliates) Medicare product, within all applicable Medicare Advantage Marketing Guidelines, as set forth in Chapter 3 of CMS' Medicare Managed Care Manual, as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 C.F.R. § 422.111. [42 C.F.R. § 438.104(b)]

6.1.E Submit Materials in Advance of Events

Coordinate and submit to the Department all of its schedules, plans, and informational materials for community education, networking and outreach programs. The schedule shall be submitted to the Department at least two (2) weeks prior to any event.

6.1.F Assure Flesch Readability Scores

Assure that all marketing and informational materials shall set forth the Flesch readability scores of forty (40) or better (at or below 12th grade reading level) and certify compliance therewith (See Section 6.4 "Communication Standards).

6.1.G Be Subject to Sanctions

Be subject to a fine or other sanctions if it conducts any marketing activity that is not approved in writing by the Department. (42 C.F.R. § 438.700)

6.2 PERMITTED MARKETING AND OUTREACH ACTIVITIES

The Contractor may engage in the following promotional activities:

6.2.A General Public

Notify the general public of the Medicaid Managed Care program in an appropriate manner through appropriate media, including social media, throughout its enrollment area.

6.2.B Through the Department

Distribution through the Department or its agents and posting of written promotional materials pre-approved by the Department.

6.2.C Pre-Approved Mail Campaigns

Pre-approved mail campaigns through the Department or its agents to regions of potential members and pre-approved informational materials for television, radio, and newspaper dissemination.

6.2.D Potential Member Request

Fulfillment of potential member requests to the MCO for general information, brochures, and/or provider directories that will be mailed to the member. Where appropriate, member requests for general information may also be provided telephonically.

6.2.E Community Sites

Marketing and/or networking at community sites or other approved locations.

6.2.F Health Awareness/Community Events

Hosting or participating in health awareness events, community events, and health fairs pre-approved by the Department where Representatives from the Department, the enrollment broker and/or local health departments may be present. The Contractor must make available informational material that includes the enrollment comparison chart. The Contractor is allowed to collect names and telephone numbers for marketing purposes; however, no Medicaid ID numbers may be collected at the event. The Department will supply copies of comparison charts upon proper notification.

6.2.G Health Screenings

Health screenings may be offered by the Contractor at community events, health awareness events, and in wellness vans. The Contractor shall ensure that every member receiving a screening is instructed to contact his or her PCP if medical follow-up is indicated and that the member receives a printed summary of the assessment information to take to his or her PCP. The Contractor is encouraged to contact the member's PCP directly to ensure that the screening information is communicated.

6.2.H Promotional Items or "Giveaways"

Offers of free non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of $25.00 to any prospective member or family for marketing purposes. Such items must be offered to all prospective members for marketing purposes whether or not the prospective member chooses to enroll in the Contractor's plan. The Contractor is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules.

6.2.I Non-Cash Incentives

The Contractor is allowed to offer non-cash incentives to their enrolled members for the purposes of retaining membership, and/or rewarding for compliance in immunizations, prenatal visits, or participating in disease management, HEDIS or HEDIS-related measures/activities, etc. These incentives shall be limited to $25.00 for individual "giveaways" as stated in item "h." above unless an approved exception is made by the Department within its discretion. Gifts of this type cannot exceed $50.00 in any fiscal year to any one individual. For raffles or prize drawings, only 1 special incentive drawing a year per health plan in excess of the $50.00 will be allowed. The prize has to be health related. Wii or Xbox game consoles with exercise video will meet this requirement. Contractors are required to keep a database to ensure that giveaways (including gift cards) do not exceed $50.00 per member per contract year. This incentive shall not be extended to any member not yet enrolled in the Contractor's plan. The Contractor must submit all incentive award packages to the Department for approval prior to implementation. Non-cash incentives may include gift cards. The Contractor must have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash.

6.3 PROHIBITED MARKETING AND OUTREACH ACTIVITIES

The following are prohibited marketing and outreach activities targeting prospective members under this Contract:

6.3.A Certain Informational Marketing Activities

Engaging in any informational or marketing activities which could mislead, confuse, or defraud members or misrepresent the Department. [42 C.F.R. § 438.104(b)(2)(i)-(ii)]

6.3.B "Cold-call Activities"

Directly or indirectly, conducting door-to-door, telephonic, email, texting, or other "cold call" marketing of enrollment at residences and provider sites. [42 C.F.R. § 438.104]

6.3.C Direct Mailing

All mailings must be processed through the Department or its agent except mailings to Medicaid or Medicare members of the Contractor.

6.3.D Home Visits/Direct Marketing or Enrollment

Making home visits for direct marketing or enrollment activities except when requested by the member.

6.3.E Financial Incentives

Offering financial incentive, reward, gift, or opportunity to eligible members as an inducement to enroll in the Contractor's plan other than to offer the health care benefits from the Contractor pursuant to their contract or as permitted above.

6.3.F Prospective Member Marketing

Continuous, periodic marketing activities to the same prospective member, e.g., monthly or quarterly giveaways, as an inducement to enroll.

6.3.G Improper Use of DMAS Eligibility Database

Using the DMAS eligibility database to identify and market its plan to prospective members or any other violation of confidentiality involving sharing or selling member lists or lists of eligibles with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract.

6.3.H Targeting on Basis of Health Status

Engaging in marketing activities which target prospective members on the basis of health status or future need for health care services, or which otherwise may discriminate against members eligible for health care services.

6.3.I Contacting members after disenrollment date

Contacting members who disenroll from the plan by choice after the effective disenrollment date except as required by this Contract or as part of a Department approved survey to determine reasons for disenrollment.

6.3.J Marketing a Rebate or Discount

Engaging in marketing activities which offer potential members a rebate or a discount in conjunction with the sale of any health care coverage, as a means of influencing enrollment or as an inducement for giving the Contractor the names of prospective members (42 C.F.R. § 438.104). No enrollment-related activities may be conducted at any marketing, community, or other event unless such activity is conducted under the direct on-site supervision of the Department or its enrollment broker.

6.3.K DSS Offices

No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department of Medical Assistance Services.

6.3.L Statements of Endorsement (Government)

No assertion or statement (whether written or oral) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity. [42 C.F.R. § 438.104(b)(2)(i)-(ii)]

6.3.M Enroll to Keep Benefits

No assertion or statement that the member must enroll with the Contractor in order to keep from losing benefits. [42 C.F.R. § 438.104(b)(2)(i)-(ii)]

6.3.N Renewal of Medicaid Benefits/Reason for Disenrollment

Contacting members at any time for the purpose of determining the need for, or providing assistance with, recertification/renewal of Medicaid benefits. In addition, health plan may not solicit reason for disenrollment from members leaving Contractors plan, except as authorized in Section 6.3.I.

6.3.O Influence Enrollment

Seeking to influence enrollment in conjunction with the sale or offering of any private insurance. [42 C.F.R. § 438.104(b)]

6.4 COMMUNICATION STANDARDS

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity as detailed in 42 C.F.R. §440.262. The Contractor shall have

mechanisms in place to help members and potential members understand the requirements and benefits of their plan as specified in 42 C.F.R. § 438.10(c)(7).
The Contractor is required to provide all written materials for members and potential members in an easily understood language and format as specified in 42 C.F.R. §438.10(d)(6)(i). Additionally, under 42 C.F.R. § 438.10(d)(6)(ii)-(iv), the Contractor is required to:

- Provide all written materials for members and potential members in a size no smaller than twelve (12) point font.
- Make written materials for members and potential members available in alternative formats in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.
- Make written materials for members and potential members through auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.
- Include on all written materials a large print tagline and information on how to request auxiliary aids and services, including materials in alternative formats. Large print means printed in a font size no smaller than eighteen (18) point.

In following with 42 C.F.R. § 438.10(c)(4)(i), the definitions provided in the Attachment XII *Common Definitions For Managed Care Terminology* shall be used by the Contractor in all Member communications and materials.

The Contractor shall ensure that documents for its membership, such as the member handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12th grade educational level). The document must set forth the Flesch score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) Additionally, the Contractor shall ensure that written membership material is available upon request in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited. [42 C.F.R. § 438.10(d)(1)(2)]

As set forth in 42 C.F.R. § 438.10(d)(3), the Contractor must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices available in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by Medallion 3.0 regions and will only affect handbooks distributed in the affected region. Per 42 C.F.R § 438.10(d)(1), the prevalent non-English languages spoken by the members and potential members in the State and each MCO service are to be identified by the Department and provided to the Contractor.

Additionally, the Contractor's written materials must include taglines in the prevalent non-English languages in the state, as well as large print (no smaller than 18 point), explaining the availability of written translation or oral interpretation to understand the information provided. Further, the written materials must include the prevalent non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDD) telephone number of the Contractor's member/customer service unit.

The Contractor must make auxiliary aids and services available upon request of the member or potential member at no cost. [42 C.F.R. § 438.10(d)(3)]

The Contractor must institute a mechanism for all members who do not speak English to communicate effectively with their PCPs, Contractor staff, and subcontractors.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. [42 C.F.R. §§ 438.10(c)(4) and 42 C.F.R. §438.(d)(2] Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the member, a family member or a friend. If five hundred (500) or more of its members are non-English speaking and speak a common language, the Contractor must include, if feasible, in its network at least two (2) medically trained professionals who speak that language. In addition, the Contractor must provide TTY/TDD services for the hearing impaired, and American Sign Language (ASL), free of charge to each member.[42 C.F.R. § 438.10(d)(4)]

All of the following requirements in 42 C.F.R. 438.10(c)(6)(i)-(v) must be met in order for the Contractor to provide information electronically:

- It must be in a font that is readily accessible.
- The information must be placed in a location on the Contractor's website that is prominent and readily accessible.
- The information must be provided in an electronic form which can be electronically retained and printed.
- The language is consistent with content and language requirements.
- The Contractor must notify the member that the information is available in paper form without charge upon request.
- The Contractor must provide, upon request, information within five (5) business days.

All enrollment, disenrollment, and educational documents and materials made available to members by the Contractor must be submitted to the Department for its review at start-up, upon revision, and upon request unless specified elsewhere in this Contract.

6.4.A Member Notification

In accordance with 42 C.F.R. § 438.10(d)(5)(i)-(iii), the Contractor shall notify its members that:

- Oral interpretation is available for any language, and how to access those services.
- Written translation is available in prevalent languages and how to access those services.

- Auxiliary aids and services are available upon request at no costs for members with disabilities and how to access those services.

Additionally, under 42 C.F.R. §438.10(c)(4)(ii), the Contractor is required to use Department developed member notices. A model notice template is available on the Medallion 3.0 website at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

6.5 MEMBER IDENTIFICATION (ID) CARD

The Contractor shall provide each member an identification card that is recognizable and acceptable to the Contractor's network providers. The Contractor's identification card must also serve as sufficient evidence of coverage for non-participating providers. The Contractor's identification card will include, at a minimum, the name of the member, the Medicaid identification number, member co-payment responsibility (as applicable), the name and address of the Contractor, the name of the member's primary care provider, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, a Contractor identification number, and any other information needed to process claims or provide customer service numbers, if applicable. All member identification cards are also required to include the telephonic contact information for the Smiles For Children program. The Contractor must submit and receive approval of the identification card from the Department prior to production of the cards.

Please see Section 6.7 for mailing requirements for Member I.D. cards and New Member Packets. The Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the member's Medicaid identification number, first/last name, incorrect address, and correct address, if available.

6.6 NEW MEMBER PACKET

The Contractor shall provide its members, as expediently as possible upon receiving the end of the month 834 file in which their enrollment starts, an identification card (if not already mailed) and an information packet indicating the member's first effective date of enrollment. (Reference Section 11 and the Managed Care Technical Manual for time frames related to enrollment report information exchange.) The Contractor may send this information in a single mailing to the household (by case number listed in the enrollment report), and is only required to send one (1) member handbook per case. Each member must receive an individual identification (ID) card. Further, the Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the member identification cards. The Department must receive a copy of this packet for review due prior to signing original contract, upon revision, upon request, and as needed. At a minimum, the member information packet shall include:

6.6.A Information Packet Requirements

6.6.A.I An introduction letter

6.6.A.II Identification card

An identification card that includes the Medicaid ID number and the member's co-payment responsibility, if applicable.

6.6.A.III Member Handbook Notification

In accordance with 42 C.F.R § 438.10 the contractor must notify the member in writing of the following, at minimum:

- Advises the member that the information is available on the MCO's member website and the DMAS web site and includes the applicable Internet address, and provides information to members on auxiliary aids and services for members with disabilities that cannot access this information online, upon request at no cost;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is available in paper form upon request within five (5) business days at no cost to the member by using a toll free number;
- All written correspondence mailed to the member shall include a tag line on how the member can obtain a member handbook using the process described above

6.6.B Network Provider Directory

The Contractor shall make available in paper form upon request and electronic form, a provider directory that includes the following information about its network providers, including physicians, specialists, hospitals, pharmacies, and behavioral health providers.

6.6.B.I Content of Provider Directory

In accordance with 42 C.F.R. § 438.10(h)(l)(i)-(viii), the provider directory must include, at a minimum, the following information for all providers in the Contractor's provider network:

- The names, addresses, and telephone numbers of all current network providers;
- For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, office hours, including the names of any network provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;
- As applicable, whether the health care professional or non-facility based network provider has completed cultural competence training;
- For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, licensing information, such as license number or National Provider Identifier;
- Whether the network provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam room(s) and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;
- Whether the provider is accepting new patients as of the date of publication of the directory;
- Provider website/URL, if available;
- Whether the network provider is on a public transportation route;
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, or access to language line interpreters;
- For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use;

- Whether there are any restrictions on the Member's freedom of choice among network providers.
- For pharmacy providers, names, addresses, and telephone numbers of all current network pharmacies and instructions for the Member to contact the Contractor's toll-free Member Services telephone line for assistance in finding a convenient pharmacy.

6.6.B.II Maintenance and Distribution

The Contractor shall maintain, update, and distribute the directory as follows:

- Update information in its paper directory at least monthly;
- Update information in its online and printed directories no later than thirty (30) calendar days after receipt of provider updates;
- Provide either a copy, or a separate notice about how to access this information online or request a hard copy, to all new Members and annually thereafter;
- When there is a significant change to the network, the Contractor shall send a special mailing to Members;
- Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 CFR §438.10;
- Consistent with 42 C.F.R. § 438.10(f)(l), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all members who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified; and,
- Include written and oral offers of such provider and pharmacy directory in its outreach and orientation sessions for new members.
- Make available on the Contractor's website in a machine readable file and format per 42 C.F.R.§438.10(h).

6.6.C Member Handbook

If a member is re-enrolled within sixty (60) days of disenrollment, the Contractor is only required to send the member a new identification card. However, the complete Member Information Packet and Provider Directory must be supplied upon request by the member.

6.7 MAILING REQUIREMENTS FOR MEMBER ID CARDS AND NEW MEMBER PACKETS:

The Contractor must have a policy/procedure in place to ensure member access to services and expedient issuance of all Member ID Cards and New Member Packets.

6.7.A Mid-Month 834 – Member Identification Card Only

The Contractor shall provide each member, as identified in the mid-month 834 file, within five (5) days of receipt of the mid-month 834 file, a New Member Identification Card. The Contractor must mail all member identification cards, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

6.7.B End of Month 834 – All New Member Packets & Member Identification Cards for Those New Members not on Mid-Month

The Contractor shall provide each member, as identified in the end of the month 834 file, within five (5) days of receipt of the end-of-month 834 file, a New Member Identification

Card. The Contractor shall provide each member, regardless of when identified, a New Member Packet.

The Contractor must mail all New Member Packets, and member identification cards utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

6.8 MEMBER HANDBOOK

In accordance with 42 CFR § 438.10, the Contractor shall develop a Member Handbook that includes all required elements as defined in this Contract and in the Department's Medallion 3.0 model Member Handbook template, available on the Medallion 3.0 website at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

The Contractor is required to utilize the model Member Handbook to include a clause stating that in the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor must inform members that the service is not covered by the Contractor, and how they can obtain information from the State about how to access those services. [42 C.F.R. § 438.10(g)(2)(ii)(A)-(B); 42 C.F.R. § 438.102(b)(2)]

The Contractor shall submit a copy of the Member Handbook to the Department for approval sixty (60) calendar days prior to distribution. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The Contractor must update the Member Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or a red-lined handbook showing before and after language. The red-lined document may be submitted on paper or electronically. Such changes must be approved by the Department prior to dissemination to members and shall be submitted to the Department at least sixty (60) calendar days prior to planned use. The Department will respond to changes within thirty (30) calendar days of the date of the Department's receipt of the request. If the Department has not responded to the Contractor within thirty (30) days from receipt of the Member Handbook, the Contractor may proceed with its printing schedule. The Contractor may choose to either update the Member Handbook along with other Annual Deliverables by September 30 at 11:59pm, or notify the Department by that date of another scheduled time within the Contract year for submission of the annual Member Handbook update to allow Departmental resources to be allocated for review. If the Contractor prints and distributes a version of the handbook that was not approved by the Department, the Contractor will be required to amend and redistribute to its entire member population within thirty (30) days. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Department. The Member Handbook must include instructions advising members about EPSDT and how to access such services. [42 C.F.R § 438.10 (g)(2)]

The Contractor's Member Handbook shall reflect a copy of the member rights (as referenced in this Contract) as provided at open enrollment.

The Member Handbook must be provided to each member (and potential member if requested) within a reasonable time after the Contractor receives notice of the member's enrollment. [42 C.F.R § 438.10 (g)(1) and 45 C.F.R.§ 147.200(a)**]**

In accordance with 42 C.F.R **§** 438.10 (g)(3)(i)-(iv), the handbook information is considered to be provided to the member if the Contractor:

- Mails a printed copy of the information to the member's mailing address.
- Provides the information by email after obtaining the member's agreement to receive the information by email.
- Posts the information on its website and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that the members with disabilities that cannot access this information online are provided auxiliary aids and services upon request at no cost.

Under 42 C.F.R. § 438.10(g)(2),the Handbook must provide information that enables the member to understand how to effectively use the managed care program. The Handbook shall include, at a minimum, the following information:

6.8.A Table of Contents

6.8.B Member Eligibility

6.8.B.I Effective date and term of coverage.

6.8.B.II Terms and conditions under which coverage may be terminated.

6.8.C Choosing or Changing an MCO

6.8.C.I Procedures to be followed if the member wishes to change MCOs.

6.8.D Choosing or Changing a PCP

6.8.D.I Information about choosing and changing PCPs and a description of the role of Primary Care Providers. [42 C.F.R § 438.10 (g)(2)(x)]

6.8.E Making Appointments and Accessing Care

6.8.E.I Appointment-making procedures and appointment access standards.

6.8.E.II A description of how to access all services including specialty care and authorization requirements.

6.8.E.III The role of the PCP and the Contractor in directing care.

6.8.F Member Rights

6.8.F.I Includes the member rights and responsibilities listed in Section 6.9.A-H of this Contract. [42 C.F.R §§ 438.10 (g)(2)(ix) and 438.100(b)(2)(i)-(vi)]

6.8.G Member Services

6.8.G.I A description, including the amount, duration, and scope of all available covered services, as outlined in Section 7 of this Contract, including preventive services, and an explanation of any service limitations, referral and service authorization requirements, and any restrictions on the member's freedom of choice among network providers. The description shall include the procedures for obtaining benefits, including family planning services from out-of-network providers. [42 C.F.R § 438.10 (g)(2)(iii)-(iv)]

6.8.G.II A description of the enhanced services that the Contractor offers.

6.8.G.III An explanation that the Contractor cannot require a member to obtain a referral before choosing a family planning provider. [42 C.F.R § 438.10 (g)(2)(vii)]

6.8.G.IV Instructions on how to contact Member or Customer Services of the Contractor and a description of the functions of Member or Customer Services.

6.8.G.V Notification that each member is entitled to a copy of his or her medical records and instructions on how to request those records from the Contractor.
6.8.G.VI Instructions on how to utilize the after-hours Medical Advice and Customer Services Departments of the Contractor. [42 C.F.R § 438.10 (g)(2)(v)]
6.8.G.VII A description of the Contractor's confidentiality policies.
6.8.G.VIII Advice on how enrolled members may acquire services that are covered under Medicaid, but not under this contract, including home and community based care waiver services as applicable. A description of these services, including how they may be accessed, is provided as Attachment II.

6.8.H Emergency Care

6.8.H.I The telephone number to be used by members for assistance in obtaining emergency care.
6.8.H.II The definition of an emergency using the "prudent layperson" standard, a description of what to do in an emergency, instructions for obtaining advice on getting care in an emergency, the fact that service authorization is not required for emergency services, and the fact that the member has the right to use any hospital or other setting for emergency care. Members are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911. [42 C.F.R § 438.10 (g)(2)(v)]
6.8.H.III A description of how to obtain emergency transportation and other medically necessary transportation.
6.8.H.IV How to appropriately use emergency services and facilities.
6.8.H.V Information indicating that emergency services are available out-of-network without any financial penalty to the member.

6.8.H.VI Definition of and information regarding coverage of post-stabilization services in accordance with 42 C.F.R. § 422.113(c) as described in Section 7 of this Contract.
6.8.H.VII The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this Contract.

6.8.I Member Identification Cards

6.8.I.I A description of the information printed on the identification card, including the Medicaid ID number.
6.8.I.II A description of when and how to use the identification card**.**

6.8.J Member Responsibilities

6.8.J.I A description of procedures to follow if:

6.8.J.I.a The member's family size changes;
6.8.J.I.b The member's address changes;
6.8.J.I.c The member moves out of the Contractor's service area, (where the member must notify the DSS office regarding change of address and must notify the Contractor for assistance to receive care outside of the Contractor's service area until the member is disenrolled);
6.8.J.I.d He or she obtains or has health coverage under another policy or there are changes to that coverage.

6.8.J.II Actions the member can make towards improving his or her own health, member responsibilities, appropriate and inappropriate behavior, and any other

information deemed essential by the Contractor. [42 C.F.R §§ 438.10 (g)(2)(ix) and 438.100(b)(3)]

6.8.J.III Information about advance directives, such as living wills or durable power of attorney, in accordance with 42 C.F.R. §§ 489.102, 422.128, and 438.6(i)(1).

6.8.J.IV Notification of any co-payment in accordance with Section 7.1.A, if applicable, the member will be required to pay.

6.8.J.V Information regarding the member's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid.

6.8.K MCO Responsibilities

6.8.K.I Notification to the member that if he or she has another health insurance policy to notify their local Department of Social Services caseworker. Additionally, inform the member that the MCO will coordinate the payment of claims between the two insurance plans.

6.8.L Grievances and Appeals [42 C.F.R. Part 438.10 Subpart F)]

6.8.L.I A description of the grievance and appeals procedures and timeframes including, but not limited to, the issues that may be resolved through the grievance or appeals processes; the fact that members have the right request to a State fair hearing after the Contractor has made a determination in the member's appeal which is adverse to the member, and providing the Department's address for the appeals; the process for obtaining necessary forms; and procedures and applicable timeframes to register a grievance or appeal with the Contractor or the Department as described in this Contract. [42 C.F.R § 438.10 (g)(2)(xi)]

6.8.L.II The availability of assistance in the filing process.

6.8.L.III The toll-free numbers that the member can use to file a grievance or an appeal by telephone.

6.8.L.IV A description of the continuation of benefits process as required by 42 C.F.R. § 438.420 and information describing how the member may request continuation of benefits, as well as information on how the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

6.8.L.V The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (Managed Care Helpline, 800-643-2273, Fraud 800-371-0824 and 888-323-0587).

6.8.M Interpretation and Translation Services

6.8.M.I Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42 C.F.R. § 438.10(c)-(d)]

6.8.M.II A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services. [42 C.F.R. § 438.10(c)-(d)] As the size of the Contractor's non-English speaking member population attains the threshold specified in Section F for translation of the member handbook into a language other than English, the Contractor shall be responsible for such translation as required by Section 6. Some of this information may be included as inserts in or addenda to the Member Handbook. As the member handbook is translated into other languages, the Contractor shall provide a language appropriate copy to all such non-English speaking members.

6.8.M.III Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments. [42 C.F.R. § 438.10(d)]

6.8.N Program Referral and Service Changes

6.8.N.I When there are changes to covered services, benefits, or the process that the member should use to access benefits, (i.e., different than as explained in the member handbook), the Contractor shall ensure that affected members are notified of such changes at least thirty (30) calendar days prior to their implementation. For example: changes to who they call for transportation services, changes to covered and/or enhanced benefits, as described in the Contractor's member handbook, etc. [42 C.F.R § 438.10 (g)(4)]

6.8.O Additional Information that is available upon request, including the following:

6.8.O.I Information on the structure and operation of the Contractor.

6.8.O.II Physician incentive plans as set forth in 42 C.F.R. § 438.10(f)(3) and 42 C.F.R. § 438.3 (i).

While not required to be contained within the member handbook, under Section 7.2.S of this Contract, in accordance with 42 CFR §§438.10(h) and 438.10(i)(1)-(3), the Contractor shall make available in electronic or paper form, the following information about its formulary:

- Covered Medications (both generic and name brand);
- Medication Tier Level;
- Machine readable file and format of all formulary drug lists, available on the Contractor's website;;
- Drug benefits subject to prior authorization by the Contractor;
- The Contractor's prior authorization procedures; and
- Prior authorization request forms accepted by the carrier.

This information should be available through a central location on the Contractor's website, and must be updated seven (7) days prior to the effective date of any approved changes to such information.

6.9 MEMBER RIGHTS

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding member rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to member rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964 as implemented at 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; Section 1557 of the Patient Protection and Affordable Care Act and other laws regarding privacy and confidentiality.

At a minimum such member rights include the right to:

6.9.A Receive information

Receive information in accordance with 42 C.F.R. § 438.10 as described in Section 3 and Section 6 of this Contract.

6.9.B Respect

Be treated with respect and with due consideration for his or her dignity and privacy.

6.9.C Information on available treatment options

Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand.

6.9.D Participate in Decisions

Participate in decisions regarding his or her health care, including the right to refuse treatment.

6.9.E Be free from restraint/seclusion

Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

6.9.F Request/Receive Medical Records

Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 C.F.R. §§ 164.524 and 164.526.

6.9.G Free exercise of rights

Have free exercise of rights and the exercise of those rights does not adversely affect the way the Contractor and its providers treat the member.

6.9.H Health Care Services

Be furnished health care services in accordance with 42 C.F.R. §§ 438.206 through 438.210 as described in this Contract.

6.10 ADVANCED DIRECTIVES

Members must be provided information about advance directives (at a minimum those required in 42 CFR §§ 489.102, 422.128, and 438.3(j)), including:

1. Member rights under the law of the Commonwealth of Virginia;
2. The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
3. That complaints concerning noncompliance with the advance directive requirements may be filed with the Department;
4. Designating a health care proxy and other mechanisms for ensuring that future medical decisions are made according to the desire of the Member; and,
5. The Contractor is required to reflect changes in Virginia law in its written advance directives information as soon as possible, but no later than ninety (90) days after the effective date of the change.

Nothing in this Contract shall be interpreted to require a Member to execute an advanced directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicaid program.

Under 42 C.F.R. § 438.3(j)(1) and (2), the Contractor must maintain written policies and procedures on advance directives for all adults receiving medical care by or through the

Contractor. Additionally, the Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. Further, the Contractor shall educate staff concerning their policies and procedures on advance directives.

The Contractor's advance directive written policies, procedures, and proof of staff education shall be submitted to the Department annually as outlined in the Managed Care Technical Manual.

6.11 CULTURAL COMPETENCY

The Contractor must demonstrate cultural competency in its dealing, both written and verbal, with members and must understand that cultural differences between the provider and the member cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

Under 42 C.F.R. § 438.206(c)(2), the Contractor must promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

6.12 MEMBER SERVICES

6.12.A Toll-Free Member/Customer Services Function

The Contractor agrees to maintain and staff a toll-free Member or Customer Services function to be operated at least during regular business hours and to be responsible for the following:

6.12.A.I Explaining the operation of the MCO, including the role of the PCP and what to do in an emergency or urgent medical situation;
6.12.A.II Assisting members in the selection of a PCP**;**
6.12.A.III Assisting members to make appointments and obtain services**;**
6.12.A.IV Arranging medically necessary transportation for members; and
6.12.A.V Handling member inquiries and grievances.

6.12.B Specific standards for ensuring acceptable levels of service are as follows:

6.12.B.I Call Recording Technology

The Contractor shall record one-hundred percent 100% of incoming calls to its member and provider helplines using up-to-date call recording technology. Call recordings must be searchable by provider NPI, API, Member ID Number # (if available) and date and time of the call. Recordings will be made available to the Department upon request, and stored for a period of no less than fifteen (15) months from the time of the call.

6.12.B.II Abandonment Rate & Call Center Statistics –

The Contractor's daily telephone abandonment rate for member service helpline (Virginia Medicaid/FAMIS only) access calls shall be less than five percent (5%) for all incoming calls.

The Contractor shall report call center statistics for the Provider and Member Inquiry lines to the Department on a monthly basis, as described in the MCTM.

6.13 MEMBER EDUCATION PROGRAM

The Contractor must develop, administer, implement, monitor, and evaluate a program to promote health education services for its new and continuing members, as indicated below. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12th grade education level). (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) The Contractor shall maintain a written plan for health education and prevention which is based on the needs of its members. The Contractor shall submit a health education and prevention plan to the Department sixty (60) calendar days prior to signing original contract, ten (10) business days prior to any published revision, and within ten (10) business days of receiving a request. At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual, or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Department prior to implementation.

The Contractor will be responsible for developing and maintaining member education programs designed to provide the member with clear, concise, and accurate information about the Contractor's health plan. Additionally, the Contractor will provide the Department with a copy of all member health education materials, including any newsletters sent to its members at start up and upon revision thereafter or upon request as needed.

7. Benefit Service Requirements and Limits

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase, or otherwise make available all services required under this Contract to all of its members. (A chart summarizing covered services, carved-out services, and non-covered services is provided in Attachment II to this Contract.) Please note that the Contractor must permit any member who is identified as an Indian to receive health care services from a participating Indian Health Provider, to choose covered services from that Indian Health Provider (as defined in this Contract). Contractor should adhere to all special payment terms found in §12, Financial Management.

7.1 GENERAL RULES

7.1.A Cost-Sharing

In accordance with Federal regulations at 42 C.F.R. § 447.56 and by the Department's directive, the Contractor shall not impose any cost-sharing for services unless cost sharing exists under the Department's fee for service program. There are no cost sharing responsibilities for services to children under age twenty- one (21), family planning services, or for services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy. Additionally, in accordance with 42 C.F.R. §§ 447.50 through 447.82,, the Contractor shall not impose any cost-sharing obligations on members for covered and non-covered services, except as set forth in 12 VAC 30-20-150 and 12 VAC 30-20-160. The Contractor may not impose co-payments on prescription drugs, as stated in Section 7.2.S.

The Contractor shall include a description of any member co-payment responsibility in the member handbook and shall list the applicable co-payment information on the member identification card.

For the purposes of this Contract, the Contractor's decision to implement or change benefits must follow the same guidelines as listed in this Contract for enhanced benefits.

7.1.B Court-Ordered Services

The Contractor shall be liable for covering all covered, court-ordered services, in accordance with the terms set forth in this Contract. In the absence of an agreement otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.

7.1.C Coverage of Authorized Services

7.1.C.I The Contractor (the member's current MCO) shall assume responsibility for all managed care contract covered services authorized by the Department, its designee, or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written agreement. The Contractor shall allow their new members who are transitioning from Medicaid fee-for-service to receive services from out-of-network providers if the member contacts the Contractor in advance of the service date and the member has an appointment(s) within the initial month of enrollment with a specialty physician(s) that was scheduled prior to the effective date of membership. For on-going services, such as

home health, outpatient behavioral health, and outpatient rehabilitation therapies, etc., the Contractor (the member's current MCO) shall continue prior authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider.

7.1.C.II The Department, or its designee, shall assume responsibility for all covered services authorized by the member's previous MCO within the DMAS Provider Network which are rendered after the effective date of disenrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s).

7.1.C.III If the authorized service is an inpatient stay, the financial responsibility shall be allocated as follows: For per diem provider contracts, reimbursement will be shared between the Contractor and either the Department or the new MCO. In the absence of a written agreement otherwise, the Contractor and the Department or the new MCO shall each pay for the period during which the member is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment. For DRG provider contracts, in accordance with Section 12, the Contractor is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any member actively enrolled in the MCO on the date of admission, regardless of the members' disenrollment from the MCO during the course of the inpatient hospitalization.

7.1.C.IV If services have been authorized using a provider who is out of network, the Contractor may elect to re-authorize (but not deny) those services using an in-network provider.

7.1.D Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

7.1.D.I In accordance with 42 C.F.R. § 441 Subpart B (Sections 50 – 62), the Early and Periodic Screening Diagnosis, and Treatment (EPSDT) program is a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislation and includes periodic screenings; and vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care services listed in Section 1905(a) of the Act be provided to an EPSDT member when the service is needed to correct or ameliorate a medical condition. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. The Department reports to CMS each April EPSDT screening information results.

7.1.D.II Nothing in this Contract shall require the Contractor to provide services and benefits which are specifically excluded under the program. EPSDT may provide additional benefits for children outside the basic Medicaid benefit package including, but not limited to, extended behavioral health benefits, nursing care (including private duty), pharmacy services, treatment of obesity, neurobehavioral treatment, and other individualized treatments specific to developmental issues where it is determined that otherwise excluded services/benefits for a child is a medically necessary service that will correct, improve, or is needed to maintain (ameliorate) the child's medical condition.

7.1.D.III In addition to the traditional review for medical necessity, Medicaid children who are denied services that do not meet the plan's general coverage criteria must receive

a secondary review to ensure that the EPSDTs provision has been considered. The Contractor's secondary review process for medical necessity must consider the EPSDT's correct, maintain, or ameliorate criteria. The Department must approve the Contractor's second review process for EPSDT prior to implementation or when requested. Denial for services to children cannot be given until this secondary review has been completed. The Contractor shall establish a process approved in advance by the Department which allows providers to contact case managers to explore alternative services, therapies, and resources for members when necessary. No service provided to a child under EPSDT can be denied as "non-covered", "out-of-network" and/or "experimental" unless specifically noted as a carved-out service under this Contract. See Section 7.2.C "Clinical Trials as EPSDT" for additional information.

7.1.D.IV Screenings –

Comprehensive, periodic health assessments, or screenings, from birth through age twenty (20), at intervals as specified in the EPSDT medical periodicity schedule established by the Department and as required and indicated in the Screenings and Assessments provisions of this Contract. The medical screening shall include**:**

7.1.D.IV.a A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screens (CPT 96110) rendered by providers other than the primary care provider.

7.1.D.IV.b A comprehensive unclothed physical examination, including:

7.1.D.IV.b(i) vision and hearing screening;

7.1.D.IV.b(ii) dental inspection;

7.1.D.IV.b(iii) nutritional assessment;

7.1.D.IV.b(iv) height/weight and Body Mass Index (BMI) assessment; and

7.1.D.IV.b(v) The Contractor shall encourage pediatric primary care providers to incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings should be documented in the medical record using a standardized screening tool. The Contractor shall not require any service authorization associated with the appropriate billing of these developmental screening services (e.g., CPT 96110) in accordance with AAP recommendations.

7.1.D.IV.c **Appropriate immunizations** according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.

7.1.D.IV.d **Appropriate laboratory tests:** The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.

7.1.D.IV.d(i) hemoglobin/hematocrit

7.1.D.IV.d(ii) tuberculin test (for high-risk groups)
7.1.D.IV.d(iii) blood lead testing including venous and/or capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than five (5) ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

The Virginia "Reportable Disease" regulations require the directors of laboratories to report all "detectable" blood lead levels to the local Health Department within three (3) days. "Lead, reportable levels" means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10).
The providers are to report children's blood lead levels that are greater than or equal to 5 µg/dL using the EP-1 form.
http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf

7.1.D.V Health Education/Anticipatory Guidance

7.1.D.V.a The Contractor shall refer members for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

7.1.D.V.b The Contractor must educate and inform members identified as not complying with EPSDT periodicity and immunization schedules, as appropriate. The Contractor shall provide copies of any such notices to the Department and advise as to the frequency and timing of these notices.

7.1.D.VI Vision Services

Periodic vision assessments appropriate to age, health history, and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided according to the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

7.1.D.VII Hearing Services

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.
Periodic auditory assessments appropriate to age, health history, and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at

a minimum at intervals recommended in the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

7.1.D.VIII Dental Screenings

An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions, or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her six month/biannual screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three (3) or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, a referral must be made for needed dental services.

The Contractor is not required to cover testing of fluoridation levels in well water.

7.1.D.IX Dental Varnish

Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a CMS 1500 form shall be covered.

7.1.D.X Tobacco Cessation Services

Medically-necessary tobacco cessation services, including both counseling and pharmacotherapy, for children and adolescents shall be covered by the Contractor. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when medically necessary for individuals under age twenty-one (21). (State Medicaid Director Letter, June 24, 2011 – page 4).

7.1.D.XI Private Duty Nursing (PDN)

The Contractor shall cover medically necessary PDN services for children under age twenty-one (21), in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement, and as required in accordance with EPSDT regulations described in 42 C.F.R. §§ 441.50, 440.80, and the Social Security Act §§ 1905(a) and 1905(r) I.

Members who may qualify for PDN include members who require continuous nursing that cannot be met through home health. Under EPSDT PDN, the member's condition warrants continuous nursing care including, but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT PDN differs from home health nursing which provides for short-term intermittent care where the emphasis is on member or caregiver teaching. Examples of members that may qualify for PDN coverage include,

but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention. Another example of members who may qualify for PDN includes members waiting to be screened for the Technology Assisted Waiver.

While the Contractor may utilize its own criteria for medical necessity determination for most covered services, since there are no nationally recognized published criteria for EPSDT PDN, the Contractor shall use the Department's criteria, as described in the DMAS EPSDT Nursing Supplement when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument, if desired, which must be approved by the Department. However, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit.

7.1.D.XII Other

7.1.D.XII.a Other medically necessary health care, diagnostic services, treatment, and measures as needed to correct or treat defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's current level of functioning or to prevent the child's medical condition from getting worse including, but not limited to private duty nursing.

7.1.D.XII.b The Contractor shall inform members about EPSDT services.

7.1.D.XII.c EPSDT services shall be subject to all the Contractor's documentation requirements for its network provider services. EPSDT services shall also be subject to the following additional documentation requirements:

7.1.D.XII.c(i) The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider.

7.1.D.XII.c(ii) Documentation of a comprehensive screening shall, at a minimum, contain a description of the components described herein.

7.1.D.XII.d The Contractor shall assure that a participating child is periodically screened and treated in conformity with the periodicity schedule. To comply with this requirement, the Contractor shall design and employ policies and methods to assure that children receive prescreening and treatment when due. If the family requests assistance with transportation and scheduling to receive services, the Contractor is to provide this assistance.

7.1.D.XII.e The Contractor shall incorporate EPSDT requirements such as lead testing and developmental screenings in its quality assurance activities. The Contractor must implement interventions/strategies to meet the following criteria.

7.1.D.XII.e(i) Childhood Immunization rates must meet requirements pursuant to Section 8.
7.1.D.XII.e(ii) Well-child rates in all age groups must meet requirements pursuant to Section 8.
7.1.D.XII.e(iii) Lead testing rates must meet requirements pursuant to Section 8.
7.1.D.XII.e(iv)Increase percentage of lead testing of one to five (1-5) year olds for prior contract year.
7.1.D.XII.e(v) Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).
7.1.D.XII.e(vi)The Contractor will follow a long-term improvement plan not to exceed five (5) years to increase EPSDT levels.

7.1.D.XII.f When a developmental delay has been identified by the provider, the Contractor shall ensure appropriate referrals are made and documented in the member's records.

7.1.D.XII.g Case management services for infants up to age two (2) are required as set forth in 12 VAC 30-50-280 through 410, to include:

7.1.D.XII.g(i) Case management services for all newborns/infants admitted to the NICU (Nursery Level 3/NICU) for neonatal intensive care

EPSDT requires that all medically necessary services for children needed to correct, ameliorate, or maintain health status shall be covered by the Contractor.

7.1.E Behavioral Therapy Services under EPSDT

See Section 7.5.B

7.1.F Early Intervention Services

See Section 7.5.C.

7.1.G Medical Necessity

The Contractor shall cover medically necessary services, as defined in this Contract, and in accordance with 42 C.F.R. § 440.230, State Plan for Medical Assistance (State Plan), as amended and as further defined by written Department policies (including agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The actual provision of any service is subject to the professional judgment of the Contractor's providers as to the medical necessity of the service, except in situations in which the Contractor must provide services ordered by the Department pursuant to an appeal from the Contractor's grievance process or an appeal directly to the Department by a member or for emergency services as defined in this Contract. Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness and the application of EPSDT criteria (for those under age twenty-one (21)). Disputes between the Contractor and members about medical necessity may be appealed to the Department by the member or the member's representative.

7.1.H Modification in Scope of Covered Services During a Contract Year

The Department may modify covered services required by this Contract through a contract amendment and, if applicable, will adjust the capitation payment in an amount deemed acceptable by the Department and the Contractor. The Department shall notify the Contractor in advance of any mid-year modification to the services, contract, and/or capitation payment.

7.1.I Moral or Religious Objections

In accordance with 42 C.F.R. § 438.102 the Contractor shall not be required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with all of the following guidelines:

Information Requirements – The Contractor must furnish information about the services it does not cover, subject to department approval:

7.1.I.I To the Department:

7.1.I.I.a With the initiation of the Contract, whenever changes are made, and upon request.

7.1.I.I.b Upon adoption of such policy in the event that the Contractor adopts the policy during the term of the Contract.

7.1.I.II To potential members, before and during enrollment.

7.1.I.III To members, within thirty (30) days before the effective date of this policy.

7.1.J Notification to the Department of Sentinel Events

The Contractor shall maintain a system for identifying and recording any member's sentinel event. The Contractor shall provide the Department or its Agent with reports of sentinel events upon discovery. See the Managed Care Technical Manual for details.

7.1.K Out-of-Network Services

7.1.K.I The Contractor shall cover and pay for all care that it has pre-authorized and provided out of its established network. Out-of-network claims must be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the Contractor and the provider of services.

7.1.K.II The Contractor shall cover and pay for emergency and family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract**.**

7.1.K.III The Contractor shall cover, pay for, and coordinate care, rendered to members by out-of-network providers when the member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract.

7.1.K.IV The Contractor shall cover and pay for services furnished in facilities or by practitioners outside the Contractor's network if the needed medical services or necessary supplementary resources are not available in the Contractor's network.

7.1.K.V The Contractor must provide out-of-network coverage for any of the following circumstances:

7.1.K.V.a When a service or type of provider (in terms of training, experience, and specialization) is not available within the MCO's network,

7.1.K.V.b Where the MCO cannot provide the needed specialist within the contract distance standard of more than thirty (30) miles in urban areas or more than sixty (60) miles in rural areas,

7.1.K.V.c For members other than those residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the Contractor must provide out-of-network coverage for up to thirty (30) days to transition the member to an in-network provider when a provider that is not part of the MCOs network has an existing relationship with the member, is the member's main source of care, and has not accepted an offer to participate in the MCOs network,

7.1.K.V.d When the type of provider needed and available in the MCOs network does not, because of moral or religious objections, furnish the service the member seeks,

7.1.K.V.e When the Department determines that the circumstance warrants out-of-network treatment.

7.1.K.VI In addition to a – e above, for members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, per 42 C.F.R. § 438.52(b)(2)(B), the Contractor shall provide out-of-network coverage in all of the following circumstances:

7.1.K.VI.a When a provider is not a part of the Contractor's network, but is the main source of a service to the member, provided that:

7.1.K.VI.a(i) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type;

7.1.K.VI.a(ii) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider within sixty (60) days (after being given the opportunity to select a provider who participates);

7.1.K.VI.b The member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

7.1.K.VII Mental Health or Substance Use Disorder Benefits

In accordance with 42 C.F.R. § 438.910(d)(3), the Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

7.1.L Out-of-State Services

The Contractor is not responsible for services obtained outside the Commonwealth <u>except under any of the following circumstances</u>:

7.1.L.I Necessary emergency or post-stabilization services,

7.1.L.II Family planning where it is a general practice for members in a particular locality to use medical resources in another State,

7.1.L.III The required services are medically necessary and not available in-network and within the Commonwealth**.**

7.1.L.IV While the MCO is honoring a transition of care plan authorized by the Contractor, another MCO, or the Department until services can be safely and effectively transitioned to a provider in the MCO's network within the Commonwealth.

7.1.L.V Further, direct and indirect payments to out-of-country individuals and/or entities are prohibited pursuant to Section 6505 of the Affordable Care Act and State Medicaid Director Letter (SMD# 10-026**).**

7.1.M Patient Utilization Management & Safety (PUMS) Program for Members

The Contractor must have a Patient Utilization & Safety Management Program (PUMS) intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and case management program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the Contractor must refer members to appropriate services based upon the member's unique situation.

7.1.M.I Placement into a PUMS Program

Members may be placed into a PUMS program for a period of twelve (12) months when **either** of the following trigger events occurs:

7.1.M.I.a The Contractor's specific utilization review of the member's past twelve (12) months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications found in the Managed Care Technical Manual (MCTM).

7.1.M.I.b Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

At the end of the twelve (12) month period, the member must be re-evaluated by the Contractor to determine if the member continues to display behavior or patterns that indicate the member should remain in the PUMS Program. The Contractor is encouraged to utilize the Prescription Monitoring Program (PMP), described in Section 9.5 of this Contract, when evaluating PUMS members.

7.1.M.II PUMS Program Details

Once a member meets the requirements of 7.1.M.I and the minimum criteria found in the MCTM, the Contractor may limit a member to a single pharmacy, primary care provider (PCP), controlled substances prescriber, hospital (for non-emergency hospital services only) and/ or, on a case-by-case basis, other qualified provider types as determined by the Contractor and the circumstances of the member.

If the member changes from another health plan to the Contractor's health plan while the member is enrolled in a PUMS, the Contractor must re-evaluate the member within thirty

(30) days to ensure the member meets the minimum criteria above for continued placement in the Contractor's PUMS.

7.1.M.III Member Rights Notifications & Requirements

The Contractor must, upon placement of a member into its PUMS program, issue a letter to the member that includes the following information:

- A brief explanation of the PUMS program
- A statement that the member was selected for placement into the program,
- An explanation that the decision is appealable,
- A statement explaining the Prescription Monitoring Program (PMP) and how its use may affect the member enrolled in the PUMS program, as applicable. See Section 9.5.
- A statement that the Contractor shall provide appeals rights to members placed in the PUMS Program, including the right to directly request a State Fair Hearing including normal appeals in addition to the issue of whether the member qualified for the PUMS based on the minimum criteria in 7.1.M.I.
- A statement clearly outlining the provisions for emergency after hours prescriptions if the member's selected pharmacy does not have twenty-four (24)-hour access.
- A statement indicating the opportunity and mechanisms by which the member may choose a pharmacy, primary care provider, controlled substance provider, hospital (for non-emergency hospital services only), and/or, on a case-by-case basis, other qualified provider types. The language must clearly state that if the member does not select the relevant providers within fifteen (15) days of enrollment into the PUMS Program, the Contractor may select one for the member;

7.1.M.IV Reporting Requirements

- **Annual PUMS Plan**: The Contractor shall annually submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as substance abuse treatment services, etc.).
- **Summary Report:** The Contractor must report a detailed summary of members enrolled in its PUMS program on a Monthly basis (see Managed Care Technical Manual).

7.1.N Second Opinions

The Contractor shall provide coverage for a second opinion when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for a second opinion from a qualified health care professional within the network or arrange for the member to obtain one outside the network, at no cost to the member. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.

7.1.O At-Risk Populations

7.1.O.I Protection of Children and Aged or Incapacitated Adults

Suspected or Known Child Abuse or Neglect - The Contractor shall report immediately upon learning of any suspected or known abuse of a child to the local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred or to the Virginia Department of Social Services' toll-free child abuse and neglect hotline:

In Virginia: (800) 552-7096
Out-of-state: (804) 786-8536
Hearing-impaired: (800) 828-1120

Suspected or Known Abuse of Aged or Incapacitated Adults – In accordance with Section 63.2-1606 of the *Code of Virginia* , the Contractor shall report immediately upon learning of any suspected or known abuse of aged or incapacitated adults to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline at:

(888) 832-3858.

7.1.O.II Member Assessment (–Members with Special Health Care Needs)

Refer to Section 7.7 "Assessments & Annual Plan for Members."

7.1.O.III Children and Youth with Special Health Care Needs (CSHCN), Foster Care, Adoption Assistance, and HAP Individuals

The Contractor shall make every reasonable effort to assure that Children and Youth, and Adults with Special Health Care Needs, members meeting the criterial of the HAP initiative, Foster Care children, and Adoption Assistance children receive a visit to their assigned primary care provider within sixty (60) calendar days of enrollment with the Contractor. See Section 7.7.E "Health and Acute Care Program (HAP)" for more details on that population, and Section 7.7 for additional requirements for members with special health care needs.

The Contractor must develop and maintain a system of policies and procedures for identifying children and youth with special health care needs, including children with disabilities or chronic or complex medical and behavioral health conditions including obesity. These policies and procedures should be submitted to the Department upon creation and thereafter when changed or upon request by the Department.

In the event that the Contractor is not successful in having its enrolled children and youth with Special Health Care Needs visit the child's PCP, the Contractor shall communicate to the child/family, in a format which has been approved in advance by the Department, advising that the member is due for a visit to receive an assessment or for a specific service (immunization, well-child visit, etc.).

Children and Youth with Special Health Care Needs must be assessed by the Contractor in the following manner:

7.1.O.III.a **Identification** - Children and Youth with Special Health Care Needs (CYSHCN) include children under age twenty-one (21) who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CYSHCN consist of at a minimum, children in the eligibility category of SSI, children identified as Early Intervention (Part C) participants, Foster care or Adoption Assistance (includes any individuals who have been enrolled in a particular health plan under a non-disabled or Foster Care/Adoption Assistance when the individual becomes enrolled in a disabled or Foster Care/Adoption Assistance), and others as identified through the Contractor's assessment or by the Department.

7.1.O.III.b **Assessment and Referral -** In accordance with 42 C.F.R. § 438.208(c), the Contractor shall make a best effort to conduct an assessment of all CYSHCN, as identified and reported by the Department All CSHCN shall be assessed pursuant to Section 7.7, except that Foster Care children shall be assessed pursuant to the standards in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications.

The Contractor shall provide a monthly report to the Department detailing and confirming by identification number the number of completed assessments and members with special health care needs as defined in Section 7.7. The Contractor shall provide copies of completed assessments upon request. The Contractor shall provide, prior to signing the initial contract, upon revision, or on request, to the Department a copy of the detailed policies and procedures of the Contractor's assessment mechanism. This mechanism must reflect the utilization of appropriate health care professionals and must identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.

<u>The Contractor shall assess the quality of care of CYSHCN in the following areas</u>:

7.1.O.III.b(i) **Program Development** – Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.

7.1.O.III.b(ii) **Enrollment Procedures** – Identify and collect data on children and youth with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs. The Children with Chronic Conditions Satisfaction Survey described in Section 8 (CAHPS – Child Supplemental Questions) is sufficient in meeting this Satisfaction survey requirement.

7.1.O.III.b(iii) **Provider Networks** – Assure the availability of providers who are experienced in serving children and youth with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.

7.1.O.III.b(iv) **Care Coordination** – Provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN.

7.1.O.III.b(v) **Access to Specialists** – The Contractor shall have a mechanism in place for members determined to have ongoing special conditions that require a course of treatment or regular care monitoring that allows the member direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member's condition and identified needs.

7.1.O.III.c **Assurance of Expertise for Child Abuse and Neglect and Domestic Violence**

The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of child abuse, neglect, and domestic violence. The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community.

The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

7.1.O.III.d **Case Management**

The Contractor is responsible for establishing policy and procedures which facilitate provider contact with medical management staff to explore alternative resources and services for members with special health care needs. Case managers serving children and youth with special health care needs and children requiring special assistance shall assist these members in scheduling appointments, providing referrals to appropriate medical providers, offering assistance in identifying resources, other appropriate treatment options, referrals to resources, and shall make contact with the member or his family on a regular basis. The Contractor shall assess and provide if necessary, members' needs for special transportation requirements, which may include but not be limited to: ambulance, stretcher van, curb to curb, door to door, or hand to hand services. "Hand to hand" service includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported "hand-to-hand."

7.1.O.IV Foster Care

7.1.O.IV.a **Care Collaboration and Workgroup**

The Contractor shall work collaboratively with the Department in meeting the federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care. The Contractor shall participate in mandatory case management collaboration. Additionally, the Contractor shall establish a process to notify youth in foster care who are approaching age eighteen (18) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor shall assist in care coordination during this transitional period.

7.1.O.IV.b **Additional Reports**

The Contractor shall submit the following program data for foster care members:

- PCP Visits
- Emergency Room Visits
- Pregnancy rates for members aged fifteen to nineteen (15-19)
- Health Risk Assessments
- Medication management for Psychotropic and Antipsychotics
- EPSDT
- Immunization data

Report specifications are located in the Managed Care Technical Manual.

Additionally, the Contractor shall submit a monthly Barrier Report as specified in the Managed Care Technical Manual.

7.1.P Utilization Management/Authorization Program Description

The Contractor must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. In accordance with 42 C.F.R. § 438.210, the Contractor's UM program must ensure consistent application of review criteria for authorization decisions and must consult with the requesting provider when appropriate. The program shall demonstrate that members have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the members.

The program shall reflect the standards for utilization management from the most current NCQA Standards. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

The Contractor shall use the Department's service authorization criteria or other medically-sound, scientifically-based criteria in accordance with national standards in making medical

necessity determinations. Contractor criteria shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department.

In accordance with 42 C.F.R. § 438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's medical, behavioral health, and supports needs.. Additionally the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. § 438.910(d) and 438.3(n)(1). In accordance with 42 C.F.R. § 438.210(c), the Contractor shall notify the requesting provider and give the member written notice 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 must meet the requirements outlined in Section 7.1 of this Contract.

<u>The following timeframe for decision requirements apply to service authorization requests, per 42 C.F.R. § 438.210:</u>

7.1.P.I Standard Authorization Decisions

For standard authorization decisions, the Contractor shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if: the member or the provider requests extension; or the Contractor justifies to the Department upon request that the need for additional information per 42 C.F.R. §438.210(d)(1)(ii) is in the member's interest.

7.1.P.II Expedited Authorization Decisions

For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life, physicalor mental health, or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

The Contractor may extend the seventy-two (72) hours s turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or the Contractor justifies to the Department a need for additional information and how the extension is in the member's interest.

If the Contractor delegates (subcontracts) responsibilities for UM with a subcontractor, the Contract must have a mechanism in place to ensure that these standards are met by the subcontractor. The UM Plan shall be submitted to the Department prior to signing original contract, upon revision, upon request, & as needed**.**

The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Reference Section 7.2.S for provisions regarding authorizations for prescription drugs.

The Contractor (the member's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in this Section of this Contract.

7.2 COVERED SERVICES

The Contractor shall provide, arrange for, purchase, or otherwise make available the full scope of services, with the exception of the carved-out services defined in Section 7.5 and other exceptions noted herein to which persons are entitled under the State Plan for Medical Assistance (State Plan), as amended, and as further defined by written Department policies (including, but not limited to, agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding), and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Brief descriptions of covered services are provided herein.

In no case shall the Contractor establish more restrictive benefit limits for medically necessary services than those established by Medicaid as defined in the State Plan and other documents identified above. The Contractor shall manage service utilization through utilization review, service authorization, and case management, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid.

The Contractor shall ensure that coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210:

1) The Contractor shall provide services for adult members and members under the age of twenty-one (21) to the same extent that services are furnished to adults and individuals under the age of twenty one (21) under fee-for-service Virginia Medicaid.
2) The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.
3) The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.
4) The Contractor shall ensure that coverage decisions for individuals with ongoing or chronic conditions are authorized in a manner that fully supports the Member's ongoing need for such services and supports and considers the Member's functional limitations by providing services and supports to promote independence and enhance the member's ability to live in the community;
5) The Contractor shall ensure that coverage decisions for family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.
6) The Contractor shall ensure that services are authorized in a manner that supports:
    a. the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder, health impairments and/or disability,

b. ability for a Member to achieve age-appropriate growth and development,
c. ability for a Member to attain, maintain, or regain functional capacity,

in the case of EPSDT, correct, maintain or ameliorate a condition.Coverage decisions that depend upon service authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the requirements described in this Contract.

The Contractor shall assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions. This responsibility for all covered medical conditions shall not apply in the case of persons temporarily excluded from enrollment due to hospitalization.

7.2.A Behavioral Health & Substance Abuse Treatment Services (BHS)

§438.910(b)(2), if a member is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the member in every classification in which medical/surgical benefits are provided. Under §438.910(c)(3), the Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, or prescription drugs) that accumulates separately from any established medical/surgical benefits in the same classification. Further, per §438.910(d), the Contractor may not impose nonquantitative treatment limitations (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. **Traditional & Non-Traditional Behavioral Health Service Categories**

Coverage responsibility for Behavioral Health and Substance Abuse Treatment Services (BHS) is shared by the Contractor and the Department's Behavioral Health Services Administrator (BHSA), within two (2) categories of service: 1) traditional and 2) non-traditional. The Contractor shall cover traditional BHS, including: inpatient, outpatient (individual, family, and group) therapies, and temporary detention and emergency custody order services. The Department's BHSA provides coverage for non-traditional, community mental health rehabilitation services (for MCO and fee-for-service enrolled members).

7.2.A.I.a **Traditional Behavioral Health Services –**

The Contractor shall cover all of the following traditional behavioral health and substance abuse treatment services within Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001; available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.):

7.2.A.I.a(i) **Inpatient Behavioral Health Services:**

Inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all eligible members regardless of the age of the member, as set forth in 12 VAC 30-50-100. The Contractor shall cover all medically necessary services rendered in freestanding psychiatric hospitals to members up to twenty-one (21) years of age and members over sixty-four (64) years of age. The Contractor shall cover inpatient substance abuse treatment services for children under age twenty-one (21) when medically necessary in accordance with EPSDT criteria.

The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements. If a member aged twenty-one (21) through sixty-four (64) is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the Contractor and reimbursed by the Contractor as an enhanced service, that member will be excluded from managed care participation, effective one day prior to admission. See also Section 7.5 "Carved Out & Excluded Services."

All inpatient mental health admissions shall be approved by the Contractor using its own service authorization criteria, consistent with the guidelines described in Section 7.2.I. of this Contract.

7.2.A.I.a(ii) **Outpatient Behavioral Health and Substance Abuse Treatment Services (Traditional Individual, Family, and Group Therapies)**

The Contractor shall provide coverage for medically necessary outpatient individual, family, and group behavioral health and substance abuse treatment services for children, adolescents, and adults, except for carved out non-traditional, community based BHS.

7.2.A.I.a(iii) **Temporary Detention Order (TDO)**

Pursuant to 42 C.F.R. § 441.150, the *Code of Virginia*, § 16.1-335 et seq. and § 37.2-800 *et. seq.*, and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age twenty-one (21) through sixty-four (64) **and** admitted to a freestanding facility. The MCO is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is

assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the client is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services**. The duration of temporary detention shall be in accordance with the *Code of Virginia,* as follows:**

For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the ninety-six (96)hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services.

For Adults age 18 and over – Pursuant to § 37.2-809.H of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the seventy-two (72) hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.

Coverage for services for members admitted to a freestanding psychiatric facility under a TDO will be handled as follows:
If the individual is under age twenty-one (21) or over age sixty-four (64), and the member goes into private freestanding IMD for a TDO, the MCO is responsible for the TDO. If the individual remains admitted to the IMD after the TDO expires, the MCO is responsible for the psychiatric stay. Following expiration of the TDO, the MCO can require that the individual transfer to a network facility.

If the individual is under age twenty-one (21) or over age sixty-four (64), and the member goes into a State freestanding IMD for a TDO, the MCO is responsible for the TDO. If the individual remains admitted to the State IMD after the TDO expires, the member is disenrolled from the MCO on the expiration of the TDO and FFS is responsible for the State facility psychiatric stay.

For individuals age twenty-one (21) through sixty-four (64), where the member goes into private freestanding IMD for a TDO, providers should submit the TDO claim to the state TDO program. The individual will remain enrolled with the MCO beyond the TDO timeframe. The MCO will manage the individuals treatment needs beyond the TDO timeframe and can require that the individual transfer to a network facility.

For individuals age twenty-one (21) through sixty-four (64), where the member goes into a State freestanding IMD for a TDO, providers should submit the TDO claim to the State TDO program. Coverage beyond the TDO timeframe in a State facility for individuals age twenty-one (21) through sixty-four (64) is not a covered benefit. The MCO should transition the individual to a network facility where possible. Otherwise, the individual will lose Medicaid benefits for the period in which they are institutionalized in an IMD**.**

When an out-of-network provider provides TDO services, the Contractor shall be responsible for reimbursement of these services. In the absence of an agreement otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered.

Following the expiration of the TDO, if it is determined by the judge, as the result of a hearing, that the member may be transferred without medically harmful consequences, the Contractor may designate an appropriate in-network or out-of-network facility for the provision of care. Utilization review for medical necessity for meeting continued, acute care stay criteria is appropriate after the TDO for Mental Health Services has been concluded. The Contractor shall cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO.

In the event that an MCO-enrolled member between twenty-one (21) and sixty-four (64) is admitted to a freestanding psych facility

under a TDO, the MCO will be responsible for reimbursing transportation to the facility.

7.2.A.I.a(iv) **Emergency Custody Orders (ECO)**
Pursuant to the *Code of Virginia*, § 16.1-335 et seq. (minors) and § 37.2-800 *et. seq.* (adults), and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide and be responsible for coverage of medically necessary screenings, assessments, and treatment services, as covered under this Contract, for members who are under an emergency custody order.

7.2.A.I.b **Non-Traditional Behavioral Health Services (Carved-Out)**
Non-traditional BHS, including community mental health rehabilitation (CMHRS), are managed through the Department's Behavioral Health Services Administrator within the Department's established coverage criteria and guidelines. Additional information is also available on the BHSA website, http://www.MagellanofVirginia.com, and in the Department's appropriate provider service manual (manuals governing Behavioral Health include: "Children's Mental Health Program," "Community Mental Health-Rehab Services," "Mental Health Clinic," and "Psychiatric Services."), available on the Department web-portal (under the provider services tab) at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

7.2.A.I.b(i) Contractor Coverage for Carved-Out Related Services
The Contractor shall provide coverage for transportation and pharmacy services necessary for the treatment of behavioral health and substance abuse conditions, including for carved out services. The contractor shall provide coverage for opioid drugs in instances where the member obtains such drugs through a pharmacy. If the opioid medication is administered by a substance abuse treatment provider as part of an opioid treatment program, where the substance abuse treatment provider obtains the drugs for the member, such drugs shall be considered carved-out of this contract and shall be covered by the Department as part of opioid treatment, and in accordance with the Department's coverage criteria and guidelines.

7.2.A.II Community Mental Health Rehabilitation Services (CMHRS) Data Sharing

The Department will provide community mental health services authorization and claims payment data to the Contractor on a monthly basis. Details on these reports are described in Section 4.1 of the Managed Care Technical Manual. Although CMHRS are carved-out from the MCO contract, this information is

provided to help identify recipients who may need additional behavioral health services or referral to an MCO behavioral health case manager.

7.2.A.III Behavioral Health Services Administrator (BHSA)

The 2011, 2012, 2013 Acts of Assembly directed the Department to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization. In addition, the 2013 *Acts* of *Assembly*, Chapter 806, Item RRRR identifies expectations that there exist "direct linkages" between medical and behavioral services that makes it easier for consumers to obtain timely access to needed care and services. Pursuant to this directive, in December 2011, the Department solicited proposals from interested Behavioral Health Services Administrators (BHSA). The Department's BHSA assumed the role effective December 1, 2013. The BHSA manages the full spectrum of behavioral health and substance abuse treatment services (traditional and non-traditional) to members who are not enrolled in managed care and the subset of "non-traditional" BHS that are carved-out of this contract for MCO enrolled members.

7.2.A.IV Coordination with the BHSA

Management of the Department's behavioral health benefits is shared by the Contractor and the Department's BHSA. Therefore, the Contractor and the BHSA shall work together closely and cooperatively to coordinate services in a manner that fully supports timely access to appropriate person-centered services through a seamless continuum of care that is based on the individual clinical needs of the member. Care coordination opportunities between the Contractor and the BHSA shall include, but are not limited to, the following circumstances:

- Facilitating the effective transition for members that move between fee-for-service and MCO enrollment with the Contractor,
- Enabling the smooth transition for members that move between levels of care as managed by the Contractor and the BHSA, and
- Facilitating efficient and effective continuity of care for members in need of or receiving services concurrently through the Contractor and the Department's BHSA.

7.2.A.IV.a In addition to the requirements above, all the following shall apply:

7.2.A.IV.a(i) The Contractor and the BHSA shall provide the names and contact information for a primary and back-up behavioral health care coordinator for use by the Department, the BHSA, and the Department's contracted MCOs as necessary for care coordination purposes.

7.2.A.IV.a(ii) The Contractor and the BHSA shall assure reasonable efforts to share clinically relevant information for care coordination purposes in a manner that complies with State and Federal confidentiality regulations, including:

7.2.A.IV.a(ii)(1) HIPAA regulations at 45 C.F.R. parts 160-164, allowing for the exchange of clinically relevant information for care coordination of services (i.e., without the need of a patient release of information form), and

7.2.A.IV.a(ii)(2) Federal regulations at 42 C.F.R. § 2.31(a) pertaining to substance abuse preventing and treatment services, which requires member consent, and where such consent must include the member's name, the description of the information to be disclosed, the identity of the person or class of persons who may disclose the information and to whom it may be disclosed, a description of the purpose of the disclosure, an expiration date for the authorization, and the signature of the person authorizing the disclosure. [Member consent is not required in instances related to "public interest," when required by law (court-ordered warrants, law enforcement); when appropriate to notify authorities about victims of abuse, neglect, or domestic violence; and, when necessary to prevent or lessen serious and imminent threat to a person or the public, where information shared must be limited as needed to accomplish the purpose.]

7.2.A.IV.a(iii) The Contractor and the Department's BHSA shall honor service authorizations issued by one another for services, in accordance with each entity's (Contractor's and BHSA's) contract with the Department, and shall ensure continuation of the authorized services without interruption until the responsible entity (Contractor/ BHSA) completes its own medical necessity review.

7.2.A.IV.a(iv) The Contractor shall assure that it has processes in place to refer members seeking services covered through the BHSA to the Department's BHSA, offering special assistance when necessary. Conversely, the Department's BHSA is required to have referral processes in place as needed, to refer members seeking services covered through the Medallion 3.0 contract to the member's MCO as appropriate. These referral processes include hands-on assistance as needed for members with special medical or behavioral health needs, high-risk cases, and other circumstances as warranted. (Examples include, but are not limited to: warm transfer of telephone calls from members to the correct entity and collaborative discussions between the member's BHSA and MCO care managers. The Contractor shall assure that it has processes in place to receive referrals for services covered under this contract from the Department's BHSA. Conversely the BHSA is required to assure that it has appropriate procedures in place for receiving referrals from the member's MCO.

7.2.A.IV.a(v) The Contractor and the Department's BHSA shall continue to work closely together and with the Department to expand these care coordination policy and procedures as needed to facilitate highly effective and efficient referral, care coordination, and treatment arrangements; to improve quality of care; and to eliminate duplicative services or conflicting treatment plans, on behalf of members served by the Contractor and the Department's BHSA.

7.2.A.IV Behavioral Health Network

The Contractor shall monitor and assure that the Contractor's behavioral health network is adequate (in terms of service capacity and specialization) to serve child, adolescent, and adult populations timely and efficiently for all BHS services covered by the Contractor. The Department will assess the MCO's inpatient and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

7.2.B Clinic Services

The Contractor shall cover clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients, as set forth in 12 VAC 30-50-180. With the exception of certified nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.

7.2.C Clinical Trials as EPSDT

Clinical Trials are considered under EPSDT when no acceptable or effective standard treatment is available for the child's medical condition and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.

7.2.D Colorectal Cancer Screening

The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

7.2.E Dental and Related Services

7.2.E.I Services Covered Under Medical

Under the terms of this Contract, the Contractor shall not cover routine dental services, which are provided by a dental benefits administrator (DBA). The Contractor shall assure efforts to coordinate outreach with the DBA to improve utilization. The Contractor shall be responsible for transportation and medication related to covered dental services. The Contractor will be responsible for medically necessary procedures of the mouth for adults and children, including but not limited to, the following:

7.2.E.I.a CPT codes billed for dental services performed as a result of external trauma from a dental accident that results in damage to the hard or soft tissue of the oral cavity;

7.2.E.I.b Medically necessary procedures for adults and children, including but not limited to: cleft palate repair, preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

7.2.E.II Hospitalization and Anesthesia Related Services

In accordance with § 38.2-3418.12 of the *Code of Virginia*, the Contractor shall cover anesthesia and hospitalization for medically necessary dental services. The Contractor shall work with the Department's DBA to coordinate coverage for these services as follows:

7.2.E.II.a Coverage is required for children under the age of five (5), persons who are severely disabled, and persons who have a medical condition that require admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the covered

person's treating physician that such services are required to effectively and safely provide dental care.

7.2.E.II.b The Contractor shall designate a liaison (by name, phone number, and email address) and a back-up to work collaboratively with the Department's DBA and to assure that the required authorizations are handled timely and in accordance with the provisions described below.

7.2.E.II.c Authorizations for these services shall be handled as follows:

7.2.E.II.c(i) The dental service provider must submit the request for authorization directly to the DBA;

7.2.E.II.c(ii) If the DBA reviews the request for dental related hospitalization and/or anesthesia based upon medical necessity;

7.2.E.II.c(iii) If the DBA approves the request, the DBA coordinates anesthesia and hospitalization authorization for Dental Services with the Contractor and within the Contractor's provider network.

7.2.E.II.c(iv) The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA. The Contractor shall respond in writing via facsimile (262) 834-3575 to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request.

If the Contractor disagrees with the DBA's decision for medical necessity, the Contractor may appeal within two (2) business days of notification by the DBA of the authorization. The appeal must be made directly with the Department's Dental Benefit Manager. The Department's decision shall be final and shall not be subject to further appeal by the Contractor. The Department's decision, however, does not override any decisions made as part of the member's State Fair Hearing Process as described in Section 10 of this Contract.

7.2.F Durable Medical Equipment (DME)

All medically necessary medical supplies and equipment shall be covered as set forth in 12 VAC 30-50-165. The Contractor shall provide a secondary review for children for denied services in accordance with EPSDT review requirements.

Any specialized DME authorized by the Contractor will be reimbursed by the Contractor, even if the member is no longer enrolled with the plan or with Medicaid. For a complete listing of Medicaid covered medical supplies and equipment refer to the Durable Medical Equipment (DME) and Supplies Appendix B of the Medicaid DME Provider Manual, as amended.

Retraction of the payment for specialized equipment can only be made if the member is retroactively disenrolled for any reason by the Department and the effective date of the retroactively disenrollment precedes the date the equipment was authorized by the Contractor. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;
- Customized prone standers; and,
- Customized positioning devices.

The Contractor shall cover supplies and equipment necessary to administer enteral nutrition. See Section 7.2.M "Nutritional Supplements and Supplies."

7.2.G Emergency Services

The Contractor shall cover emergency and post stabilization services rendered by qualified participating or non-participating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions; or,
- Serious dysfunction of any bodily organ or part.

In accordance with 42 C.F.R. § 438.114, the Contractor shall ensure that all covered emergency services are available, without requiring service authorization, twenty-four (24) hours a day and seven (7) days a week through the Contractor's network.

In accordance with 42 C.F.R. § 438.114, the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Additionally the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the Contractor of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. Title 42 C.F.R. § 438.114 further requires that a member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The Contractor is also prohibited from denying payment for treatment obtained when a representative of the Contractor instructs the member to seek emergency services.

The Contractor may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature.

In accordance with Section 1867 of the Social Security Act, hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in an un-stabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements.

<u>When emergency services are provided to a member of the Contractor, the organization's liability for payment is determined as follows</u>:

7.2.G.I Presence of a Clinical Emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor must pay for both the services involved in the screening examination and the services required to stabilize the patient.

7.2.G.II Post-Stabilization Care

The Contractor shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred as determined by the attending emergency physician, or the provider actually treating the member. This shall include payment for post-stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the Contractor concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member.

Coverage and payment for post-stabilization care services must be in accordance with provisions set forth in 42 C.F.R. § 422.113(c), as described below.

7.2.G.II.a Coverage - The Contractor shall cover post-stabilization care services that are:

7.2.G.II.a(i) Pre-approved by a plan provider or the MCO;

7.2.G.II.a(ii) Not pre-approved by a plan provider or the MCO, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services;

7.2.G.II.a(iii) Not pre-approved by a plan provider or the MCO, but administered to maintain, improve, or resolve the member's stabilized condition if:

7.2.G.II.a(iii)(1) The MCO does not respond to a request for pre- approval within one (1) hour;

7.2.G.II.a(iii)(2) The MCO cannot be contacted; or

7.2.G.II.a(iii)(3) The MCO and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the member until a plan physician is reached or until one of the criteria listed in number 2 below is met.

7.2.G.II.b Payment - In accordance with 42 C.F.R. § 422.113 (c), the Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

7.2.G.II.b(i) A plan physician with privileges at the treating hospital assumes responsibility for the member's care;

7.2.G.II.b(ii) A plan physician assumes responsibility for the member's care through transfer;

7.2.G.II.b(iii) The Contractor and the treating physician reach an agreement concerning the member's care; or,

7.2.G.II.b(iv) The member is discharged.

7.2.G.III Absence of a Clinical Emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the Contractor shall pay for all services involved in the screening examination if the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the "prudent layperson" standard, as defined herein. If a member believes that a claim for emergency services has been inappropriately denied by the Contractor, the member may seek recourse through the MCO or State appeal process.

7.2.G.IV Referrals

The Contractor shall be responsible for payment for the medical screening examination and for other medically necessary emergency services, without regard to whether the patient meets the "prudent layperson" standard, as defined herein.

The Contractor shall cover those medical examinations performed in emergency departments for enrolled children as part of a child protective services investigation. In the absence of an agreement otherwise, these services shall be reimbursed at the applicable Virginia Medicaid fee-for-service program rate in effect at the time the service was rendered.

The Contractor may require that continuing care, following the conclusion of an emergency, be obtained from a network provider or another health care provider specified by the Contractor. An emergency shall be deemed to have concluded at such time as the member can, without medically harmful consequences, travel or be transported to an appropriate Contractor facility or to such other facility as the Contractor may designate.

In the absence of an agreement or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered.

7.2.H Home Health

The Contractor shall cover home health services, including nursing services and home health aide services, as set forth in 12 VAC 30-50-160. The Contractor is not required to cover the following home health services, medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care,

custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery. The Contractor is prohibited from paying for home health care provided by an agency or organization unless said agency or organization provides the Commonwealth with a surety bond as specified in Section 1861 (o)(7)of the Social Security Act (42 U.S.C. 1395x).

Visits by a licensed nurse and home health aide services shall be covered as medically necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the member's home health benefit, in accordance with the guidelines cited in Section 7.2.O.

7.2.I Hospital Services

7.2.I.I Inpatient Hospital

The Contractor shall cover inpatient hospital stays in general acute care and rehabilitation hospitals for all members. The Contractor's pre-authorization process for inpatient hospital services must be congruent with guidelines detailed in Section 7.1 of this Contract.

7.2.I.II Outpatient Hospital

The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative, or palliative in nature that are furnished to outpatients, except in the case of certified nurse-midwife services that are furnished under the direction of a physician, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to twenty-three (23) hours. A patient stay of twenty-four (24) hours or more shall require inpatient pre-certification and admission.

Transportation and pharmacy services necessary for the treatment of mental health and substance abuse treatment, including for carved out services, shall be the responsibility of the Contractor.

7.2.I.III Inpatient Rehabilitation Hospitals

The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System, as set forth in 12 VAC 30-50-200 and 12 VAC 30-50-225, and 12 VAC 30-70-10 through 12 VAC 30-70-90, excluding 12 VAC 30-70-50.

7.2.I.IV Inpatient Behavioral Health Hospitalization Services (Traditional Inpatient BHS)

See Section 7.2.A.I.a(i). See Section 7.5 "Carved Out & Excluded Services."

7.2.I.V General Obstetrical Hospital

The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and follow-up visits as set forth in 12 VAC 30-50-220.

7.2.J Immunizations/Vaccinations

The Contractor shall ensure that providers render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening and that members are not inappropriately referred to other providers for immunizations. The Contractor shall, as set forth elsewhere in this Contract, work with its network providers to adhere to the ACIP recommendations.

The Contractor is responsible for educating providers about reimbursement of immunizations, educating members about immunization services, and coordinating information regarding member immunization. The Contractor shall encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health and shall include enrollment instructions and a "Vaccines for Children" application (or, if electronic, a hyperlink to the application) in its provider network enrollment and re-enrollment packages.

The capitation rate paid to the Contractor does include the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The Contractor shall not allow primary care providers to routinely refer Medicaid members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, the Contractor and its network of providers shall participate in the Statewide immunization registry database. Further, the Contractor is required to submit its immunization data to the Virginia Immunization Registry on a monthly basis. Coordination of Benefits is not applicable for VVFC claims submitted by VVFC providers. Payments for such claims are to be made by the Contractor.

7.2.J.I Flu Vaccinations:

The Contractor shall be required to cover adult flu vaccinations in accordance with the Affordable Care Act (ACA) as a required preventative service.

7.2.K Laboratory and X-Ray Services

The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the healing arts, as set forth in 12 VAC 30-50-120. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified.

7.2.L Nursing Facilities (Screening)

The Contractor is not required to cover nursing facility care. However, the Contractor shall make a good faith effort to refer all members in need of nursing facility care to be prescreened prior to admission. This screening must be done regardless of the member's anticipated length of stay in the nursing facility setting.

Once a member is screened, authorized, and enters a nursing facility, the nursing facility submits a Patient Intensity Rating Survey (PIRS) form to Department's Fiscal Agent. This information is used to enroll the member into the DMAS MMIS system. Once a nursing facility admission is entered into the MMIS system, any open managed care enrollment is closed on the day prior to the nursing facility admission date. The Contractor must cover all medically necessary services until the member is disenrolled from the MCO.

Nothing in this Contract shall preclude the Contractor from providing additional health care improvement services or other services not specified in this Contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to members

7.2.M Nutritional Supplements and Supplies

Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for members under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrotomy tube, and is necessary to treat a medical condition. Sole source means that the member is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that the nutritional supplements are medically indicated for the treatment of the member's condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Specialized formula for children and enteral nutrition/medical foods for members under twenty-one (21) are carved out of this Contract. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition.

7.2.N Obstetric and Gynecologic Services

The Contractor shall cover routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered members. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists. The Contractor shall reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule. If the female member's designated primary care physician is not a women's health specialist, the Contractor is required to provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's care services.

Note that a pregnant minor is deemed an adult for the purpose of consenting for herself and her child to both survival and medical treatment relating to the delivery as well as treatment for her child pursuant to the *Code of Virginia* § 54.1-2969 (E), as amended,

7.2.N.I Certified Nurse-Midwife

The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260.

7.2.N.II Family Planning

The Contractor shall cover all family planning services which includes services and supplies for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. Covered services include drugs, supplies, and devices provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 C.F.R. § 441.20.

In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 C.F.R. § 431.51(b)(2), as amended, the Contractor may not restrict a member's choice of provider for family planning services, drugs, supplies, or devices. The Contractor must cover family planning services, including drugs, supplies, and devices by network and out-of-network providers. Federal law (42 C.F.R. § 441.20) requires that the Contractor also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. *Code of Virginia* § 54.1-2969 (E), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

7.2.N.III Sterilizations

The Contractor shall not perform sterilization for a member under age twenty-one (21). The Contractor shall comply with the requirements set forth in 42 C.F.R. § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in *Code of Virginia* , § 54.1-2974. The Contractor shall ensure that the consent form DMAS-3004 of 42 C.F.R. § 441.258 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the member being informed, the members giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor shall comply with State and Federal (42 C.F.R. Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

7.2.N.IV Hysterectomies

The Contractor may not impose a thirty (30) day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor shall inform the patient that the hysterectomy will result in sterility and must have the patient acknowledge her understanding. Patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Contractor shall comply with State and Federal (42 C.F.R. Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes

used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

7.2.N.V Women's Health

7.2.N.V.a The Contractor shall permit any female member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the *Code of Virginia* , to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.

7.2.N.V.b The Contractor shall cover screening mammograms for female members ages forty to forty four (40-44) and over, consistent with the guidelines published by the American Cancer Society. The Contractor must meet all requirements set forth in 12 VAC 30-50-220.

7.2.N.V.c The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

7.2.N.V.d The Contractor shall provide coverage for at least a forty-eight (48) hour hospital stay following a radical or modified radical mastectomy and not less than twenty-four (24) hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) (1) through §32.1-325 (A)(25) of the *Code of Virginia* .

7.2.N.V.e The Contractor shall cover reconstructive breast surgery in accordance with 12 VAC 30-50-140.

7.2.N.V.f The Contractor shall cover lactation consultation and breast pumps.

7.2.N.V.g The Contractor shall cover services to pregnant women, including:

7.2.N.V.g(i) Pregnancy-related and postpartum services to the end of the month in which the sixtieth (60th) calendar day after the pregnancy ends, as set forth in 12 VAC 30-50-290;

7.2.N.V.g(ii) Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290;

7.2.N.V.g(iii) Prenatal and infant programs as described in this subsection under Prenatal and Infant Programs (Section 7.2.N.V).

7.2.N.V.h In cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of delivery, the Contractor shall cover at least one (1) early discharge follow-up visit as indicated by the most recent "Guidelines for Perinatal Care" developed by the American Academy of Pediatrics and the American Collee of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers and newborns or the newborn alone, if the mother has not been

discharged, who meet the Department's criteria for early discharge, as set forth in 12 VAC 30-50-220.

7.2.N.V.i The early discharge follow-up visit shall be provided within forty-eight (48) hours of discharge and must include, at a minimum, a maternal assessment and a newborn assessment, as set forth in 12 VAC 30-50-220.

7.2.N.V.j The Contractor shall not be responsible for covering Medicaid covered residential or day treatment substance abuse treatment services for pregnant women. The Contractor must have in place written policies and procedures related to the coordination of substance abuse treatment services with other providers and a mechanism whereby member's seeking or needing these services may obtain from the Contractor the Department's listing of appropriate providers. The Contractor shall submit to the Department prior to initial contract signature and on request for review its policies and procedures addressing coordination of substance abuse services for pregnant women.

7.2.N.V.k The Contractor shall ensure that, as a routine component of prenatal care, every pregnant member shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant member consent to testing as set forth in § 54.1-2403.01 of the *Code of Virginia* . Any pregnant member shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record.

7.2.O Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Language Pathology & Audiology Services)

The Contractor shall cover all physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and audiology services at least equal in amount, duration, and scope as described in 12 VAC 30-50-160, 12 VAC 30-50-200, and 12 VAC30-130-40. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define "acute conditions" as conditions that are expected to be of brief duration (less than twelve (12) months) in which progress toward goals is likely to occur frequently. "Non-acute conditions" are defined as conditions that are of long duration (greater than twelve (12) months) in which progress toward established goals is likely to occur slowly. The Contractor shall cover medically necessary PT, OT, and SLP therapies, including for both acute and non-acute conditions, regardless of whether or not the child is receiving PT, OT, and SLP therapies through the school or through Early Intervention.

The Contractor shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs), as set forth in 12 VAC 30-50-225.

7.2.P Organ Transplants

The Contractor shall cover organ transplantation services for kidneys and corneas for all eligible individuals, regardless of age as set forth in 12 VAC 30-50-540 and 12 VAC 30-50-550. The contractor shall provide coverage for reasonable and necessary procurement/donor related services. The Contractor shall cover services for bone marrow transplants and high-

dose chemotherapy for adult (age twenty-one (21) or over) members diagnosed with breast cancer, leukemia, lymphoma and myeloma, as set forth in 12 VAC 30-50-570. The Contractor shall cover liver, heart, and any other medically necessary transplant procedures for members up to age twenty-one (21), as set forth in 12 VAC 30-50-580 and 12 VAC 30-50-560. The Contractor shall cover liver, heart and lung transplantation procedures for individuals over the age of twenty-one (21) years when medically necessary, as set forth in 12 VAC 30-50-560. Coverage of liver transplants (for adults and children) includes coverage for partial or whole, and orthotopic or heterotopic liver transplantation, from cadaver or living donor, within the amount duration and scope, (and for individuals meeting the criteria) as outlined in 12 VAC 30-50-560, and 12 VAC 30-10-280.

The Contractor must use Department service authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department. The Contractor is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by the Department must be honored by the Contractor, as with all authorizations, until such time that the Department can disenroll the member from the Contractor, if applicable, if the transplant is scheduled concurrent with the member's enrollment with the Contractor. Required coverage for transplants is summarized in the following table.

Transplant	Under 21 *	Age 21 and Over	Coverage Criteria
Kidney From Cadaver or Living Donor	Yes	Yes	12 VAC 30-50-540 and 12 VAC 30-10-280
Corneas	Yes	Yes	12 VAC 30-50-550 and 12 VAC 30-10-280
Liver From Cadaver or Living Donor	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Heart	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Artificial Heart Transplant	Yes	Yes	
Lung	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Heart & Lung	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280

Bone Marrow	Yes	Yes - for limited diagnoses, specifically: myeloma, lymphoma, breast cancer or leukemia	12 VAC 30-50-560 and 12 VAC 30-50-570 and 12 VAC 30-10-280
Small Bowel	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280
Small Bowel with Liver	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280
Simultaneous Kidney/Pancreas	Yes	No	
Pancreas	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280
Pancreatic Islet Cell	Yes	Coverage of pancreatic cell auto transfusion is currently under review by the DMAS Medical Support Unit.	

*Any medically necessary transplants that are not experimental or investigational are covered for children under twenty-one (21) years of age, when preauthorized.

7.2.Q Physician Services and Screenings

The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses as set forth in 12 VAC 30-50-140. Cosmetic services are not covered unless performed for medically necessary physiological reasons. The Contractor is only required to cover routine physicals when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The Contractor is strongly encouraged to cover routine physicals for members not covered through the EPSDT program.

7.2.R Podiatric Services

The Contractor shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture, as set forth in 12 VAC 30-50-150.

7.2.S Pharmacy Services

7.2.S.I General Coverage Provisions

The Contractor shall be responsible for covering all Food and Drug Administration (FDA) approved drugs for Members, as set forth in 12 VAC 30-50-210 and 42 CFR 438.3(s)(1), and in compliance with § 38.2-4312.1 of the *Code of Virginia*. Drugs for which Federal Financial

Participation is not available, pursuant to the requirements of §1927 of the Social Security Act (OBRA 90 §4401), shall not be covered.

The Contractor is required to maintain a drug formulary to meet the unique needs of its Membership. The Contractor's formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit its formulary to the Department after review by its P&T Committee and inform the Department of changes to their formulary. The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including prior authorizations and quantity limits. The Contractor shall submit changes for review and approval as specified in the MCTM at least forty-five (45) calendar days prior to the effective date of the change. The Department will respond within fifteen (15) calendar days.

The Contractor must have an updated link to its formulary available on their website.

The Contractor must allow access to all non-formulary or non-preferred drugs, other than those excluded (see *Pharmacy Exclusions* below) and subject them to service authorization consistent with the requirements of the Contract.

The Contractor agrees to follow the most recent clinical edits and recommendations established by the Department's fee-for-service P&T Committee with regard to specific prescription drugs indicated to treat and/or cure Hepatitis C. Criteria are available on the Department's P&T website: http://www.dmas.virginia.gov/Content_pgs/pharm-pdl.aspx

7.2.S.II Pharmacy Co-Pays

The Contractor may not impose co-payments on any medications.

7.2.S.III Pharmacy Exclusions

The Contractor must exclude coverage for the following:

- Drugs used for anorexia or weight gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are
- used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs; and,
- Any drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

7.2.S.IV Pharmacy and Therapeutics (P&T) Committee

The Contractor shall have a P&T Committee that will ensure safe, appropriate, and cost effective use of pharmaceuticals for the Virginia Medicaid enrollees of this Contract.

The P&T Committee shall serve in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of this Contract and the appropriate use of medications.

The Contractor's P&T Committee shall meet at least biannually.

The Contractor shall require all individuals participating in the P&T Committee to complete a financial disclosure form annually which is reviewable by the Department upon request.

7.2.S.V Drug Utilization Review (DUR) Programs

In following with 42 C.F.R.§ 438.3(4)(5), the Contractor shall develop and maintain a DUR program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR 456, subpart K including prospective DUR, retrospective DUR, educational program, and the DUR Board.

The Contractor is not required to have a separate DUR Board. The Contractor may utilize its P&T Committee or comparable committee to fulfill the DUR requirements defined at 42 C.R.F. 456, Subpart K and 1927 (g) of the Social Security Act. If the Contractor does not maintain a separate DUR Board; the Contractor must define, for the Department's review and approval, how it will fulfill the DUR requirements under the Contract.

The Contractor's DUR Board will meet at least biannually. The DUR Board must include a voting representative from the Department. The Contractor must provide the Department with the minutes from each DUR Board meeting within thirty (30) calendar days of the date of the meeting.

The Contractor must provide the Department with a detailed description of its DUR program activities annually and it must complete and submit the annual Drug Utilization Review (DUR) Annual Report as required by CMS. The Contractor must submit the CMS DUR Annual report to the Department at least forty-five (45) days prior to the due date established by CMS. The Department will share with the Contractor all reporting requirements including the web link for the submission of the DUR Report to CMS.

The Contractor shall require all individuals participating on the DUR Board to complete a financial disclosure form annually which is reviewable by the Department upon request.

7.2.S.VI Drug Rebates

Any outpatient drugs dispensed to Members covered by the Contractor (including where the Contractor paid as the primary and/or secondary payer under this Contract) shall be subject to the same rebate requirements as the State is subject to under Section 1927 and the State shall collect such rebates from pharmaceutical manufacturers.

Drug utilization encounter data must include all drugs 1) dispensed at point-of-sale (POS), 2) administered in a provider's office or 3) other outpatient settings including

outpatient hospitals. Pursuant to Section 2501(c)(1)(C)(III) of the Social Security Act, the Department requires encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS drug code. Unless otherwise specified by the Department in supporting documentation, the quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier (F2, ML, GR or UN) is also required. Each HCPCS drug code must be submitted with a valid NDC and NDC units on the corresponding claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a separate claim line. For the purpose of this contract the term "administer" is defined to include the terms "provide" and "dispense." Drug utilization data for MCO reporting must be reported based upon the date dispensed (date of service) within the quarter, as opposed to the claim paid date. A set forth in 42 C.F.R. §438.3(s)(2), the Contractor must report drug utilization encounter data that is necessary for the Department to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period.

As set forth in 42 C.F.R. §438.3(s)(3), the Contractor must develop a process and procedure to identify drugs administered under Section 340B of the Public Health Service Act as codified at 42 USC § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate program. Failure to identify aforementioned 340B drugs on submissions to the Department or its rebate vendor shall be treated as a compliance violation. The Contractor shall identify encounter claims administered under Section 340B in a manner, mutually agreed upon between the Department and the Contractor, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing. (See *Technical Manual* for reporting requirements.). If a Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the Contractor shall ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This shall include the use of a unique BIN/PCN combination to distinguish Medicaid managed care claims from commercial or other lines of business. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered as part of the DMAS FFS pharmacy benefit. The Contractor may cover 340B Drugs.

The Contractor (and/or its Pharmacy Benefits Manager) must make available two (2) pharmacy representatives (one primary and one secondary) to work directly with the Department and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

7.2.S.VII Long Acting Reversible Contraception (LARC) Utilization and Reimbursement

Appropriate family planning and/or health services shall be provided based on the Member's desire for future pregnancy and shall assist the Member in achieving her plan

with optimization of health status in the interim. Use of long acting reversible contraceptives should be encouraged and barriers such as service authorization shall not be required for approval.

Consistent with 42 CFR § 441.20, the Contractor shall provide coverage for its enrolled Members for all methods of family planning including, but not limited to, barrier methods, oral contraceptives, vaginal rings, contraceptive patches, and long acting reversible contraceptives (LARCs). As required by section 1902(a)(23)(B) of the Act, the Contractor cannot require the Member to obtain a referral prior to choosing a provider for family planning services. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral. In addition to a member's free choice of family planning provider, Members are free to choose the method of family planning, as provided in 42 CFR § 441.20.

7.2.S.VII.a **Immediate Post-Partum Coverage**

The Contractor must provide reimbursement for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor shall also reimburse practitioners for the post-partum insertion of the LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.

7.2.S.VII.b **Outpatient Coverage**

The Contractor must provide coverage for all LARC devices, The Contractor shall not impose service authorization requirements or quantity limits on LARCs. The Contractor shall reimburse practitioners for evaluation/management (E/M) visits, where the practitioner and member discuss contraceptive options, in addition to same day LARC insertion or removal procedures. The Contractor must reimburse practitioners for LARC devices and procedures at a rate no less than the Medicaid fee schedule.

7.2.S.VIII Prescription Monitoring Program (PMP)

The Department of Health Professions established, maintains, and administers an electronic system to monitor the dispensing of Schedule II, III, and IV controlled substance prescription drugs pursuant to § 54.1-2520 and § 54.1-3400 et. seq of the *Code of Virginia*, known as the Prescription Monitoring Program (PMP).

Under § 54.1-2523 of the *Code of Virginia*, the Contractor may obtain information from the PMP about specific Members in order to determine eligibility and to manage the care of the specific Member participating in the PUMS or a similar program (Refer to the *Patient Utilization Management & Safety (PUMS) Program* section of this Contract for more information.) Information may only be obtained by a current employee of the Contractor who is also a physician or pharmacist licensed in the Commonwealth.

Notice shall be given to Members that information may be requested from the Prescription Monitoring Program by a licensed physician or pharmacist employed by the Contractor. The Contractor must notify its Members of the possibility that the Member's information may be accessed using the PMP, such as via the Member Handbook,

postcard mailings, PUMS letters, etc. Note that all data related to the PMP are exempt from FOIA requests and considered confidential information.

7.2.S.VIII.a Process for Contractor Access to the PMP

The Contractor shall provide to DMAS, in the format specified by the Department of Health Professions, an actively maintained list of up to four (4) Commonwealth-licensed pharmacists/physicians employed by the Contractor who will be utilizing the PMP. PMP access login credentials will be provided by the Department of Health Professions and shall not be delegated to or used by other staff. The Contractor, and its employees accessing the PMP, shall only use the PMP in accordance with all applicable State laws, including but not limited to § 54.1-2520, § 54.1-2523, and § 54.1-3400 et. seq of the *Code of Virginia*, and will be required to attest to such usage as a conditional term of access. The Contractor shall notify the Department of Health Professions immediately (within twenty-four (24) hours) when an employee is terminated or of any other situation (such as a transfer of position or change in job responsibilities) arising that would render PMP access by the individual employee as no longer required or appropriate. The Contractor acknowledges that the Department of Health Professions will be able to monitor Contractor use for compliance, outlier activity, and has the authority to sanction any misuse of the PMP without DMAS involvement.

7.2.S.IX Utilization Management for Pharmacy Services

7.2.S.IX.a **Transition of Care**

The Contractor shall have in place policies and procedures to ensure the continuity of care for Members with established pharmacological treatment regimens.

7.2.S.IX.b **Service Authorization**

The Contractor shall have in place authorization procedures to allow providers to access drugs outside of the formulary, if medically necessary. This includes medications that are not on the Contractor's formulary, and especially in relation to the Attention-Deficit/Hyperactivity Disorder (ADHD) class of medications (e.g., safeguards against having individuals go back through the Contractor's step therapy program when pre-authorizations end).

The Contractor may require service authorization as a condition of coverage or payment for a covered outpatient drug. The Contractor shall follow service authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and comply with the requirements for prior authorization for covered outpatient drugs in accordance with Section 1927(d)(5)(A) of the Social Security Act and 42 C.F.R. §§ 438.3(s)(6), and 438.210(d)(3). The Contractor shall incorporate the requirements into its pharmacy provider contracts.

The Contractor must accept telephonic, facsimile, or electronic submissions of service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug programs' SCRIPT standards for service authorization requests.

Pharmacy services for children must be reviewed in accordance with EPSDT requirements to cover drugs when medically necessary based upon a case-by-case review of the individual child's needs, such as for off-label use.

The Contractor must submit all pharmacy service authorization and step therapy policies, procedures, and any associated criteria to DMAS for review and prior approval.

The Contractor must submit any proposed pharmacy program changes, such as pill-splitting programs, quality limits, etc. to DMAS for review and approval prior to implementation.

7.2.S.X Denial of Services

If the Contractor denies a request for service authorization, the Contractor must issue a Notice of Action within twenty-four (24) hours of the denial to the prescriber and the Member. The Notice of Action must include appeal rights and instructions for submitting an appeal in accordance with the requirements described in the *Grievances and Appeals* section of this Contract.The Department reserves the right to conduct random reviews to ensure that enrollees are being notified in a timely manner in accordance with 42 C.F.R §438.228.

7.2.S.XI Emergency Supply

If needed, a seventy-two (72) hour emergency supply of a prescribed covered pharmacy service shall be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, feels that the Member's health would be compromised without the benefit of the drug.

7.2.S.XII Notification Requirement

7.2.S.XIII The Contractor must have policies and procedures for general notifications to participating providers and Members of revisions to the formulary and service authorization requirements. Notification for changes to the formulary and service authorization requirements and revisions must be provided to all affected participating providers and Members at least thirty (30) calendar days prior to the effective date of the change. Pricing Data for Pharmacy Benefit Management Programs

Beginning July 1, 2017 contracted health plans shall report to the Department for all pharmacy claims:

- The actual amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. Reporting requirements are defined in the State Companion Guides and the Technical Manual.
- In the event the Department identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy benefit manager the health plan shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. On a monthly basis, the Department will notify the health plan when this report is required. Health plans are

required to provide such reports by the 15th of each month or the next business day. Further reporting requirements are defined in the Technical Manual.

7.2.S.XIV Interventions to Prevent Controlled Substance Abuse (Report)

The Contractor must submit an annual report that describes its interventions targeted to prevent controlled substance abuse. The annual report does not apply exclusively to PUMS members under Section 7.1.M, but rather the actions described in this report should reflect the Contractor's entire Medicaid membership. The report must describe actions taken by the Contractor to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, a detailed definition of what, if any substances the Contractor targets that are not scheduled substances under the Controlled Substances Act (21 U.S.C. § 801 et seq.) but may place an individual at higher risk for abuse, prior authorization requirements, quantity limits, poly-pharmacy considerations, and related clinical edits, as specified in the MCTM.

7.2.T Private Duty Nursing (PDN)

The Contractor is not required to cover PDN services for adults. See also, Section 7.1D "EPSDT."

The Contractor is not required to cover PDN services in the school setting. When the Contractor receives a request for PDN services to be rendered in the school setting, the Contractor should require the requesting provider to pursue payment for services through the Department directly in accordance with the Department's established criteria and guidelines for school-based private duty nursing.

7.2.U Prostate-Specific Antigen (PSA)

The Contractor shall cover Prostate-Specific Antigen (PSA) testing and digital rectal examinations for the purpose of screening for prostate cancer as set forth in 12 VAC 30-50-220.

7.2.V Prosthetic/Orthotic

The Contractor shall cover medically necessary prosthetic and orthotic services and devices at least equal in amount duration and scope as described in 12 VAC 30-50-210 and 12 VAC 30-60-120. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for members under twenty-one (21) years of age. The Contractor shall cover medically necessary prosthetics and orthotics for a member regardless of the member's age when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.

7.2.W Telemedicine

The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-

for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services. The Department recognizes the following "remote" providers for telemedicine services: physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors, licensed marriage and family counselors, and licensed substance abuse practitioners. The listed provider types are also recognized for the telemedicine "originating" sites, where the Medicaid recipient is located. Originating sites also include other providers, such as staff at renal dialysis centers, health departments, and community services boards. The originating site provider bills the Q3014 service code. A description of the Department's telemedicine coverage is available as a "Medicaid Memo" issued September 29, 2009 and coverage is subject to updates. Federal and State laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

7.2.X Tobacco Cessation Services

The Contractor shall ensure tobacco cessation services, education, and pharmacotherapy are covered for all children under the age of twenty-one (21), not exclusively under EPSDT.

7.2.Y Transportation

The Contractor shall cover emergency transportation as well as non-emergency transportation to ensure that members have necessary access to and from providers of medical services for emergency or non-emergency services. Per 12 VAC 30-50-530, these modes of transportation include, but shall not be limited to: non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The Contractor shall assess, and provide if necessary, members' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services. "Hand to hand" service includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported "hand-to-hand." The Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in 42 C.F.R. § 440.170(a). The Contractor shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services as defined in Section 7.5, with the exception of transportation to home and community based waiver services, which shall be paid by the Department under fee-for service. The Contractor shall cover transportation to and from Medicaid covered community mental health and rehabilitation services. The Department allows the Contractor to subcontract for all transportation services. The Contractor shall assure that provider agreements (through the Contractor or the subcontractor) include the following language:

7.2.Y.I Requirements for Drivers

The Contractor shall assure that all drivers of vehicles transporting members meet the following requirements:

7.2.Y.I.a Are at least eighteen (18) years of age and have had a valid driver's license for at least one (1) year.

7.2.Y.I.b All drivers shall have a current valid driver's license from the Commonwealth of Virginia.

7.2.Y.I.c Drivers shall not have been convicted of any crime as defined in § 37.2-314(B) *Code of Virginia.*

7.2.Y.I.d No driver or attendant shall use prescription medications that impact the ability to perform while on duty, alcohol, narcotics, or illegal drugs and no driver shall abuse alcohol or drugs at any time.

7.2.Y.I.e All drivers and attendants shall wear or have visible, easily readable proper identification.

7.2.Y.I.f Drivers shall not use mobile telephones (including texting) or headphones while the vehicle is in motion.

7.2.Y.II Requirements for Vehicles

7.2.Y.II.a All vehicles shall have functioning, clean, and accessible seat belts for each passenger seat position. Each vehicle shall utilize child safety seats when transporting children under age eight (8).

7.2.Y.II.b All vehicles shall have a functioning speedometer, odometer, heating, and air-conditioning systems.

7.2.Y.II.c All vehicles shall have the transportation provider's name, vehicle number (if applicable), and the Contractor's phone number prominently displayed within the interior of each vehicle.

7.2.Y.II.d Smoking is prohibited in all vehicles while transporting members. All vehicles shall post "no smoking" signs in all vehicle interiors, easily visible to the passengers.

7.2.Y.II.e All vehicles shall be equipped with a first aid kit.

7.2.Y.II.f All vehicles must meet State, Federal, local, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles.

7.2.Y.II.g Vehicles shall comply with the American's with Disabilities Act (ADA) specifications for transportation, 49 C.F.R. § 38, subparts A and B.

7.2.Z Vision Services

The Contractor shall cover vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all members, shall be allowed at least once every two (2) years. The Contractor shall cover eyeglasses and contact lenses prescribed by a physician skilled in diseases of the eye or by an optometrist for member s up to age twenty-one (21), as medically necessary and as set forth in 12 VAC 30-50-210.

The Contractor shall submit annually a plan detailing its efforts to increase utilization of vision services for children to the Department. The Contractor shall gradually increase

screening and eye examinations rates for all children between the ages of three to eighteen (3-18) using the American Academy of Pediatrics' recommendations for Preventive Pediatric Health Care.

7.2.AA Addiction and Recovery Treatment Services (ARTS)

The Contractor shall work with the Department to improve the ARTS benefit and delivery systems for individuals with a substance use disorder (SUD). The Department's system goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a SUD.

The Contractor's ARTS criteria shall be consistent with the American Society for Addiction Medicine (ASAM) criteria as well as the Department's criteria for the Addiction and Recovery Treatment Services (ARTS) benefit as defined in 12 VAC 30-130-5000 et al.

The Contractor shall implement all ARTS requirements and improvements as directed by the Department. The Contractor shall work with the Department and the ARTS Stakeholder Implementation Workgroup to ensure that the Contractor's ARTS system of care is able to meet its Members' needs.

Critical Elements of the Contractor's ARTS System of Care

7.2.AA.I Comprehensive Evidence-Based Benefit Design

The Contractor's ARTS system of care shall include recognized best practices in the Addiction Disease Management field, including a robust array of services and treatment methods to address the immediate and long-term physical, mental, and SUD care needs of the individual. The Contractor's system of care shall include recognized best practices in the Addiction Disease Management field such as the American Society of Addiction Medicine (ASAM) criteria and the Centers for Disease Control Opioid Prescribing Guidelines.

The Contractor shall provide coverage for services at the most appropriate American Society of Addiction Medicine (ASAM) level of care based on the most current version of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, which includes inpatient detoxification services provided in an acute care hospital settings licensed by the Virginia Department of Health (VDH); residential treatment services provided in a facility licensed by DBHDS; and SUD outpatient services by licensed or credentialed staff through the Department of Health Professions (DHP). DMAS is pursuing delivery opportunities for short-term acute and residential SUD treatment in a facility that meet CMS' definition of an institution for mental disease (IMD), as defined in 42 CFR § 435.1010, for adults age twenty-one to sixty-four (21-64). As directed by DMAS, the Contractor shall provide coverage in IMD settings as appropriate based on the ASAM Criteria for adults who are twenty-one (21) through sixty-four (64) years of age.

7.2.AA.II Appropriate Standards of Care

The Contractor shall use the DMAS defined medical necessity criteria for coverage of ARTS. In order to receive ARTS services, the Member must be enrolled in the Medallion 3.0 program and must meet the following medical necessity criteria:

- Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under twenty-one (21));

- Must meet the severity and intensity of treatment requirements for each service level defined by the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*. Medical necessity for all ASAM levels of care is based on the individual's assessed biopsychosocial severity and is defined by the extent and severity of the individual's problems as defined by a licensed clinician based on the individuals documented severity of need in all six (6) ASAM multidimensional assessment areas; and,

- If applicable, must meet the ASAM adolescent treatment criteria. For individuals under the age of twenty-one (21) who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review will be administered to ensure the individual's treatment needs are assessed and medically necessary services will be coordinated to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-130-5020 and in Section 7.2 AA IV of this contract. The Contractor shall use The ASAM Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions to review and coordinate service needs by applying the ASAM treatment criteria when administering ARTS benefits and determining medical necessity for ARTS services in accord with 12VAC30-130-5100. The Contractor's ARTS Care Coordinator, or a licensed physician or Medical Director employed by the Contractor, will perform an independent assessment of requests for all ARTS intensive outpatient (ASAM Level 2.1), partial hospitalization (ASAM Level 2.5), residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0) using member information transmitted by providers via the ARTS Uniform Service Review Request Form with attached clinical documentation available.

The Contractor shall review the requests on an individual basis and determine the length of treatment and service limits are based on the individual's most current multidimensional risk profile and apply the ASAM Treatment Criteria in accord with 12VAC30-130-5100.

7.2.AA.III Strong Network Development Plan

The Contractor's ARTS network shall ensure Member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care. Reference *Specialized Network Provisions.*

7.2.AA.IV ARTS Provider Qualifications
The Contractor shall use DMAS recognized licensed and credentialed treatment professionals including: addiction credentialed physicians; buprenorphine waivered practitioners licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain; credentialed addiction treatment professionals; and certified peer recovery specialists as defined in 12VAC30-130-5020. In situations where a certified addiction physician is not available, the Contractor shall recognize physicians who are not addiction credentialed but have some specialty training or experience in treating addiction or experience in addiction medicine or addiction psychiatry. The Contractor shall credential ASAM Level 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4.0 and Opioid Treatment Programs using the *ARTS ASAM Level 2.1 to 4.0 Uniform Credentialing Form* and *ARTS Staff Roster* available: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.

The Contractor shall credential the Office Based Opioid Treatment (OBOT) providers approved by the Department and the CMO and Pharmacy Director Workgroup using the criteria as set forth by the Department in 12 VAC 30-130-4120-5121 The Contractor shall provide the Department a report on a monthly basis of the OBOT credentialed organizations in the Contractor's network as defined in the ARTS *Management and Improvement* section of this Contract.

7.2.AA.V Benefit Management
The Contractor shall provide coverage for ARTS benefits within the amount, duration, and scope of coverage requirements described in the *Medallion 3.0 Coverage Chart* of this Contract, in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. § 438.3(e)(1)(ii), and as defined in 12 VAC 30-130-5100.

To the greatest extent possible, the Contractor will aim to maintain compliance with length of stay limits, e.g., thirty (30) day average length of stay for residential services. Should length of stay limits be exceeded, the Contractor shall provide evidence to the Department that such limits were exceeded due to the lack of provider availability (e.g., provider shortage area) in a lower ASAM Level of Care as defined in this Contract.

The Contractor shall allow for the billing methods by ASAM Level of Care as defined by the Department and detailed in the table below:

ASAM Level	Billing Method
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB
2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Residential	UB
3.5 Inpatient	UB
3.7 Residential	UB

3.7 Inpatient	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Office Based Opioid Treatment	CMS-1500
Substance Abuse Case Management	CMS-1500
Substance Abuse Care Coordination	CMS-1500
Peer Supports	CMS-1500

The Contractor shall not require service authorizations for Screening, Brief Intervention and Referral to Treatment (ASAM Level 0.5), Outpatient Services (ASAM Level 1.0), or services provided by a Contractor credentialed OTP or OBOT organization. The following ARTS Services will require a service authorization to qualify for reimbursement:

- Intensive Outpatient (ASAM Level 2.1);
- Partial Hospitalization (ASAM Level 2.5);
- ASAM Level 3 residential services (ASAM Level 3.1, 3.3, 3.5, 3.7);
- ASAM Level 4 inpatient hospital services (ASAM Level 4.0); and,
- Peer Support Services.

Authorizations may be approved retroactively based on established provider enrollment contractual requirements after a provider has engaged a Member in treatment to promote immediate entry into withdrawal management processes and addiction treatment. The Contractor shall respond to the provider's service authorization submission via the ARTS uniform service authorization request form with the results of the Contractor's independent assessment within seventy-two (72) hours for requests for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1 and 2.5) as well as Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7). The Contractor must respond to the provider's service authorization submission via the *ARTS Uniform Service Authorization Request Form* within twenty-four (24) hours for requests for placement in Inpatient Hospitals at ASAM Level 4.0.

The Contractor shall employ an ARTS Care Coordinator who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner or registered nurse with clinical experience in treatment of substance use disorder. The ARTS Care Coordinator shall perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0). The ARTS Care Coordinator shall also provide clinical care coordination as defined in this Contract.

7.2.AA.VI Pharmacy

The Contractor shall be responsible for covering all Food and Drug Administration (FDA) approved drugs for Members based on the Department's approved fee-for-service clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the DMAS website at:

https://www.virginiamedicaidpharmacyservices.com. The Contractor is expected to meet all other requirements as set forth in the *Pharmacy* section of this Contract.

The Contractor or its Pharmacy Benefit Manager, at a minimum, will cover all DMAS Preferred Drug List (PDL) "preferred" non-opioid pharmacologic therapies for pain. The Contractor shall cover naloxone injection and nasal spray without restrictions for all Members. The DMAS PDL can be accessed at https://www.virginiamedicaidpharmacyservices.com. The Contract shall assure that coverage is no more restrictive than the applicable DMAS PDL requirements and that no additional service authorization criteria, quantity limits or clinical edits are applied.

The Contractor shall utilize the Department's approved service authorization criteria and quantity limits for methadone, short-acting opioids, long-acting opioids and buprenorphine containing products when evaluating benefit coverage. DMAS approved service authorization forms can be accessed at https://www.virginiamedicaidpharmacyservices.com/asp/authorizations.asp. The Contractor shall not place additional service authorization criteria, quantity limits or other clinical edits on these drugs.

The Contractor shall be responsible for complying with the DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria can be found in the DMAS Provider Memo dated December 1, 2016 titled "Implementation of CDC Guideline for Prescribing Opioids for Chronic Pain – Coverage of Non-Opioid Pain Relievers and Uniform, Streamlined Prior Authorization for New Opioid Prescriptions Effective December 1, 2016".

The Contractor shall cover buprenorphine containing drugs, naltrexone, and methadone when provided as part of Medication Assisted Therapy (MAT) program which includes psychosocial therapy at rates no less than the Medicaid Fee-for-Service fee schedule in place at the time of service.

The Contractor shall allow prescriptions for buprenorphine containing drugs written by providers of organizations that are credentialed by the Contractor as an Office Based Opioid Treatment (OBOT) provider to by-pass all service authorization requirements.

The Contractor shall allow prescriptions for methadone and buprenorphine containing drugs written by providers of organizations that are credentialed by the Contractor as an Opioid Treatment Program to by-pass all service authorization requirements.

The Contractor shall ensure all orders, prescriptions, or referrals for items, or services for Members originate from appropriately licensed practitioners. The Contractor must credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to Medallion 3.0 program Members. All claims for payment for ordered or referred drugs, items or services must include the NPI of the ordering or referring physician or other professional. If the NPI is not provided on the

claim for payment of the ordering or referring provider is not credentialed by the Contractor, the Contractor may deny the claim.

7.3 NON-COVERED & PROHIBITED SERVICES

Except where explicitly stated in the Contract, the Contractor is not responsible for covering DMAS non-covered Home and Community Based waivered services described in 12 VAC 30-50-450, 12 VAC 30-120-211 through 30-120-249. Medicaid non-covered services are those services not covered by the Department and, therefore, not included in the covered services as defined in the Virginia State Plan or State regulations, except if ordered as a result of an EPSDT screen or high-risk pregnancy screen.

7.3.A List of Medicaid Non-Covered Services

Some, but not all, Medicaid non-covered services are listed below:

7.3.A.I Chiropractors

Services rendered by chiropractors, as set forth in 12 VAC 30-50-150.

7.3.A.II Christian Science nurses

Services of Christian Science nurses, as set forth in 12 VAC 30-50-300(B).

7.3.A.III Experimental/Investigational Procedures

Any procedure that is experimental or investigational, as defined by the Department, as set forth in 12 VAC 30-50-140. Clinical trials are not always considered to be experimental or investigational, and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.

7.3.A.IV Erectile Dysfunction Drugs

Coverage of drugs for the treatment of erectile dysfunction.

7.3.A.V Incarcerated members

Services provided to inmates/incarcerated members enrolled with the Contractor. Individuals on house arrest are not considered as incarcerated. The Contractor shall report to the Department any members it identifies as incarcerated, within forty-eight (48) hours of knowledge (See the Managed Care Technical Manual).

7.3.B Abortions

Under the terms of this Contract, the Contractor shall not cover services for elective abortion. This includes any related services performed at the immediate time of the abortion. The Commonwealth will be responsible for payment of these services. The Contractor shall provide coverage for any necessary follow-up medical care, per the requirements in this contract that may be needed in relation to the abortion services performed.

7.3.B.I Annual Abortion Data Verification Submission

The Contractor shall submit to the Department annually, and upon request, a report detailing any claims for abortion services and related codes. The specific codes, services, and format for the submission will be communicated by the Department in the Managed Care Technical Manual.

7.3.C Assisted Suicide Funding Restriction Act of 1997- Prohibited Service

Under the terms of this Contract and the Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.), the Contractor shall not cover services related to assisted suicide, euthanasia, or mercy killings, or any action that may secure, fund, cause, compel, or assert/advocate a legal right to such services.

7.4 ENHANCED SERVICES & STATE PLAN SUBSTITUTED SERVICES

7.4.A Enhanced Services

Enhanced services are those services offered by the Contractor to members in excess of covered services. Nothing in this Contract shall preclude the Contractor from providing additional health care improvement services or other services not specified in this Contract, including but not limited to chiropractic care, step down nursing care, and psychiatric care provided in a freestanding psychiatric hospital, as long as these services are available, as needed or desired, to members. No increased reimbursement will be made for additional services provided by the Contractor under this Contract. The Contractor must inform the Department at least thirty (30) calendar days prior to implementing any new enhanced services and prior to implementing revisions to existing enhanced services. The Contractor must report the enhanced services it offers at start up, upon revision or upon request. Enhanced services for step-down care or adult psychiatric care provided in a free-standing psychiatric hospital may not be used to substitute for state plan covered services.

Enhanced services offered by the Contractor are listed in the Department's Managed Care Program comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services should be made only at open enrollment. However, the Contractor may revise enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts. The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to members during the contract year for rate setting purposes.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services which have been included in the response to the RFP or have since been added by the Contractor and approved by the Department.

7.4.B State Plan Substituted (In Lieu of) Services

The Contractor may provide alternative services or services in settings that are not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services that are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). Such services shall comply with Federal requirements described in 42 CFR §438.3(e)(2). The Contractor shall not require a Member to use a state plan substituted service/"in lieu of" arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

For individuals aged twenty-one (21) through sixty-four (64), and in accordance with 42 CFR §438.6(e), the Department will make a monthly capitation payment to the Contractor for coverage of a Member receiving inpatient treatment in an Institution for Mental Diseases, as defined in 42 CFR §435.1010, only within the following guidelines:

1) The Member elects such services in an IMD as an alternative to otherwise covered settings for such services;
2) The facility providing services is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services;
3) The length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly capitation payment;
4) The provision of inpatient psychiatric or substance use disorder treatment in an IMD meets the requirements for *in lieu of services* as described above and in 42 C.F.R.§438.3(e)(2).

The Contractor shall refund the full capitation payment paid by the Department for any treatment provided to the Contractor's Member in an IMD where the length of stay in the IMD exceeds fifteen (15) days during the period of the monthly capitation payment. The fifteen (15) calendar day limit does not apply to IMD treatment for substance use disorders; reference Section 7.2.AA "Addiction and Recovery Treatment Services (ARTS)."

7.5 CARVED-OUT & EXCLUDED SERVICES

7.5.A Carved-Out Services:

The following services are carved-out services:

7.5.A.I Community Mental Health Rehabilitative Services (CMHRS)

The subset of non-traditional behavioral health services that are covered by the Department's BHSA in accordance with the Department's established criteria and guidelines (See Section 7.2). Additional information on these services is available on the DMAS website, under the Behavioral Health Services tab, or at: http://www.dmas.virginia.gov/Content_atchs/obh/cmhrs-info.pdf , on the DMAS Provider Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal and on the Behavioral Health Services Administrator website at: http://www.MagellanofVirginia.com

The Department's BHSA shall cover community mental health rehabilitative services, including: crisis intervention, crisis stabilization, intensive in-home, therapeutic day treatment for children under age twenty-one (21), day treatment/partial hospitalization for adults, mental health skill-building services, psychosocial rehabilitation, intensive community treatment, mental health and substance abuse targeted case management and treatment, foster care case management, substance abuse residential treatment for pregnant women, substance abuse day treatment for pregnant women, substance abuse intensive outpatient, EPSDT behavioral therapy, and residential treatment for children under age

twenty-one (21) (Levels A, B, and C) for Medicaid members. Transportation and pharmacy services necessary for the treatment of substance abuse services, including carved out services are the responsibility of the Contractor. Inpatient substance abuse treatment is not covered except through EPSDT.

7.5.A.II School health services

Defined as medical and/or mental health services through the child's individualized education program (IEP). These services include physical therapy, occupational therapy, speech therapy, psychological and psychiatric services, nursing services, medical evaluation services, and IEP-related transportation on specifically adapted school buses. The services are rendered in a public school setting and included on the child's IEP. All school health services that are rendered in a public school setting or on school property, (including Head Start) and included on the child's IEP (except those noted below) are carved out of this Contract and are reimbursed directly by the Department.

<u>The following services provided on school grounds may be covered by the Contractor</u>:

7.5.A.II.a Services performed by an in-network clinic, FQHC, RHC, or medical facility housed on school grounds and providing covered medical and/or behavioral health services;

7.5.A.II.b Well-child screenings and/or immunizations performed by a registered nurse or nurse practitioner employed by the school system in Department-identified provider shortage areas.

7.5.A.II.c Services performed within a private school or day care setting except Early Intervention Services as defined in this Contract.

The MCO cannot directly reimburse a nurse practitioner for services rendered if not operating within the licensing requirements defined in 18 VAC 90-30-10 et seq.

The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies

7.5.A.III Targeted case management services

Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with intellectual disability; individuals with intellectual disability and related conditions participating in home- and community-based care waivers; the elderly; and members of Auxiliary Grants as provided in 12 VAC 30-50-420 through –470.

7.5.A.IV Lead Investigations by local health departments

Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of eligible children who have been diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227.

7.5.A.V Abortions

Elective abortions that are referenced in Public Law 111-8, as is written at the time of the execution of this contract. See Section 7.3.B.

7.5.A.VI Dental Services

Dental Services as set forth in 12 VAC 30-50-190.

7.5.A.VII Specialized infant formula

Specialized infant formula and medical foods for members under age twenty-one (21).

7.5.A.VIII Private duty nursing (PDN)

Private duty nursing services when provided through HCBS waivers covered in 12 VAC 30-50-170, 12 VAC 30-120-211 through 30-120-249, or when provided at school.

7.5.A.IX Personal care services.

7.5.A.X Home and Community-Based Medicaid Waivers

Services provided under the home and community-based Medicaid waivers (Individual and Family Developmental Disabilities Supports/Family and Individual Supports, Intellectual disability/Community Living, Elderly or Disabled with Consumer Direction, Day Support/Building Independence, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

7.5.A.XI Early Intervention Services

Early Intervention services as described in Section 7.5.C of this Contract.

7.5.A.XII Therapeutic Foster Care (TFC)

Therapeutic Foster Care as authorized by the Department.

7.5.A.XIII Behavioral Dietary Counseling (Medicaid Works)

Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease, currently only available for Medicaid Works members.

7.5.A.XIV Part C of Individuals with Disabilities Education Act

Certain members between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et. seq.), who are granted an exception by the Department. The member remains enrolled in Medallion 3.0, but the service is carved out.

7.5.B Behavioral Therapy under EPSDT

Behavioral Therapy under EPSDT may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Behavioral Therapy under EPSDT services are available to individuals under twenty-one (21) years of age, who meet the medical necessity criteria described in the EPSDT Supplement on Behavioral Therapy Program. The need for behavioral therapy must be identified by the child's physician, nurse practitioner, or physician assistant through an inter-periodic/problem-focused visit or an EPSDT screening/well-child visit.

Therapy services are provided within the everyday routines and activities in which families participate, and in places where the family would typically spend time to ensure that the family's daily life is supported, such as a home environment.

The Contractor is not required to provide coverage for Behavioral Therapy under EPSDT services for children who are enrolled in Medicaid MCOs. Behavioral Therapy under EPSDT

must be service authorized and billed through the Department's Behavioral Health Services Administrator (BHSA), and not through the MCO.

7.5.C Early Intervention

Early Intervention (EI) services are designed to meet the treatment needs of an infant or toddler up to age three (3) with developmental delay in one or more areas of development (physical, cognitive, communication, social or emotional, or adaptive). Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can be the child's home or a community based setting in which children without disabilities participate. EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP) which addresses the developmental needs of the child while also enhancing the capacity of families to meet those developmental needs through family centered treatment.

In October, 2009, the Department, working collaboratively with DBHDS, implemented a restructured EI program requiring providers to be trained and certified by DBHDS, and requiring providers to bill using newly established EI specific fee-based procedures codes. The restructured EI program is designed to effectively provide the necessary EI services, including developmental supports, therapies and services to EI enrolled children in natural environment settings, while ensuring compliance with Federal Part C payor of last resort requirements.

The Contractor is not required to provide coverage for Early Intervention services. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines described in 12 VAC 30-50-131. Early Intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

The Contractor shall cover other medically necessary rehabilitative/developmental therapies within EPSDT guidelines and as described in Section 7.1.D of this Contract, including for EI enrolled children where appropriate. Refer to Section 7.1.O.III, Children and Youth with Special Health Care Needs and Section 7.7 for related assessment and case management requirements.

Below are some examples/parameters for when services could fall under Outpatient Rehab instead of under EI benefits:

- When the parent elects to have outpatient treatment versus EI therapy;
- When there is not an EI provider available but there is a facility based provider available to do the physician's ordered, medically necessary therapy. For example, the child may receive PT and OT in the natural environment under EI, but needs speech language pathology in the facility – for example in a feeding clinic; and,

- Where the child suffers an acute injury during EI, where there is a medical need for outpatient rehab instead of or in addition to EI, including where the type of therapy/treatment provider is not available under the EI treatment model.

7.5.D Service Exclusion Criteria

Members who receive any of the following services shall meet the criteria for exclusion from the Medallion 3.0 Program. Once the Contractor determines that a member is receiving these services and notifies the Department, the Department will begin the process to exclude the member. Until the Department has excluded the member, the Contractor is responsible for covering services for that member. <u>However, in no event is the Contractor responsible for provision of the following services, which will be reimbursed by the Department</u>:

7.5.D.I Home and Community-Based Services

Services for members with intellectual disability and related conditions, including case management, who are participants in the Home and Community Based Services are carved out as set forth in 12 VAC 30-50-450, 12 VAC 30-120-70 through 30-120-249.

7.5.D.II Plan First

Services for members in the Plan First, Family Planning Program

7.5.D.III Inpatient Mental Health in State Psychiatric Hospital

Inpatient mental health services rendered in a State psychiatric hospital, as set forth in 12 VAC 30-50-230 through 12 VAC 30-50-250.

7.5.D.IV Hospice Services

Hospice services defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in 42 C.F.R., Part 418 and as set forth in 12 VAC 30-50-270.

7.5.D.V Nursing Facility Care

Nursing facility care, as set forth in 12 VAC 30-50-130.

7.5.D.VI Residential Treatment Facility (RTF)

DMAS authorized level C Residential Treatment Facility (RTF) programs as authorized by the Department.

7.5.E Long-Term Care Waiver Services Provided to Members of the Health and Acute Care Program (HAP)

The Medicaid home and community-based waivers are programs offered to eligible individuals who require assistance with activities of daily living and/or supportive services and would prefer to live in their own home or the community rather than in a facility setting.

Individuals participating in the HAP program shall have services provided under the home and community-based waiver reimbursed under the fee-for-service delivery system. This includes transportation to waiver related services.

Individuals participating in the HAP program will transition from the Medallion 3.0 to the CCC Plus program during the CCC Plus regional launch. See section 7.7.E.IV of this Contract.

7.6 COORDINATION AND CONTINUITY OF CARE

7.6.A Generally

In accordance with 42 C.F.R. § 438.208, the Contractor shall have systems in place that ensure coordinated patient care for all members and that provide particular attention to the needs of members with complex, serious and/or disabling conditions. The systems, policies, and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers.

The Contractor's coordination and continuity of care systems shall include provisions for all of the following processes:

7.6.A.I Primary Care

In accordance with 42 C.F.R. §438.208 (b), members must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. The member must be provided information on how to contact their designated person or entity.

7.6.A.II Coordination/Prevention of Duplicate Services

The Contractor's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.

7.6.A.III HIPAA, Member Privacy, and Health Records

The Contractor shall ensure that the process utilized to coordinate the member's care complies with member privacy protections described in HIPAA regulations and in Title 45 C.F.R. parts 160 and 164, subparts A and E, to the extent applicable.

Under 42 C.F.R.§ 438.208(b)(6), the Contractor shall ensure that each provider furnishing services to the member maintains and shares a member health record in accordance with professional standards.

7.6.A.IV Clinically Qualified Providers

The Contractor's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The Contractor shall submit to the Department prior to signing the initial contract, upon revision or on request referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

7.6.A.V Communication for Members with Disabilities

The Contractor shall require their contracted providers to ensure that members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.

7.6.A.VI List of Referral Sources

The Contractor shall have in place a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, MCOs shall provide discharge planning and/or coordination with long-term care service

providers for members who are being enrolled in home and community based care waivers or nursing facilities to assure continuity of care.

7.6.A.VII Coordination Procedures

In accordance with 42 C.F.R.§ 438.208(b), the Contractor must implement procedures to coordinate:

- The services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
- The services the Contractor furnishes to the member with the services the member receives from any other MCO.
- The services the Contractor furnishes to the member with the services the member receives in fee-for-service Virginia Medicaid.
- The services the Contractor furnishes to the member with the services the member receives from community and social support providers.

7.6.A.VIII Assessments

- In accordance with 42 C.F.R.§ 438.208(b)(3), the Contractor shall:Make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members.
- Make subsequent attempts to conduct an initial screening of each new member's needs if the initial attempt to contact the member is unsuccessful.

In accordance with 42 C.F.R.§ 438.208(b)(4), the Contractor shall share with the Department or other MCOs serving the member the results of any identification and assessment of the member's needs to prevent duplication of those activities.

7.6.B Outreach and Case Management

The Contractor shall provide local outreach and case management to its membership. Case management shall be provided through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise. **The Contractor shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor.** Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Medicaid members' case management needs at all times. In accordance with 42 C.F.R. § 438.66, the Contractor must submit medical management committee reports and minutes to the Department.

7.7 ASSESSMENTS & ADDITIONAL REQUIREMENTS FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS

7.7.A Populations Requiring Assessments

In accordance with 42 C.F.R. § 438.208, the Contractor must take all reasonable steps to assure that the following newly eligible/enrolled populations receive an assessment:

- Children and Youth with Special Health Care Needs (CYSHCN), including Early Intervention, Health and Acute Care Program children, and Adoption Assistance children,

- Foster Care children, as described in Section 7.1.O.III ARE EXCLUDED. Foster Care children will be evaluated on a sixty (60) day timeframe for the purpose of the Performance Incentive Awards, as outlined in Section 8.5 and the accompanying section of the MCTM,

- Health and Acute Care Program Members, pursuant to Section 7.7.E of this Contract, and identified by benefit package indicators, and
- Any members deemed aged, blind, or disabled.

Please note that Assessment provisions specific to high-risk pregnant women, with different requirements and thresholds, are found in Maternity Care, in, Section 8.7 of this Contract.

7.7.B Assessment Timeframes:

The Contractor shall take steps to assure that newly eligible/enrolled members requiring assessment as defined in 7.7.A, are assessed within sixty (60) calendar days of initial enrollment.

A monthly report of new members, noting who received a successful assessment must be submitted to the Department as specified in the Managed Care Technical Manual. A successful assessment is considered a contact with the member, by the health plan, which results in a fully completed health assessment that meets the requirements of this Section. A fully completed assessment must assess health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs and have all applicable questions completely answered.

7.7.C Assessment Thresholds and Completeness

The chart below illustrates the Department's thresholds for completion of an assessment for all members referenced in Section 7.7.A.

Timeframe, beginning on day member meets criteria of Section 7.7.A	**% of Required Members who must receive Completed Assessments during the Timeframe**
60 days	50%
90 days	75%
120 days	85%
After 120 days	Exception Report listing unassessed members and a reason the member did not receive an assessment.

The Contractor must submit reports documenting assessed members for the sixty (60), ninety (90), and one hundred and twenty (120) day timeframes listed above. The Exception Report due after day one hundred and twenty (120) should include only those remaining unassessed members. Details and specs of those reports are available in the MCTM.

7.7.D Annual Assessment Plan for Members

The Contractor must develop and maintain a program to address and improve the care and access of services among members requiring assessments. The Department will audit

compliance with this requirement and will request copies of monitoring activities, utilization outcomes, and completed assessments.

The Contractor shall submit an annual plan to the Department for approval by September 30th of each year outlining its assessment plan for the contract year. The submission must include its assessment tool, and include all populations referenced in Section 7.7.A. In addition to requesting specific member assessment information, the Department may request a random sampling of completed member assessments to assure the Contractor's compliance with this requirement.

The Contractor must develop and maintain a system of assessment procedures for identifying members with special health care needs (children and adults), including people with disabilities, or chronic or complex medical and behavioral health conditions, and Children and Youth with Special Health Care Needs. The assessment procedures must be consistent with the requirements of Section 7.1.O.III, and 7.7.A. The Contractor should include in its plan how it will educate and inform members who are not complying with the EPSDT periodicity and immunization section, per Section 7.1.D.V.b.

The Contractor shall make every reasonable effort to comply with the Health Plan Assessments requirements detailed in this Contract. The Contractor shall meet the reporting requirements for assessments as detailed in the Managed Care Technical Manual. [42 C.F.R. § 438.208(c)(3)-(4)]

7.7.E Health and Acute Care Program (HAP)

7.7.E.I Health and Acute Care Program (HAP) and Managed Care Expansion

The Department hereby continues its commitment to expanding the care coordination services offered by MCOs through the Acute and Long-Term Care Integration (ALTC – Phase 1) program to also include some home and community-based waiver individuals previously excluded from managed care. Collectively, these members will be known as the Health and Acute Care Program (HAP) population.
Under ALTC- Phase 1, if an MCO enrolled Medicaid member subsequently becomes eligible and enrolled into one (1) of five (5) home and community-based waivers, the member remains enrolled with the MCO for acute and primary care services. All long-term care waiver services are covered under the Department's Fee-For-Service waiver program. This process shall continue under the HAP.

The Department enrolls Medallion 3.0-eligible individuals participating in the Elderly or Disabled with Consumer-Direction (EDCD) waiver into managed care for primary medical and acute care services only. The Contractor shall authorize and provide acute and primary medical care services, pharmacy related services, and transportation to medical appointments. The provision of long term care waiver services as well as transportation to wavier services, long term care (LTC) waiver enrollments and authorization for LTC waiver services will be handled under the current processes and will be paid through the Department's Fee-For-Service system. See Section 7.5 for more information on carved-out services.

7.7.E.II Coordination of Care for Acute Care Services Only

The Contractor shall **not** be responsible for the coordination or case management of the Long-Term Care waiver services the member receives in conjunction with the acute and primary care services the Contractor provides the member. The Contractor is only responsible for the coordination and case management of the medical and acute care services it provides to the member.

7.7.E.III Reporting Requirements

All HAP members shall be included on existing managed care reporting, but shall be clearly identified as HAP members pursuant to the requirements in the Managed Care Technical Manual.

7.7.E.IV HAP Transition to CCC Plus

HAP individuals in the Medallion 3.0 will transition to the CCC Plus program during the CCC Plus regional launch. The Contractor will no longer provide acute care services for HAP members after the regional phase- in is completed. The reporting requirements for HAP members will end after the regional phase- in.

Date	Region	Population
August 2017	Tidewater; including CCC opt-outs	Duals not in CCC HAP from Medallion 3.0 LTSS Populations
September 2017	Central; including CCC opt-outs	HAP from Medallion 3.0 LTSS Populations
October 2017	Charlottesville/Western; including CCC opt-outs	HAP from Medallion 3.0 LTSS Populations
November 2017	Roanoke/Alleghany; including CCC opt-outs	HAP from Medallion 3.0 LTSS Populations
November 2017	Southwest; including CCC opt-outs	HAP from Medallion 3.0 LTSS Populations
December 2017	Northern/Winchester; including CCC opt-outs	HAP from Medallion 3.0 LTSS Populations
January 2018	Remaining populations, including ABDs and individuals enrolled in the CCC program.	

7.8 VALUE-BASED PAYMENTS (VBP)

7.8.A BACKGROUND

Value Based Payment (VBP) is a broad set of payment strategies intended to improve quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. The Contractor shall maintain a VBP strategy that follows the Alternate Payment Model (APM) framework in the Final White Paper developed by the Health Care Payment Learning and Action Network

(HCP-LAN) with a special emphasis on development, adoption, and provider readiness for models under categories three (3) and four (4). The White Paper can be accessed at https://hcp-lan.org/2016/01/final-apm-framework-white-paper/.

7.8.B CONTRACTOR VBP PLAN

The Contractor's policies and procedures shall have a VBP Plan for achieving and progressing VBP arrangements among Medicaid Members. The VBP Plan, as specified in the *Managed Care Technical Manual* and below, shall cover the current status and the strategies for the entire eighteen (18) months of this contract and address how the Contractor would expect to maintain, expand, and enhance VBP arrangements during this period. After establishing the original VBP Plan, the Contractor's VBP Plan shall be updated and resubmitted to the Department by March 30, 2018 to reflect lessons learned and necessary modifications following the first six (6) months of implementation under this Contract. Such revisions shall align with the Department's Value-Based Payment Roadmap (currently under development). The Contractor's VBP Plan shall, at a minimum, include:

1) Current State Review:
   a. A detailed description of all APMs the Contractor is currently using with its provider network, by provider type and line of business, and the HCP-LAN APM framework category/sub-category in which the APM best fits (e.g., 2, 3, or 4);
   b. To the extent an APM has been in place for greater than twelve (12) months, the Current State Review should include lessons learned and initial results following implementation (to the extent such data are available) and,
   c. For the APMs identified above, the percentage of the Contractor's total and Medicaid-specific medical expenses expected to be paid under each type of APM model in the eighteen (18) month contract period (as well as a comparison of this percentage with an estimate of prior calendar year expenditures of the same, which would cover January 1, 2016 through December 31, 2016), including what methodology and number the Contractor is using for the numerator and denominator and the types of services (e.g., primary and acute, behavioral health, and others) included in the numerator and denominator. Numerators and denominators should include all relevant medical spending associated with members covered under APM arrangements, including covered drug spending.

2) Provider Readiness, Performance Review, and Communication
   a. Assessment of provider readiness for VBP within the Contractor's provider network;
   b. Methods and frequency for collection and assessment of performance data from providers; and,
   c. Communication and collaboration approach with providers on reviewing performance and defining strategies for improvement.

3) Strategy and Alignment
   a. Three (3) APM strategies expected to be most effective for services and populations most relevant to this Contract, including how the APMs will serve to improve Member outcomes and experience without increasing associated spending. An assessment of how

such strategies are expected to impact Members' consumption of services and associated spending;

b. Specific objectives for APM implementation, including scope, provider performance, stakeholder engagement, and a timeline for implementation related to each of the proposed APM approaches; and,
c. Relationship to the Contractor's commercial VBP strategy and/or other payers, such as Medicare, in the Virginia health care marketplace and discussion of how these VBP strategies align with planned VBP efforts under the Medallion program.

The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals:

- Eliminate elective deliveries before thirty-nine (39) weeks and reduce Cesarean sections
- Promote breast feeding
- Reduce all-cause hospital readmissions
- Reduce emergent psychiatric admissions to acute care hospitals
- Reduce hospital admissions for chronic disease complications
- Encourage appropriate use of antibiotics
- Reduce adverse drug events for patients on long-term medications

The VBP Plan shall include a separate section addressing each of these subject three (3) areas and shall include sufficient detail that it could serve as a standalone business plan for the adoption, maintenance, enhancement, and/or expansion of VBP arrangements over the course of the Contract. The Contractor shall provide its initial VBP Plan for approval by the Department by September 30, 2017. The Contractor's VBP Plan shall be updated and resubmitted to the Department by March 30, 2018 to reflect lessons learned and necessary modifications following the first six (6) months of implementation under this Contract and to achieve both Contractor and Department goals to advance VBP. The Department reserves the right to request further revisions to the Contractor's VBP Plan to align with the Department's Value-Based Payment Roadmap (currently under development). These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives in which Medicaid is a participant (i.e. multi-payer alignment of incentives across Medicare, Medicaid, and commercially insured populations in Virginia). The VBP Plan and subsequent revisions shall be approved and signed by the Contractor's Chief Financial Officer or equivalent executive charge with oversight of the Contractor's provider payment arrangements.

7.8.C VBP STATUS REPORT

In tandem with creation and update of the Contractor's VBP Plan, the Contractor shall submit a VBP Status Report which includes details of its VBP initiatives. At a minimum, the Contractor shall include the following information for each VBP initiative as specified in the *Medallion 3.0 Reporting Manual* and below:

1) VBP Category (and applicable subcategory) (using the HCP-LAN model);
2) Short Description (including brief discussion of associated performance measures);
3) Goal(s) and measureable results;
4) Description of targeted providers and number of providers eligible and participating;
5) Description of targeted Members, number of eligible Members whose services are covered by VBP initiative, and number of participating Members;

6) Total plan payments for medical services (including drug spending) under the Medallion program (i.e. the Contractor's total medical spend for Medallion Members);
7) Total payments to providers for services covered in VBP initiative;
8) Total potential payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative; and,
9) Potential overlap with other VBP programs or initiatives.

The VBP Status Report shall include completion of items one (1) through nine (9) separately for both the current status of the Contractor's VBP efforts and the estimated status as of December 31, 2018 assuming successful implementation of the Contractor's VBP plan.
The VBP Status Report shall be due on the same date as the VBP Plan (September 30, 2017) and may be revised, to the extent necessary, with submission of the updated VBP Plan on March 30, 2018. Additionally, a final version of the Status Report shall be due to the Department by December 31, 2018 indicating the state of items one (1) through nine (9) as of the end of the contract period (or as close an estimate as is reasonable to develop by this time). The VBP Status Report and subsequent revisions shall be approved and signed by the Contractor's Chief Financial Officer or equivalent executive charge with oversight of the Contractor's provider payment arrangements.

7.8.D CONTRACTOR HCP-LAN APM DATA COLLECTION SUBMISSION

The Department will use measurement methodologies developed by HCP-LAN, though the Department is not limited exclusively to these measurement methodologies (see https://hcp-lan.org/groups/apm-fpt/national-apm-data-collection-effort/). DMAS will use the measurement methodologies as the framework for VBP. By July 31, 2017, each Contractor shall complete the Medicaid APM data collection tool for the twelve (12) months of calendar year 2016. The draft data collection tool is at https://hcp-lan.org/workproducts/Medicaid-Category-Metrics.pdf. By September 30, 2018, each Contractor shall resubmit the Medicaid APM data collection tool for the twelve (12) months covering July 1, 2017 through June 30, 2018. These submissions are meant to assess Contractor progress in establishing, maintaining, and expanding VBP arrangements among Medallion Members. Contractor submissions should include numerators and denominators that account for all relevant spending for medical services, including drug spending. The Contractor's HCP-LAN APM Data Collection Submission shall be approved and signed by the Contractor's Chief Financial Officer or equivalent executive charge with oversight of the Contractor's provider payment arrangements.

The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals:

- Improved birth outcomes
- Appropriate efficient utilzation of high-cost, high-intensity clinical settings
- Reduce all-cause hospital readmissions
- Reduce hospital admissions for chronic disease complications

7.9 MEDALLION CARE SYSTEM PARTNERSHIP (MCSP)

The Department established the Medallion Care System Partnership (MCSP) with the goal of improving health outcomes for Medicaid members through a system designed to integrate primary, acute, and complex health services provided by contracted MCOs through Health Care Homes or other MCSP approved arrangements. The MCSP model allows the Contractor the flexibility to create and test innovative payment models, incentive structures and arrangements, and value-and-market-based programs within geographic areas, particular populations, or even at the physician practice level to determine how to bend the cost curve while improving quality.

The Contractor must form partnerships with providers and/or health care systems in an effort to increase participation of integrated provider health care delivery systems, improve member health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and member experience.

As part of this MCSP arrangement, the Contractor shall enter into contractual Health Care Home arrangements that include:

- Gain and/or risk sharing,
- Performance-based incentives, and/or
- Other incentive reforms tied to Commonwealth-approved quality metrics and financial performance.

7.9.A Health Care Home (Formally Patient Centered Medical Home)

To qualify as an MCSP initiative, the Contractor's provider network must incorporate and be comprised of local medical groups (including individual medical providers) that meet the Health Care Home principles outlined below. The Health Care Home designation shall demonstrate adherence to the core set of Medical Home principles, such as the following:

- Demonstrated leadership;
- Team-based approach to care;
- Population risk stratification and management;
- Practice-integrated care management;
- Enhanced access to care;
- Behavioral-physical health integration;
- Connection to community resources;
- Commitment to reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services;
- Integration of health information technology; and,
- Inclusion of patients and families in implementation of the PCMH model; and
- Provider recognition for improved outcomes.

In addition, the Contractor (via its Health Care Homes) must address complex and chronic health conditions by:

- Identifying and monitoring members with complex or chronic health conditions who are enrolled in a designated MCSP/Health Care Home, and
- Assigning member enrollment in the MCSP/Health Care Home to the medical group site and identifying member-specific care needs.

7.9.A.I The MCO shall report all specified MCSP data, as defined by the Department, including specified Health Care Home Provider data**.**

7.9.B MCSP Requirements

7.9.B.I MCOs Must Operationalize at Least One MCSP

The MCO must operationalize at least one (1) MCSP. MCOs may operationalize as many additional MCSPs as it chooses, but additional MCSPs must be reported to the Department.

7.9.B.II MCSP Must Target Pediatric Populations and Coordinate Acute and/ or Behavioral Health Services

The MCSP must include pediatric care services and specifically target pediatric populations. An MCSP may also target adults. All services provided through the MCSP must be designed to individually coordinate Medicaid primary and acute care, and/or mental health services in accordance with the Contract.

7.9.B.III Quality Measure List in Attachment XV

The Department has developed a list of quality measures appropriate for populations assigned to the Health Care Home. The MCO will select measures from this list, found in Attachment XV, to link performance metrics to incentives. The MCO must select one (1) measure from Menu #1, in addition to one (1) measure from Menu #2, for each MCSP.

7.9.B.IV Provider Participation

Providers may participate in more than one (1) MCSP and may contract with more than one (1) MCO. MCOs are not required to modify or expand existing networks to establish an MCSP.

7.9.B.V Audits

The MCO must audit each MSCP annually.

7.9.C MCSP Proposals and Evaluations.

7.9.C.I Annual Proposal

The proposals shall be proposed annually, in accordance with the Managed Care Technical Manual or upon amendment; the MCO shall submit a written description of its MCSP to the Department using the proposal and evaluation template created by the Department. The Department will review each description and determine whether the MCSP criteria have been met prior to proposal acceptance and review the merits of each model upon completion of MCSP evaluation. The description of the MCSP(s) shall include:

7.9.C.I.a The service delivery and care coordination model;

7.9.C.I.b Target population, clearly indicating a focus on pediatric services;

7.9.C.I.c Current or projected enrollment numbers;

7.9.C.I.d Service area, which may be fewer counties/localities than the MCO Service Area as defined in the Contract;

7.9.C.I.e Identification of each MCSP provider, in addition to identification of those providers included in the MCSP arrangements who

are designated as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);
7.9.C.I.f The specified model options and incentive type to be used from the attached table); MCOs may combine options and incentive types within a single MCSP or use the same model in different service areas;
7.9.C.I.g The process for assigning or attributing members;
7.9.C.I.h Method that will be used for tracking cost of care or total costs of care as needed to implement the model chosen;
7.9.C.I.i The MCO's process for monitoring and evaluating the MCSP performance; and
7.9.C.I.j The benchmarks or standards used to determine whether the Provider entity is effectively managing performance and costs of care.
7.9.C.I.k Evaluations must provide the same information as proposals, as well as a comprehensive review of the MCSP in terms of quantitative data, financial incentive relationship with quality, and substantive policies/procedures analysis to determine the successes and/or failures of the MCSP models selected the previous year. The evaluation submitted to the Department should not exceed fifteen (15) pages in total length, with more detailed information available to the Department upon request.

7.9.D MCSP Payment Types.

7.9.D.I Incentives and Performance Results

The MCSP subcontracts must establish incentives. Performance results must be reported annually to the Department. The MCO will provide data necessary to verify reported results upon request.

7.9.D.II Requirements

Care Coordination, quality metrics, financial performance measures, Department review and acceptance, and reporting requirements are required for each payment type.

7.9.D.III MCSPS Payment Types

The following table outlines MCSP model options and payment types:

MCSP Payment Types

The Contractor must implement one (1) MCSP. Accordingly, the quality measures selected must coincide with the model MCSP selected by the Contractor, as indicated in this chart.

	Payment Types	Type A	Type B	Type C	Type D
Model Options		Performance rewards: performance pool or pay for performance	Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Alternative Proposals

MCSP Payment Types The Contractor must implement one (1) MCSP. Accordingly, the quality measures selected must coincide with the model MCSP selected by the Contractor, as indicated in this chart.					
	Payment Types	**Type A**	**Type B**	**Type C**	**Type D**
Model 1.1	MCO contracts with Primary Care Providers	OPTION "1.1.A"	NA	NA	NA
Model 1.2	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees.	NA	OPTION "1.2.B"	NA	NA
Model 2	MCO contracts with provider Care System or a collaborative (primary care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/ performance payment models across services	NA	NA	OPTION "2.c"	NA
Model 3	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes	OPTION "3.A"	OPTION "3.B"	OPTION "3.c"	NA
Model 4	Alternative defined by proposal	NA	NA	NA	OPTION "4.D"

7.10 BEHAVIORAL HEALTH HOME PILOT

As part of Governor Terry McAuliffe's, " A Healthy Virginia" 10-Step Plan (https://governor.virginia.gov/media/3096/a-healthy-virginia-report-final.pdf) to increase healthcare services to Virginians, the Contractor must work collaboratively with the Department, and relevant stakeholders to develop behavioral health homes for members suffering from severe mental illnesses.

7.10.A Pilot Population

The Contractor shall target adults enrolled in the Contractor's health plan who have been diagnosed with Serious Mental Illness (SMI) in a specific locality or region, as stated in Section 7.9.B, below. The Contractor may focus its behavioral health home pilot in areas where eligible members reside and where the Contractor has developed a pilot delivery system to support those members. Contractors are required to cooperate with the Department to ensure the presence of a Behavioral health home in different regions of the Commonwealth.

7.10.B Automatic Enrollment with Opt-Out in Targeted Areas

Assignment/enrollment into the behavioral health home pilot will be automatic within the available slots in a Contractor's targeted area(s). The member shall be afforded an opportunity to opt-out of the pilot. The Contractor will assign/enroll current members in its selected localities/region(s) who meet the criteria below.

7.10.C Eligibility Criteria

Eligibility will be defined by standardized criteria, as found in the MCTM.

7.10.C.I Pathways for Enrollment

An individual may meet criteria for participation in the Behavioral Health Home by any one of the following pathways:

7.10.C.I.a Medicaid Behavioral Health Medical Claims History
7.10.C.I.b High Mental Health Pharmaceutical Use
7.10.C.I.c History of Inpatient Admission to Hospital
7.10.C.I.d History of Emergency Department Use

7.10.D Models for Community Mental Health Rehabilitative Services (CMHRS Models A/B)

The Contractor must select one (1) of the following two (2) models to indicate how it will address Community Mental Health Rehabilitative Services (CMHRS), as described Section 7.2.A.I.b, and Section 7.5.A.I of this Contract.

- Model A
  - The Contractor must manage the member and authorize services during the Behavioral Health Home Pilot Initiative. Under this model, the Contractor collaborates with the Department's Behavioral Health Service Administrator (BHSA) to use the BHSA's network of providers and the BHSA is responsible for paying claims.
  - The Contractor must meet with the Department's BHSA to identify its business needs and develop two-way communication processes to ensure quality and access of care. All communication processes developed for Model A must be approved by the Department, and meet the requirements of section 7.9.E.IV, below.
- Model B
  - The Contractor will fully manage the behavioral health home pilot population for all services, including community mental health rehabilitative services, medical, pharmacy, etc. Under this model, the Contractor does not utilize the Department's Behavioral Health Service Administrator for delivery of, nor the

coordination of, non-traditional behavioral health services. Pilot members are exempt from participation with the Department's BHSA and receive all services through the Contractor.

7.10.E Behavioral Health Home Plan

The Contractor must submit its choice of model and its plan for executing the Behavioral Health Home Pilot to the Department, and receive the Department's approval. The BHH Pilot Plan must address the following elements.

7.10.E.I Selection of Model A or Model B

7.10.E.II Requirements for Network Analysis

- For Model A this requirement, requires a self-attestation from the Contractor that the network utilized through the BHSA meets the requirements of Section 7.9.
- For Model B, the Contractor shall submit its pilot network with assurances that pilot members have access to comprehensive behavioral health care based on existing time and travel distance standards.

7.10.E.III Requirements for Care Team

The behavioral health home pilot care team must include the following individuals, whose names and contact information must be submitted to the Department at the beginning of the pilot and upon changes. If membership on the Care Team will rotate, please include all members:

7.10.E.III.a Behavioral Health Home Pilot Lead
7.10.E.III.b Psychiatrist
7.10.E.III.c Case manager
7.10.E.III.d Pharmacist
7.10.E.III.e Primary Care Physician

7.10.E.IV Outreach and Marketing Plan

The Contractor will develop internal processes to educate members. The education materials must submitted annually to be reviewed by the Department and geared to obtain positive health (medical and behavioral) outcomes.

7.10.E.V Acknowledgement of Data Sharing & Reporting between the Department, the Contractor and the Department's Behavioral Health Services Administrator (BHSA)

- Assignment/enrollment in the Behavioral Health Home (BHH) pilot will be determined by the Contractor and communicated prospectively, and on a monthly basis, to the Department.
- The Contractor will identify assigned/enrolled members and provide a list of those members on a monthly basis to the Department as specified in the MCTM.
- The Contractor must submit an additional Monthly Report to the Department, as specified in the MCTM.
- The Department will broker several transactions between the Contractor and the Department's BHSA.
  - The Department will transmit the following documents to its BHSA each month upon receipt from the Contractor(s):
    - Behavioral Health Home Pilot Assignment/Enrollment Reports
      - Preliminary file with prospective enrollment, effective 7/1

        - Monthly Full replacement file
    - The Department will transmit the following documents to the Contractor each month upon receipt from the Department's BHSA:
        - Monthly Authorization file, containing services that have already been authorized
        - Transition file of past community mental health services covered by the BHSA.

7.10.E.VI Quality Measures and Quality Reporting

The Contractor is required to submit to the Department, on a monthly basis, information on the two (2) indicators of quality described below:

- Percentage of members participating in the Behavioral Health Home Pilot with at least one (1) successful contact (in person, via phone, or via telemedicine or tele-health technology) with the member's primary care physician, or, the treating psychologist/psychiatrist, the Contractor's behavioral health consultant or resident psychologist/psychiatrist, or a licensed clinical behavioral health case manager over the past month.
- Follow-up Behavioral Health Hospitalization (thirty (30) day). The Contractor is required to adhere to the HEDIS specifications for this measure, and report the measure to the Department on a monthly basis.

Details on the quality measures and details on the reporting structure and template can be found in the MCTM.

7.11 WELLNESS AND MEMBER INCENTIVE PROGRAMS REPORT

The Contractor shall, on an annual basis and in the manner detailed in the Managed Care Technical Manual, provide the Department with a report summarizing all wellness and member incentive programs used by the Contractor to encourage active patient participation in health and wellness activities to both improve member health and control costs.

8. Quality Improvement (QI) & Oversight

8.1 QUALITY IMPROVEMENT (QI), GENERALLY

The Contractor shall cooperate with the Department's quality improvement requirements to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor shall cooperate with the Department or its designated agent (EQRO) with quality improvement activities in accordance with CMS recommended protocols and the processes utilized by the Department or its designated agent.

8.2 QUALITY COLLABORATIVE

The Contractor shall participate in the Department's quality collaborative meetings such that at least one (1) member of the Contractor's quality improvement team shall participate in person as required.

8.3 QUALITY IMPROVEMENT STRUCTURE

In compliance with 42 C.F.R § 438.330, the Contractor shall provide to the Department no later than July 31st of each year, a written description of its ongoing Quality Assessment and Performance Improvement (QAPI) program. The Contractor should clearly define its quality improvement structure. The Contractor must include all of Element A: QI Program Structure and all of Element B: Annual Evaluation, located under Standards for Quality Management and Improvement from the most recent version of NCQA's Standards and Guidelines for the Accreditation of Health Plans.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 C.F.R. § 438.332 the accreditation status of each MCO will be posted to the Department's Medallion 3.0 website.

8.4 HEDIS MEASURES

The Contractor is required to consent to publication via NCQA's Quality Compass of all Medicaid HEDIS measures for the Virginia Medicaid product. In addition, the Contractor shall, at a minimum, consider the following Medicaid HEDIS performance measures as a priority. The Contractor will assure annual improvement in these Medicaid HEDIS measures until such time that the Contractor is performing at least at the 50th percentile for "HMOs" as reported by

Quality Compass. Thereafter, the Contractor is to at least sustain performance at the Medicaid 50th percentile. The Contractor is encouraged to set goals to support the Department's goal of attaining the seventy-fifth (75th) percentile for each of these measures. Beginning with HEDIS 2016, in alignment with NCQA requirements, the Contractor shall not be permitted to rotate any HEDIS measures. All measures must be calculated without rotation per NCQA technical specifications.

8.4.A Childhood Immunization Status (Combo 3)

Each vaccine must be reported separately as well.

8.4.B Comprehensive Diabetes Care (all indicators)

All indicators include: Hemoglobin A1C testing and control, retinal eye exam, medical attention for nephropathy, and blood pressure control.

8.4.C Controlling High Blood Pressure

8.4.D Medication Management for People with Asthma

8.4.E Postpartum visits

8.4.F Timeliness of Prenatal Care

8.4.G Breast Cancer Screening

8.4.H Antidepressant Medication Management

2 indicators acute phase and continuation phase

8.4.I Follow-up Care for Children Prescribed ADHD Medication

2 indicators, initiations phase; continuations and maintenance phase

8.4.J Follow-up after Hospitalization for Mental Illness

(thirty (30) day follow up only)

8.4.K Well-Child Visits in the First 15 Months of Life

8.4.L Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

8.4.M Adolescent Well-Care Visits

8.4.N Cervical Cancer Screening

8.4.O Medical Assistance with Smoking and Tobacco Use Cessation

Difference facets include: advising smokers to quit, discussing cessation medication, discussing cessation strategies.

8.4.P Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics

8.4.Q Adults' Access to Preventative/Ambulatory Health Services

8.4.R Children and Adolescents Access to Primary Care Practitioners

In conducting these HEDIS calculations, the Contractor shall use the hybrid methodology unless HEDIS technical specifications only require the use of administrative data only. Failure to use hybrid methodology may result in corrective action. The Contractor shall provide the HEDIS measures' data in Excel format.

The scores for the measure which are in effect on January 1 of the applicable contract year must be reported to the Department by July 31 of the same year. *(For example, HEDIS technical specifications used for calculating and uploading scores to NCQA in June 2017 must be reported to the Department by July 31, 2017).* In order to facilitate the Department's reporting requirements to the CMS on national measures, the Contractor is required to provide all numerators and denominators for all measures listed above.

With respect to the HEDIS measures listed above and in Section 8.5 and Section 7.9, the Contractor's scores may be publicized in a manner that ensures the results are available and understandable to the general public and actual and potential Medicaid members.

The Contractor will perform the Children and the Adult CAHPS annually. The CAHPS Adult Survey and the CAHPS Child Survey reports provided to the Department shall include detailed results for all survey items. Composite scores shall also be reported. The Contractor is required to submit their CAHPS for Children and CAHPS for Adults results to the Agency for Healthcare Research and Quality (AHRQ) for inclusion in the National CAHPS Benchmarking Database if the option is available through AHRQ. Performance on CAHPS surveys may also be publicized as described above. Beginning with HEDIS 2017, the Contractor is required to identify Spanish speaking members through administrative data and ensure those members who are included in the CAHPS sample receive the Spanish version of the survey rather than the English version.

8.4.S Other Measure, calculated by the Department's EQRO:

Measure - APP-CH Use of First- Line Psychosocial Care for Children and Adolescents on Antipsychotic.

- **Description**: Percentage of children and adolescents one through seventeen (1–17) years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment. Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration indication and are thus clinically appropriate: schizophrenia, bipolar disorder, psychotic disorder, and autism disorders. Data should be stratified by: Managed care regions; race; categories of complications/rates.

8.5 OTHER QUALITY ACTIVITIES

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the EQRO, which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for members' medical records in the format and timeframe requested by the EQRO or the Department.

The Contractor shall also submit requested information from the Department or EQRO for Performance Measure Validation, Performance Improvement Projects, and Comprehensive or Modified Operational Systems Reviews as described in this Section by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the Contractor to the Department at least one week prior to the requested due date.

8.5.A Performance Improvement Project Validation

The Contractor shall conduct annual performance improvement projects (PIPs) for validation by the EQRO, in accordance with CMS requirements in 42 C.F.R § 438.330(d). The Department shall select the topics. The Contractor shall assure effective interventions for

improving its performance on quality measures. The Department is not responsible for developing or implementing interventions for the Contractor. It is the sole responsibility of the Contractor to develop, implement, track, and evaluate the effectiveness of its own PIPs. For the August 2017 PIP submission, the emphasis will be on diabetes. The Contractor will focus on a specific diabetes measure or measures under the rapid cycle PIP process.

The measures for 2017 will be communicated by the Department to the Contractor at a time and in a format as determined by the Department. The due date for PIPs and validation shall be in accordance with the process & methodology of the Department's EQRO agent.

The Contractor must comply with any methodology for PIPs and validation, including but not limited to, rapid cycle improvement models.

8.5.B Performance Measure Validation (PMV)

To meet a CMS EQR mandated activity for validating performance measures, the EQRO will validate a select group of the Contractor's HEDIS scores on an annual basis. The measures for 2016 and 2017 will be communicated by the Department to the Contractor each year at a time and in a format as determined by the Department.

The EQRO will follow the current CMS recommended protocol for validating performance measures, "Validating Performance Measures, A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol."
New Health Plans: The timing of this requirement will be in alignment the with NCQA's timeline for the 2016 Standards and Guidelines for Accreditation of Health Plans. The first performance measure validation will occur the same year as the "First" NCQA evaluation option, which would occur during year three (3) of the health plan delivering care to Virginia Medicaid members. However, all MCOs that are not accredited and receive a comprehensive onsite review from the EQRO this contract year should expect the EQRO to review the MCOs data validation capabilities during the IS assessment.

8.5.C Operational Systems Review (OSR)

Once every three (3) years, the Contractor shall cooperate with and allow the EQRO to perform an onsite review of each of the MCO's operational systems as mandated by CMS through 42 C.F.R. §438.358 (b)(iii).

During the years when the comprehensive OSR is not conducted, the Department may convene a team of internal subject matter experts or contract with the EQRO to perform a "modified-OSR" of the Contractor. The modified-OSR will focus on those elements identified during the most recent OSR as needing improvement and any critical elements of the MCO contract that may need focused attention. The following schedule reflects the OSR schedule:

- Comprehensive OSR during calendar year 2017
- Modified OSR during calendar year 2018

For all modified and comprehensive operational system reviews, the Contractor shall adhere to the timelines and tasks set forth by the EQRO or the Department.

8.5.D Coordination of QI Activity with Other Management Activity and Publication of Results

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels.

QI activities shall be coordinated with other performance monitoring activities, including the monitoring of members' grievances and appeals and shall reflect the most current requirements of NCQA.

As required by CMS per 42 C.F.R. § 438.334 to publish a quality rating system (QRS), the Department will publish a consumer decision support tool, comprised of performance measurement data collected from the Contractor. This data will include performance measures identified by CMS and stakeholders and will be published once a year and posted on the Department's Medallion 3.0 website. The consumer decision support tool will be available by May 2018.

As outlined in 42 C.F.R. § 438.340 the Department will draft and implement a quality strategy for assessing and improving the quality of health care and services furnished by the Contractor. This strategy will be reviewed and updated as needed, but no less than once every three (3) years.

8.6 PERFORMANCE INCENTIVE AWARDS (PIA)

Performance Incentive Awards will be made to the Contractor according to criteria established by the Department and will include the quality performance measures listed below in Section 8.6.A. The PIA criteria will include three HEDIS measures and three administrative measures designed to measure managed care quality. The PIA awards/penalties will be proportionate to the extent by which the Contractor's performance compares with benchmarks for each HEDIS measure, thresholds determined by the Department for each of the three administrative measures, and the relative performance as compared against other Contractors. The maximum amount at risk for each Contractor is 0.15% of the PMPM capitation rate system payments for FY 18 as of three (3) months after the end of the fiscal year. And the maximum award is 0.15% of the PMPM capitation rate system payments. Total awards for all Contractors will equal total penalties for all Contractors.

Note that Quality Compass® is NCQA's comprehensive national database of health plans' HEDIS® results and will be used as the validated HEDIS scores for the Contractor. The Department is the steward of the three administrative measures, and will contract with its EQRO

to validate the self-reported scores from the Contractor. The Contractor is required to provide the EQRO full access to documentation, data, and other information the EQRO deems necessary to validate the Contractor's reported scores. The scoring structure and processes are included in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications.

Please note that the structure of the performance incentive awards follows a HEDIS year timeframe. HEDIS 2016, for instance, reflects services provided in the calendar year 2015. The three administrative measures below in Section 8.6.A, however, are based on the monthly reporting deliverables received by the Department from July 1 to June 30 of each measurement year. The technical specifications and scoring methodology for the PIA are provided in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications.

The implementation schedule for the performance incentive awards is as follows:

Second Year (FY 2017)

• Three HEDIS Measures: HEDIS 2017, reflecting services provided in 2016. NCQA's Quality Compass, scheduled for release in October 2017, shall trigger evaluation by the Department. Performance incentive scores for the Contractor, based on HEDIS 2017, will be finalized by March 2018.

• Three Administrative Measures: Performance on these measures will be validated by the EQRO on an annual basis. The measurement year for the administrative measures will include the relevant reports received by the Department from July 1, 2016 – June 30, 2017.

The Department anticipates that Performance Incentive Award reports for each Contractor, reflecting the calculated performance scoring for the three administrative measures will be completed by December 31, 2017. Penalties pursuant to the PIA should be received by the Department by March 2018, and payments to the Contractor will be disbursed within 60 days of receiving full payment(s) from the Contractor(s) incurring a penalty. NCQA's Quality Compass, scheduled for release in October 2017, will be the basis for the evaluation of performance incentive scores by the Department or its EQRO. Performance incentive scores for the Contractor, based on HEDIS 2017, will be finalized and provided in a report card for the Contractor by December 31, 2017.

The procedure will recur in following years.

8.6.A Quality Measures for Performance Incentive Awards

The measures used to determine the performance incentive awards are as follows:

- **HEDIS: Combo 3 Immunization Measure: Percent of 2 year olds who are fully immunized.**
    - This measure includes all of the following vaccines by second birthday: "at least four DTaP"-diphtheria, tetanus and acellular pertussis; "at least three IPV" - polio; "at least one MMR"- measles, mumps and rubella; "at least three Hep B-

hepatitis B; "at least three HiB" – H influenza type B; "at least one VZV" – chicken pox; "at least four PCV"- pneumococcal conjugate.

- **HEDIS: Percent of Members with Hypertension Cardiovascular Condition and whose blood pressure is controlled.**
- **HEDIS: Percent of Members Who Are Pregnant and Receive Timely Prenatal Care.**
- **Administrative Measure: Claims Reporting and Processing Measure**. The technical specifications for this measure are provided in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications.
- **Administrative Measure: Timeliness and Accuracy of Reporting Deliverables.** The technical specifications for this measure are provided in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications.
- **Administrative Measure: Assessments – Foster Care Children.** The technical specifications for this measure are provided in the Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications. By August 15th of each year, the Contractor must provide the Department with its self-reported numerator and denominator for the foster care assessment measure.

8.7 COMPLEX CARE MANAGEMENT PROGRAMS

8.7.A Complex Care Management Programs:

8.7.A.I Minimum requirements

The Contractor must have, at a minimum, complex care management programs that focus on identifying and improving the health status of members diagnosed with the following conditions:

8.7.A.I.a Respiratory Conditions such as Asthma & Chronic Obstructive Pulmonary Disease (COPD),
8.7.A.I.b Heart disease, including Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF),
8.7.A.I.c Diabetes,
8.7.A.I.d Co-occurring Mental/Behavioral Health conditions, and
8.7.A.I.e Cancer.

8.7.A.II Special Focus – Pediatric asthma/diabetes

A special focus shall be placed on pediatric asthma and pediatric diabetes programs. Nothing in this section shall limit the Contractor from implementing additional complex care management programs.

8.7.A.III Complex Care Management

The Contractor must have operational complex care management programs, as set forth in this Contract, in order for the Contractor to serve eligible populations. The Contractor must have a process in place to refer members with Kidney disease to the National Kidney Foundation.

8.7.A.IV Complex Care Management Plan Submission to the Department

8.7.A.IV.a The Contractor must submit to the Department, on September 30th of each contract year, a document outlining the approach taken to address individuals with the conditions listed above. The Complex Care Management Plan must include the following elements:

8.7.A.IV.a(i) A description of how the Contractor identifies the members with the six focus conditions,
8.7.A.IV.a(ii) A description of any predictive modeling techniques employed by the Contractor,
8.7.A.IV.a(iii) A description of how success is measured in the program (HEDIS outcomes and non-HEDIS outcomes, and other measures that may include such things as: member satisfaction, decreased utilization of avoidable, inappropriate, and/or unnecessary services such as hospital readmissions, unsuitable emergency department use, preventable hospitalizations related to the chronic disease(s) at issue, etc.,
8.7.A.IV.a(iv) A description of how and why the program has or has not been successful under that definition, and
8.7.A.IV.a(v) A description of any successful measures employed by the Contractor in another state (Commercial or Medicaid lines of business), and a brief justification as to whether these measures could be successfully utilized by the Commonwealth.

8.8 MATERNITY CARE

When the Department determines a pregnant woman's enrollment into the Contractor's plan (via aid categories 91, 05, 97), or when the Contractor identifies a pregnant woman, the Contractor shall:

- Cover pregnancy-related and postpartum services to the end of the month in which the sixtieth (60th) calendar day after the pregnancy ends, as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290 and as stated in Section 7.2.N.V.g(i).
- Cover services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290 and Section 7.2.N.V.g(ii).
- Cover prenatal and infant programs as described in Section 7.2.N.V.g(iii).
- Have written policies and procedures that describe how all the requirements in Sections 8.7 will be met.

8.8.A Prenatal Care Requirements

The Contractor shall have written policies and procedures that outline how the Contractor will provide access to prenatal services. At a minimum, the policies and procedures must outline how the following requirements will be met:

- Within ten (10) days of identification, the Contractor shall send information to pregnant women to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services.
- The Contractor shall cover all obstetric and gynecological services as stated in Section 7.2.N.
- The Contractor shall ensure that the travel time and distance standards stated in Section 3.11 are met.
- The Contractor shall ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant members as follows:

    - First trimester - within fourteen (14) calendar days of request
    - Second trimester - within seven (7) calendar days of request
    - Third trimester - within five (5) business days of request
    - Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.
- The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g., reducing preterm birth, breast feeding, applying for WIC, safe sleep practices, and family planning), etc.
- The Contractor shall, via its agreements with providers, screen pregnant women (or refer to an appropriate practitioner to screen) for prenatal depression in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) standards. The Contractor shall have a process to refer women who screen positive for depression to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment.
- The Contractor shall ensure that every pregnant member is advised of the value of HIV testing as set forth in 12 VAC 30-50-510 and shall request that each pregnant member consent to testing as set forth in § 54.1-2403.01 of the *Code of Virginia*. Pregnant members shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record.
- The Contractor shall ensure preauthorization requirements do not apply to basic prenatal care as stated in Section 7.1.P.II.
- The Contractor shall cover the services of certified nurse-midwives as stated in Section 7.2.N.I.
- The Contractor shall provide for the dissemination of information to potentially eligible women, infants, and children to the WIC Program and the provision of medical information by providers working within Medallion 3.0 managed care plans to the WIC Program as stated in Section 4.12.

8.8.B Ancillary Service(s) Requirements

8.8.B.I Smoking Cessation Services

The Contractor shall ensure tobacco cessation services, education and pharmacotherapy are covered for all pregnant individuals (12VAC30-50-60).

8.8.B.II Day and Residential Treatment for Substance Abuse

Day and residential treatment for substance abuse for pregnant and postpartum women are carved out of this contract. However, the Contractor must have written policies and procedures as stated in Section 7.2.N.V.j that describe how referrals and services for substance abuse services for pregnant and postpartum women are coordinated with the Department's fee-for-service program.

8.8.C High Risk Pregnancy Requirements

8.8.C.I Policies and Procedures

The Contractor shall have written policies and procedures that outline how the Contractor differentiates pregnant women according to risk status. At a minimum, the process must consider:

- The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.
- Previous pregnancy complications and adverse birth outcomes.
- History of\or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use).
- History of\or a current positive screen for depression and/or other behavioral health issues.
- The member's personal safety (e.g., housing situation, violence).

8.8.C.II Special Needs of Pregnant Women

Within thirty (30) days of a member being identified as high-risk, the Contractor should make its best effort to contact the member and/or the member's physicians to identify and assess the specialized needs of the member (medical, psychosocial, nutritional, etc.).

8.8.C.III Minimum Services

At a minimum, the Contractor shall provide the following services to members identified as having high risk pregnancies:

8.8.C.III.a **Case Management Services**

8.8.C.III.b Case management services, including assessing and planning of services; referring members to appropriate services and resources for evaluation and follow-up on identified issues ((e.g., substance abuse treatment services, tobacco cessation, behavioral health services, housing, domestic violence, etc.); coordinating services with other agencies and providers; and, monitoring ongoing progress and ensuring services are delivered; **Service Plans**

Service plans that include individualized descriptions of what services and resources are needed and how to access those services and resources to assist the high-risk pregnant woman in meeting her identified needs; and;

8.8.C.III.b(i) **Other Services**

Services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when medically necessary and within the amount, duration, and scope provisions described in 12 VAC 30-50-510.

8.8.D Postpartum Care Requirements

The Contractor shall have written policies and procedures that outline how the Contractor will provide access to postpartum services. At a minimum, the policies and procedures must outline how the following requirements will be met:

8.8.D.I Promotion and Incentives

The Contractor shall promote and incent access to and adherence to timely and adequate postpartum services within sixty (60) calendar days of delivery, as may be appropriate based on aid category or eligibility. Strategies may include scheduling postpartum visits before discharge, telephone reminders, member incentives, etc.

8.8.D.II Depression Screenings and Referrals

The Contractor shall screen women (or refer to an appropriate practitioner to screen) for postpartum depression in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) standards. The Contractor shall have a process to refer women who screen positive for depression to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment.

8.8.D.III Early Discharge Follow-up Visit

The Contractor shall cover at least one (1) early discharge follow-up visit as stated in Sections 7.2.N.V.h and 7.2.N.V.i in cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of delivery.

8.8.D.IV Lactation Consultation and Breast Pumps

The Contractor shall cover lactation consultation and breast pumps as stated in Section 7.2.N.V.f.

8.8.D.V Family Planning Services

The Contractor shall cover all family planning services as stated in Section 7.2N.II.

8.8.D.VI End of Eligibility Notification

The Contractor shall have a system to notify women whose eligibility will end within sixty (60) calendar days of delivery, as may be appropriate based on aid category, of their options for receiving continuing health care services (e.g., FQHC, free clinics, etc.).

8.8.E Reporting and Quality

8.8.E.I Maternity Quality

See Sections 8.3 and 8.5.A for measures the Department uses when determining quality of the Maternity Program.

8.8.E.II Reporting

- **Maternity Policies and Procedures:**
  The Contractor shall submit its maternity program policies and procedures annually to the Department in accordance with the requirements outlined in the Managed Care Technical Manual. This report shall also include copies of educational, training, and informational materials that it provided to OBGYNs.
- **Maternity Program Summary Report:**
  The Contractor shall submit its maternity program summary report, including results of one initiative to support positive birth outcomes, annually to the Department in accordance with the requirements outlined in the Managed Care Technical Manual.
- The Contractor shall submit maternity-related ad hoc reports to the Department within the timeframes specified by the Department.

8.8.F.I ARTS SPECIFIC MEASUREMENT AND REPORTING

DMAS will collect reliable and valid data from the Contractor to enable reporting of the ARTS specific quality measures listed in the table below to CMS. The Department has authority to add and remove ARTS specific quality measures to the list below as its discretion. The Contractor shall be able to report these ARTS specific quality measures on the ARTS population only, according the specifications outlined in the Contractor's *Performance Measure Reporting Requirements*. The

Contractor shall also be able to report these measures for the general population if any measures are also listed within the Contractor's *Core Performance Measures List*, according the specifications outlined in the Contractor's *Performance Measure Reporting Requirements*.

Source	Measure
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
NQF # 1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
NQF # 2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
NQF #0648 (modified)	Timely Transmission of Transition Record
PQA	Use of Opioids at High Dosage in Persons Without Cancer (PQA)
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)
PQA	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)

8.8.F.II ARTS Specific Quality Measures

The Contractor shall submit monthly dashboards specific for ARTS according the specifications and template given by the Department. The Dashboard at minimum will include data elements outlined below. The Department will have authority to change any dashboard specifications and template, and follow up on questions and issues identified via dashboard data. The Contractor shall respond in a timely manner to all Department questions and concerns and resubmit dashboard data if deemed by the Department as needed.

- **Process measures**
  - Number of Medicaid Members served by region;
  - Number of licensed and credentialed providers of each ASAM Level of Care, including Opioid Treatment Programs and Office Based Opioid Treatment organizations, and peer supports by region; and,
  - Member and provider grievances and appeals by region.

- **Outcome measures**
  - ED utilization rates;
  - Hospitalization rates; and,
  - Readmission rates to the same level of care or higher.

- **Utilization rates for each service to include any denials for services, including peer supports.**

9. Program Integrity (PI) & Oversight

9.1 GENERAL PRINCIPLES

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse. The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct and prevent fraud, waste, and abuse. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal government. All policies and procedures required as a part of this Contract must be approved by the Department prior to implementation. The policies and procedures must be reviewed and approved prior to the original contract signing, at time of revision (if any), and must be made available upon request by the Department for additional review and/or approval.

9.2 COMPLIANCE OFFICER

The Contractor shall designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors. The Contractor shall establish effective lines of communication between the Compliance Officer and the Contractor's employees.

The Contractor shall also establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract. The Compliance Officer shall maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis.

Lastly, pursuant to 42 CFR § 438.608, the Compliance Officer and Regulatory Compliance Committee shall coordinate with the Department on any fraud, waste, or abuse case.

9.3 PROGRAM INTEGRITY LEAD

The Contractor shall designate a PI Lead who will represent the Contractor and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, and pre- and

post- claim edits, PA/SA review, and any other fraud activities and outcomes. This individual must also attend all scheduled meetings of the Department's Quarterly Program Integrity Collaborative. If the PI Lead is unable to attend the PI Collaborative, the Contractor must notify the Department prior to the meeting and identify an alternative representative who will be in attendance. The Contractor must be aware and actively involved with State, Federal, and CMS initiatives of Program Integrity.

9.4 PROGRAM INTEGRITY PLAN, POLICIES, & PROCEDURES

The Virginia Medicaid Program Integrity Plan (the PI Plan) must define how the Contractor will adequately identify and report suspected fraud, waste, and abuse by Members, by network providers, by subcontractors, and by the Contractor. The Contractor shall develop a written integrity plan specific to this contract that identifies the specific resources dedicated to program integrity activities related to claims, members, providers and subcontractors involved in delivering the services outlined in this contract. The PI Plan must be submitted annually (See the *Managed Care Technical Manual*) and must include all items listed in this section.

9.4.A Written Policies and Procedures

The Contractor shall have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection, and reporting of incidents of potential fraud, waste, and abuse by Members, by network providers, by subcontractors and by the Contractor. The Contractor shall have administrative and management arrangements or procedures to the extent that the Contractor delegates responsibility for coverage of services and payment of claims under the contract to a subcontractor, the Contractor shall include policies and procedures utilized by the subcontractor to detect and prevent fraud, waste, and abuse.

The Contractor should have, at a minimum, the following policies and procedures in place:

1. A commitment to comply with applicable statutory, regulatory, and contractual commitments.
2. A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules, and regulations in a timely basis (no later than thirty (30) days after the determination that there is a potential violation of civil, criminal or administrative law may have occurred).
3. Procedures for the identification of potential fraud, waste, and abuse in a Contractor's network.
4. A process to ensure the Contractor, agents and brokers are marketing in accordance with applicable Federal and State laws, including state licensing laws, and CMS policy.
5. A process to identify overpayments at any level within the Contractor's network and properly recover such overpayments in accordance with Federal and State policy.
6. Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct.
7. Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.

8. Provider contracts that require a network provider to report to the Contractor when it has received an overpayment, and defined procedures for the provider to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.
9. Written policies for all employees of the Contractor, and any Contractor or agent of the Contractor that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19.

9.4.B Program Integrity Staffing and Contractors

The PI Plan must include the Contractor PI Lead and contact information. The PI Plan must also include the following elements, described in more detail in this section, and follow the template in the *Managed Care Technical Manual*:

1. PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
2. A listing of the health plan PI contractors (unless proprietary);
3. A process to act as or sub-contract with a Contractor for Recovery Audit purposes; and,
4. An internal monitoring and audit plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid. Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable State and Federal laws, as well as internal policies and procedures to protect against potential fraud, waste, or abuse.
5. The Contractor shall submit an organizational chart annually that outlines the Medallion 3.0 Program Integrity division within its chart. The organizational chart should include all divisions that handle the Medallion 3.0 program (operations, claims, member services, outreach/marketing, health services, etc.).

The Contractor shall have a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as PI audit recoveries. This process must assure that appropriate decisions are made as promptly as possible.

9.4.C Internal Monitoring and Audit - Annual Plan

The Contractor shall establish and implement provisions for ongoing internal monitoring and auditing that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The Annual Internal Monitoring and Audit plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Monitoring Activities, Types of Audits, Audit Methodology, and planned Audit Activity.

The Contractor shall identify potential fraud, waste, and abuse activity by members and providers through utilization of computer software and through regularly-scheduled audits of medical records. The Contractor shall have surveillance and utilization control programs and procedures (42 C.F.R. §§ 456.3, 456.4, 456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor is encouraged to invest in data analysis software applications that provide the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

Pursuant to 42 C.F.R. §§ 438.608(a)(5) and 455.1, the Contractor's Internal Monitoring and Audit Plan must include a method to verify whether services reimbursed were actually furnished to the Member. The Contractor must utilize a survey (telephonic or mail), explanation of benefits (EOB) mailing, or other method approved by the Department to accomplish this requirement. Regardless of the method utilized (EOB, member survey, etc.), the Contractor's verification method must include a statistically valid sample of Members based upon a percentage of the Contractor's paid claims. The Contractor may exclude certain 'sensitive' services from these verification activities.

The Contractor shall include as part of its work plan, monitoring and audit activities specific to subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors and separate audits should be conducted by the Contractor to ensure that the subcontractor program integrity controls are providing adequate protection against improper payments.

The Contractor shall include routine and random auditing as part of its contractual agreement with subcontractors. The Contractor shall include in its work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and shall make it a priority to conduct a certain number of on-site audits.

The Contractor shall also include in its plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and/or Program Integrity Lead and shall consist of, at a minimum, recovery of any identified overpayments. The Contractor may choose to utilize a pre-payment review process as a part of their program integrity plan and these activities should be included as planned activities in the Annual Plan.

The Internal Monitoring and Audit plan shall include a schedule that includes a list of all planned monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or "spot checks," when developing the schedule. In developing the types of audits to include in the audit plan, the Contractor shall:

- Determine which risk areas will most likely affect the organization and prioritize the monitoring and audit strategy accordingly.
- Identify methods used to select facilities, pharmacies, providers, claims, and other areas for review, specifying type of data analysis (outliers, billing irregularities, fraud

modeling, etc.) or source of referrals (EOBs, member complaints, internal referrals, etc.)

- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

For all monitoring and audit activities planned for the upcoming year, the annual plan should include the following information:

- Monitoring Activity Title/Type
- Description
- Priority/Risk Level
- Method of provider/claim selection
- Manner in which audits will be conducted
- # of Audits Planned

9.5 MINIMUM AUDIT REQUIREMENTS

A minimum number of medical record audits shall be conducted annually based on total dollars in medical claims expenditures. If the Contractor fails to meet this minimum standard, or is found through Program Integrity Compliance Audits (PICAs) to lack adequate program integrity controls, the Department reserves the right to impose a corrective action plan on the Contractor. If the Contractor subsequently fails to implement corrective action, the Department reserves the right to impose financial and non-financial penalties. For this Contract, the Contractor shall perform, at a minimum, one audit for every $5 million in paid claims.

9.6 TRAINING AND EDUCATION

The Contractor shall establish an effective system of program integrity training and education for the Compliance Officer, the organization's senior management, the Program Integrity Lead, all Contractor staff and subcontractors for the Federal and State standards and requirements under the contract. Contractor PI staff shall attend any required training offered by the Department. The Contractor shall be prepared to have staff members who are assigned to perform desk audits and/or field audits, to attend on-site training and orientation programs provided by DMAS.

9.7 EFFECTIVE LINES OF COMMUNICATION BETWEEN CONTRACTOR STAFF

The Contractor shall establish effective lines of communication between the Compliance Officer, Program Integrity Lead, other Contractor staff, Members, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality. The Contractor shall also establish effective lines of communication with its Members.

9.8 ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

9.9 COOPERATION WITH STATE AND FEDERAL INVESTIGATIONS

The Contractor shall cooperate with all fraud, waste, and abuse investigation efforts by the Department and other State and Federal offices. The Contractor shall cooperate with Department auditors on any Recovery Audit activity/findings.

9.10 MEDICAID FRAUD CONTROL UNIT (MFCU)

Some program integrity activities may identify issues that constitute potential fraud. DMAS and the Contractor are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). The Contractor shall cooperate fully with any request for information or technical support made by the MFCU to support their investigations. MFCU investigations may verify that some of these referrals constitute a "credible allegation of fraud." In these instances, Contractors will be notified and shall suspend payments to those providers as set forth in 42 C.F.R § 455.23.

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty recovered through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

9.11 INVESTIGATING AND REPORTING SUSPECTED FRAUD, WASTE AND ABUSE TO THE DEPARTMENT

In reporting on program integrity activities conducted under this contract, the Contractor is required to use the templates, formats, and methodologies specified by the Department in the *Managed Care Technical Manual* and on the Medallion 3.0 website, located at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

The Contractor will be required to notify DMAS in a timely manner regarding all internal (such as identified patterns of outliers, audit concerns, critical incidences) and external (such as hotline calls) allegations of potential improper payments and/or safety concerns of enrollees. The Contractor will be expected to promptly perform a preliminary review of all allegations of fraud, waste, or program abuse. The Contractor shall track each of these allegations and the outcome of the preliminary review and report them to the Department on the Quarterly Summary of PI Allegations table.

Once an allegation has been vetted and determined to warrant further investigation/audit, the Contractor shall notify the Department within forty-eight (48) hours of initiating a full investigation, using the *Notification of Provider Investigation* form (attached) via the email address provided on the form. This is regardless of whether the target of that allegation is scheduled to be investigated immediately, or is merely being placed in the queue to be investigated when resources become available. The Department reserves the right to direct the Contractor to halt investigatory activity at its discretion. The Department may identify providers through data mining or other processes and may direct the Contractor to investigate providers in their network identified through this analysis.

Unless prior written approval is obtained, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the Contractor shall not take any of the following actions as they specifically relate to claims under this contract:

- Contact the subject of the investigation about any matters related to the investigation;

- Enter into or attempt to negotiate any settlement or agreement regarding the incident; or
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.

The Contractor shall produce, and provide to the Department upon conclusion of the investigation, a standard audit report for each completed audit, that includes, at a minimum, the following:

- Purpose
- Methodology
- Findings (including identified overpayments)
- Proposed Action and Final Resolution
- Claims Detail List/Spreadsheet

The Department will conduct reviews of a valid sample of these audits to ensure that audits are being conducted correctly; overpayments are being identified accurately, and validate the general quality of Contractor PI activities.

The Contractor shall provide information and a procedure for Members, network providers and subcontractors to report incidents of potential or actual fraud, waste, and abuse to the Contractor and to the Department.

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). When the Contractor identifies potential or actual fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, it shall be reported to the Department within forty-eight (48) hours of discovery on the *Referral of Suspected Provider Fraud* form. This notification should be sent to DMAS via the email address provided on the form. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

All confirmed or suspected member fraud and program abuse shall be reported to the Department within forty-eight (48) hours of discovery on the *Notice of Suspected Recipient Fraud or Misconduct* form. This notification should be sent to DMAS via the email address provided on the form.

The Contractor shall report to the Department all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

The Contractor may choose to utilize a pre-payment review process as a part of their program integrity plan. The Contractor shall notify the Department of each provider subject to pre-payment review within forty-eight (48) hours of initiating a pre-payment review process, using the *Notification of Provider Investigation* form. Any claims that are not paid as a result of these reviews shall be reported by the Contractor through the quarterly fraud/waste/abuse report. If pre-payment review indicates a pattern of fraud, waste, or program abuse, the Contractor shall conduct a retrospective review of that provider to identify any prior overpayments.

The Contractor's Program Integrity Plan shall include provisions for corrective action initiatives. The Contractor shall conduct appropriate corrective actions in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct but must, at a minimum, include repayment of any identified overpayments.
The Contractor shall provide the Department, on March 31st of each contract year, an annual summary of prior year activities and results.

9.12 QUARTERLY FRAUD/WASTE/ABUSE REPORT

The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must follow the format specified in the *Managed Care Technical Manual*. The report must include, but is not limited to, the following:

1. Allegations received and results of preliminary review including
    a. Provider name
    b. NPI
    c. Source of allegation
    d. Description of allegation
    e. Date Identified
    f. Whether the allegation has been evaluated
    g. Date Evaluation Completed
    h. Whether further investigation is planned
2. Number of cases by providers and Members investigated with resolution including
    a. Provider/Member name
    b. Date case was opened
    c. Reason(s) for initiating case
    d. Date case was cleared (if applicable)
    e. Findings
    f. Corrective action taken
    g. Financial Summary
    h. Recovery action taken/completed
    i. Date recovery initiated

The Contractor shall report on the quarterly report when the Contractor denies a provider credentialing application for any reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

9.13 QUARTERLY PROGRAM INTEGRITY COMPLIANCE AUDIT (PICA)

The Department shall conduct a quarterly Program Integrity Compliance Audit (PICA) that is separate and distinct from the annual PICA described in section 9.15. This evaluation will examine ongoing reporting as well as the quarterly fraud/waste/abuse report to ensure that all contractual requirements are being met. The Contractor will be expected to evaluate progress towards the Internal Monitoring and Audit Plan for that contract year and identify any major changes or shortcomings to projected audit numbers. The Department will evaluate this submission and provide feedback to the Contractor.

9.14 PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES

9.14.A Formal Initiation of Recovery

The Contractor shall notify the Department upon formal initiation of a recovery from a solely conducted audit by the Contractor on its own network. The Contractor shall not proceed with any recoupment or withholding of any program integrity related funds until the Department confirms that the recoupment or withhold is permissible. The contractor shall submit adjusted encounters that reflect recovery of any identified overpayments and report to the Department quarterly on any overpayments that have not been collected.

9.14.A.I Treatment of Recoveries

Under 42 C.F.R. § 438.608(d), the Contractor must:

- Specify the retention policies for the treatment of recoveries of all overpayments for the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.[42 C.F.R. § 438.608(d)(1)(i)]
- Specify the process, timeframes, and documentation required for reporting the recovery of all overpayments.[42 C.F.R. § 438.608(d)(1)(ii)]
- Specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the Contractor is not permitted to retain some or all of the recoveries or overpayments. [42 C.F.R. § 438.608(d)(1)(iii)]
- Have and use a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing for the reason for the overpayment. [42 C.F.R. § 438.608(d)(2)]
- Submit the annual report of overpayment recoveries. [42 C.F.R. §§ 438.604(a)(7), 438.606, and 438.608(d)(3)]

9.14.B Class Action & Qui Tam Ligation

The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

9.14.C Provider Network Audits

The Department, pursuant to 42 C.F.R. § 455, et. seq. may conduct audits of the Contractor's provider network and as a result of those audits recover and retain identified overpayments. At the request of the Department, the Contractor will provide any information the Department deems necessary to conduct such audits including, but not limited to fee schedules, provider contracts, and claim payment data.

9.14.D Fraudulent Provider Recovery with MFCU

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

9.14.E Payment Suspension

Pursuant to 42 C.F.R.§§ 455.23 and 438.608(a)(8), the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible

allegation of fraud. Upon notification from the Department that such a determination has been made, the Contractor must suspend payment as soon as possible. Unless the Contractor believes there is good cause, as defined in 42 C.F.R.§ 455.23, to not suspend payments or to suspend payment only in part to such a provider. In this case, the Contractor must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider from payment suspension. The Department will evaluate the merit of the request for good cause exemption and notify the Contractor of the decision.

9.14.F Required Reporting Procedures

Under 42 C.F.R. § 438.608(a), the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract:

- Implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
- Implement and maintain arrangements or procedures for prompt notification to the Department when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or death of the member.
- Implement and maintain arrangements or procedures for notification to the Department when it receives information about a change in the network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.
- Implement and maintain arrangements or procedures that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.
- Implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department or any potential fraud to the Virginia Medicaid Fraud Control Unit.

If the Contractor makes or receives annual payments of at least $5,000,000 under this Contract, the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, to implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including the information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Act; 42 C.F.R § 438.608(a)(6)]

9.15 ANNUAL PROGRAM INTEGRITY COMPLIANCE AUDIT (PICA)

The Program Integrity Compliance Audit (PICA) is a compliance and evaluation measure completed by the Contractor to evaluate organization-level compliance and adherence to the terms of the Medallion 3.0 Contract and best practice models. Completion of the PICA requires electronic submission of any and all referenced materials (MCO Policies and Procedures manuals, etc.) and documents annually to DMAS, as specified in the *Managed Care Technical Manual*, no later than September 30th. The Department may customize the PICA to reflect areas

of particular importance or focus based on trends, previous PICA findings, or other Departmental concerns. The Contractor is required to use the most current version of the PICA tool, as found in the *Managed Care Technical Manual*, in submission of the PICA.

The PICA submission must address all elements required of the Program Integrity Plan, and supporting documentation. The Internal Monitoring and Audit section of the PICA shall demonstrate a coordinated, cohesive strategy to assess and address program integrity risks. The Contractor will be expected to explain the current year Internal Monitoring and Audit plan as it relates to the results of the prior year's audit activity. The review will consist of the following major components

- A retrospective analysis of audits performed from the previous year, including a comparison of the projected allegations and investigations from the previous year's Annual Program Integrity Plan to the actual audits conducted during that year. For each monitoring/audit activity, the Contractor will provide, at a minimum, the following
    - Monitoring Activity Title/Type
    - Description
    - Priority/Risk Level
    - # of Allegations Planned
    - # of Allegations Identified
    - # of Investigations Planned
    - # of Investigations Completed
- Explanations for why actual PI activity was lower or higher than projected for each monitoring activity.
- Description of risk evaluation methodology and identified areas of program integrity risk
- a detailed schedule of planned audits for the current year, with explanations for how evaluation of risk and results of prior year audits resulted in adjustments from the prior year's Internal Monitoring and Audit plan
- a detailed review and projections for other PI activities that do not lend themselves to the traditional allegation/investigation format of reporting

Received Allegations
Detailed information on each prior year allegation received, including referrals, providers identified through data analysis, and any other sources of potential investigations shall be submitted and will include, at a minimum, the following:

- Provider Name
- Provider NPI
- Description of allegation
- Date allegation received
- Allegation evaluated (Y/N)
- Allegation planned for investigation (Y/N)

Completed Investigations
Detailed information on each prior year investigation conducted pursuant to the Internal Monitoring and Audit Plan shall be submitted and will include, at a minimum, the following:

- Provider Name

- Provider NPI
- Description of allegation and investigation findings
- Amount of overpayments identified
- Amount of overpayments collected
- Any other corrective action taken

10. Grievance and Appeals

The Contractor shall inform providers and subcontractors, at the time they enter into a contract, about:

- Member grievance, appeal, and fair hearing procedures and timeframes as specified in 42 C.F.R. § 438.400 through 42 C.F.R. § 438.424 and described in this section of the Contract.
- The member's right to file grievances and appeals and the requirements and timeframes for filing.
- The ability of assistance to the member with filing grievances and appeals.
- The member's right to request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member.
- The member's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or State fair hearing filing, if filed within the allowable timeframes, although the member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the member.

10.1 MEMBER APPEALS

10.1.A General Requirements

In accordance with 42 C.F.R. 438.228, the Contractor shall have a system in place to respond to grievances, internal appeals, and claims received from members.

Additionally, the Contractor shall ensure that members are sent written notice of any adverse benefit determination (as defined below) which informs members of their right to internally appeal through the MCO as well as their right to access the Department's State fair hearing system after receiving notice that the internal appeal decision upheld the adverse benefit determination. The Contractor shall provide to all network providers and subcontractors information about the grievance internal appeal, and State fair hearing systems to the specifications described in 42 C.F.R. § 438.10(g)(1) (described in Sections 6.6 and 6.7 of this Contract) at the initiation of all such contracts.

The Contractor shall not be responsible for handling of internal appeals and state fair hearings related to carved out, and excluded services as outlined in Sections 7.3 and 7.5, including home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support/Building Independence, or Alzheimer's, or as may be amended from time to time) or related transportation to waiver services via the fee-for-service program.

10.1.B Member Issues

The Contractor shall provide a timely response to all inquiries received from members or on behalf of members while ensuring HIPAA compliance. Additionally, in any instance where the Contractor receives a claim for payment filed by the member, the Contractor shall respond to the member, in writing, and at the time of any action affecting the claim. This response to the member is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the member regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

10.1.C Notice of Adverse Benefit Determination

The Contractor shall notify the requesting provider and shall provide written notice to enrolled (on the date of service) members whenever rendering an adverse benefit determination. The Contractor has the option to send the member notice as an explanation of benefits statement or as a notice of adverse benefit determination.. Any statement or notice must be in accordance with the definitions, content of notice, and required timeframes listed below.

10.1.C.I Definition of Adverse Benefit Determination– Consistent with 42 C.F.R. § 438.400, **adverse benefit determination refers to the:**

10.1.C.I.a Denial or limited authorization of a service authorization request; including the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

10.1.C.I.b Failure to act on a request for services within required timeframes;

10.1.C.I.c Reduction, suspension, or termination of a previously authorized (as defined in Section 1) service;

10.1.C.I.d Denial in whole or in part of a payment for a covered service for an enrolled member ;or

10.1.C.I.e Failure by the Contractor to render a decision within the timeframes required in Section 10 and Sections 7 and 8 of this Contract; or

10.1.C.I.f For members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the denial of a member's request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside of the network; or

10.1.C.I.g The denial of a member's request to dispute a financial liability.

Please note that for other notices required by 42 C.F.R. § 431.213, the Department and/or its designees (the Department of Social Services, Department of Health, and/or Department of Behavioral Health & Developmental Services) will send notice according to internal policies & processes not later than the date of adverse benefit determination. Such notices required under 42 C.F.R. § 431.213 include the death of the member, the member's submission of signed written statement(s)requesting service termination or reduction of services and indicates an understanding that service termination or reduction will result, the member has been admitted to an institution where the member is ineligible for further services,

the member's address/whereabouts are unknown based on returned mail with no forwarding address, the member has been accepted for Medicaid services in another local jurisdiction, State, territory or Commonwealth, a change in the member's level of medical care is prescribed by the member's physician, a notice involving an adverse benefit determination with regard to a preadmission screening requirement, and transfer or discharge from a facility will occur in an expedited fashion pursuant to 42 C.F.R. § 483.12(a)(5)(ii).

10.1.C.II Content of Notice

The notice must be in writing and must meet the language and format requirements described in 42 C.F.R. §§ 438.10 and 438.404 (See Section 6.4 of this Contract.) The notice must explain the following:

10.1.C.II.a The action taken and the reasons for the action;

10.1.C.II.b The member's right to file an internal appeal with the MCO;

10.1.C.II.c Upon exhaustion of the Contractor's internal appeal process, the member's right to request a State fair hearing in accordance with 12 VAC 30-110-10 through 12 VAC 30-110-370 and as described in this section;

10.1.C.II.d The procedures for exercising appeal rights;

10.1.C.II.e The circumstances under which expedited resolution is available and how to request an expedited resolution; and

10.1.C.II.f The circumstances under which the member has the right to request that benefits continue pending resolution of the internal appeal and State fair hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services. (Reference the "Continuation of Benefits" described Section 10.1.F.)

10.1.C.III Timing of Notice

10.1.C.III.a The Contractor must mail the notice within the following timeframes:

10.1.C.III.b For termination, suspension, or reduction of previously authorized services, the notice must be issued at least ten (10) calendar days prior to the effective date of the intended adverse benefit determination, as required in 42 C.F.R. § 431, Subpart E.

10.1.C.III.c For denial of payment, the notice must be issued in accordance with Section 10 at the time of action affecting the claim.

10.1.C.III.d For standard service authorization decisions that deny services, the notice must be issued within the timeframes specified in 42 C.F.R. § 438.210(d) as described in Section 7.1 of this Contract.

10.1.C.III.e For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) calendar days, the Contractor must mail the written notice no later than the 14th day to the member, describing the reason for the decision to extend the timeframe and informing the member of the right to file a grievance if he or she disagrees with that decision. Additionally, the Contractor must issue and carry out

the review for the final determination as expeditiously as the member's health condition requires and shall not exceed the date on which the extension expires.

10.1.C.III.f For service authorization decisions not reached within the required timeframes specified in Section 7.1 of this Contract, in accordance with 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse benefit determination), the notice must be issued on the date that the established timeframes for review expire.

10.1.C.III.g For denials of a member's request to dispute a financial liability, the notice must be issued in accordance with Section 10 at the time of action affecting the request to dispute financial liability.

10.1.C.III.h For expedited service authorization decisions, the notice must be issued as expeditiously as the member's health condition requires, not to exceed seventy-two (72) hours after receipt of the request for service.

10.1.C.III.i For expedited service authorization decisions where the Contractor has extended the three seventy-two (72) hour turnaround time frame in accordance with Section 7.1, as expeditiously as the member's health condition requires, not to exceed the date on which the extension expires.

10.1.D Filing Grievances and Appeals

The Contractor shall have written policies and procedures that describe the grievance, internal appeals, and State fair hearing processes and how each operates; and the process must be in compliance with 12 VAC 30-120-420, as amended, except that the member shall have sixty (60) days to fill an appeal and no limitation on the time to file a grievance. These written directives shall describe how the Contractor intends to receive, track, review, and report all member inquiries, grievances and internal appeals. The Contractor shall make any changes to its member grievance and internal appeal procedures that are required by the Department. The procedures and any changes to the procedures must be submitted to the Department prior to signing original contract, upon revision, upon request, and as needed.

The Contractor shall provide grievance and internal appeal forms and/or written procedures to members who wish to register written grievances or internal appeals. Additionally, the Contractor shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding member notices, grievances, and internal appeals are contained in this Section.

10.1.D.I Contractor's Grievance Procedures

The Contractor's grievance process must allow the member, or the member's authorized representative (provider, family member, etc.) acting on behalf of the member, to file a grievance either orally or in writing. Each MCO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance.

This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll- free numbers that have adequate TTY/ TTD and interpreter capability. The Contractor shall acknowledge receipt of each grievance (grievances received orally can be acknowledged orally). The Contractor shall also ensure that neither the individuals nor a subordinate of any such individual who makes decisions on grievances were not involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, or is an appeal of a denial that is based on a lack of medical necessity, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 C.F.R. § 438.406(a)]. The decision-makers must take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The Contractor must respond to all grievances as expeditiously as the member's health condition requires, not to exceed thirty (30) calendar days from the date of initial receipt of the grievance. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the member or the member's authorized representative.

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the member under the Contractor's grievance process.

10.1.D.II Contractor's Internal Appeals Process

Members have the right to appeal adverse benefit determination issued by the Contractor, the Contractor's subcontractors or providers. The Contractor must accept appeals submitted within sixty (60) calendar days from the date of notice of adverse benefit determination.

Appeals Process – <u>The Contractor's internal appeals process must include the following requirements:</u>

10.1.D.II.a Allow the member, or member's authorized representative (requires <u>written</u> consent from the member) acting on behalf of the member to file an internal appeal, either orally or in writing, and unless he or she requests an expedited resolution, the oral request must be followed by a written, signed, internal appeal request. [42 C.F.R. § 438.402(c)(2)(ii)] A provider, acting on behalf of the member and with the member's written consent, may file a member an internal appeal with the Contractor and an appeal through the State Fair Hearing Process once the internal appeal process is exhausted, as described in Section 10.1.E.II below.

10.1.D.II.b Acknowledge receipt of each internal appeal.

10.1.D.II.c Ensure that the individuals who make decisions on internal appeals were not involved in any previous level of review or decision making.

10.1.D.II.d Ensure that the individuals who, if deciding on any of the following, are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

10.1.D.II.d(i) An internal appeal of a denial that is based on lack of medical necessity.

10.1.D.II.d(ii) An internal appeal that involves clinical issues.

10.1.D.II.e Provide that oral inquiries seeking an internal appeal of an adverse benefit determination are treated as internal appeals (to establish the earliest possible filing date for the internal appeal) and must be confirmed in writing unless the member or the provider appealing on the member's behalf requests expedited resolution.

10.1.D.II.f Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this, especially in the case of expedited resolution.

10.1.D.II.g Provide the member and his or her representative opportunity, sufficiently in advance of and during the internal appeals process, to examine the member's case file free of charge, including any medical records and any other documents and records considered during the appeals process.

10.1.D.II.h Include as parties to the internal appeal the member and his or her representative or the legal representative of a deceased member's estate.

10.1.D.II.i Continue benefits while the Contractor's internal appeal or the State fair hearing is pending, in accordance with 42 C.F.R. § 438.420 and Section 10.1.F below:

10.1.D.II.i(i) The member or the provider on behalf of the member files the internal appeal within ten (10) calendar days of the Contractor's mail date of the notice of adverse benefit determination or prior to the effective date of the Contractor's notice of adverse benefit determination; and

10.1.D.II.i(ii) The internal appeal involves the termination, suspension, or reduction of a previously authorized (as defined in Section 1) course of treatment; and

10.1.D.II.i(iii) The services were ordered by an authorized provider; and

10.1.D.II.i(iv) The original period covered by the initial authorization has not expired; and

10.1.D.II.i(v) The member requests extension of benefits.

10.1.D.II.j If the final resolution of the internal appeal is adverse to the member, that is, the Contractor's adverse benefit determination is upheld, the Contractor may pursue recovery of the cost of services furnished to the member while the internal appeal was pending, to the extent that the services were furnished solely because of the requirements listed above, and in accordance with the policy described in 42 C.F.R. § 438.420(d).

10.1.E Resolution and Notification

10.1.E.I Standard Resolution

The Contractor shall respond in writing to standard internal appeals as expeditiously as the member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to the Department, upon its request, that a delay in rendering the decision is in the member's interest. For any internal appeal decisions not rendered within thirty (30) calendar days where the member has not requested an extension, the Contractor shall provide written notice to the member of the reason for the delay. The Contract shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two (2) calendar days with a written notice of.

For any internal appeal decision that is pending the receipt of additional information, the Contractor shall issue a decision within no more than forty- five (45) calendar days from the initial date of receipt of the internal appeal.

10.1.E.II State Fair Hearing Process

The Contractor shall educate its members of their right to appeal directly to the Department only after filing an internal appeal with the Contractor and receiving the Contractor's internal appeal decision. The Contractor must provide notice of State fair hearing requirements to the member. Any internal appeal that is not resolved wholly in favor of the member by the Contractor may be appealed by the member or the member's authorized representative at any time after the Contractor's internal appeal process has been exhausted. [42 C.F.R. § 438.402(c)] State fair hearings are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through12 VAC 30-110-370. Appeals may be requested in writing by the member or the member's representative. The appeal may be filed within one hundred and twenty (120) days after receipt of the Contractor's internal appeal decision. For appeals not filed within this timeline, an acceptable reason for delay must exist.

Acceptable reasons for delay shall include, but not be limited to, situations or events where:

10.1.E.II.a The member was seriously ill and was prevented from contacting the Department's Appeals Division.

10.1.E.II.b The member did not receive notice of the Contractor's internal appeal decision.

10.1.E.II.c The member sent the request for appeal to another government agency in good faith within the time limit;
10.1.E.II.d Unusual or unavoidable circumstances prevented a timely filing.

Additionally, a defective notice from the Contractor (i.e., a notice that does not contain the required elements) is an acceptable reason for delay.

Upon receipt of notification that the Department has received an appeal request from a member for services to the Contractor's member, the Contractor must provide sufficient information regarding the or adverse internal appeal decision to allow the Department to determine whether the appeal request meets the timeliness requirements (i.e., the appeal was filed within one hundred and twenty (120) days of the of the member's receipt of the Contractor's internal appeal decision). The Contractor must respond to requests for information within two (2) business days of receipt of notification by the Department that a member has filed an appeal.

The Department reserves the right to sanction the Contractor $5,000 per occurrence whenever it is identified that the Contractor has failed to provide notice of adverse benefit determination or provides an incorrect notice of appeal rights.

For member appeals through the Department's Appeals Division, the Contractor is responsible for providing to the Department and to the member an appeal summary describing the basis for the internal appeal decision that upheld the adverse benefit determination. The summary must be completed in accordance with 12 VAC 30-110-70, which describes notification requirements and also serves as a guideline for information necessary to include in both the notice and the summary. The Department's Appeals Division requests that the Contractor submit the appeal summary to the Department within twenty one (21) days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all cases, the summary must be received by the Department at least ten (10) calendar days prior to the scheduled hearing date and mailed to the member on the date submitted to the Department's Appeals Division. The appeal summary must include any and all justification that the Contractor wants considered as part of the State fair hearing, including but not limited to the policy and applicable regulations (not a summary thereof) upon which the Contractor's decision is based. For expedited appeals(that meet the criteria set forth in 42 C.F.R. § 438.410), the appeal summary must be faxed to the Department and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) business hours after the Department informs the Contractor of the expedited appeal. The Department may require that the Contractor attend the hearing either via telephone or in person. The Contractor is responsible for absorbing any telephone/travel expenses incurred.

The Contractor shall comply with the State fair hearing process, no more or less and in the same manner as is required for all other Medicaid evidentiary hearings. The Contractor shall comply with the Department's fair hearing decision and all other

determinations made by DMAS. The Department's decision in these matters shall be final and shall not be subject to appeal by the Contractor.

10.1.E.III Reversed Appeal Resolutions

In accordance with 42 C.F.R. § 438.424, if the Contractor's internal appeal or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the internal appeal or State fair hearing was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination. Additionally, in the event that services were continued while the internal appeal or State fair hearing was pending, the Contractor must provide reimbursement for those services in accordance with the terms of the final decision rendered by the Department's Appeals Division and with the terms of this Contract and applicable regulations.

10.1.E.IV Contractor Grievance and Internal Appeal Reporting

The Contractor shall submit to the Department by the fifteenth (15th) day of the month after the end of each month, a mutually agreed upon report of all provider and member inquires, grievances, reconsiderations, and internal appeals as illustrated in this Contract.

10.1.E.IV.a Grievance categories identified shall be organized or grouped by following general guidelines:

- 10.1.E.IV.a(i) Transportation
- 10.1.E.IV.a(ii) Access to Services/Providers
- 10.1.E.IV.a(iii) Provider Care and Treatment
- 10.1.E.IV.a(iv) MCO Customer Service
- 10.1.E.IV.a(v) Payment and Reimbursement Issues
- 10.1.E.IV.a(vi) Administrative Issues

10.1.E.IV.b Internal appeal categories identified shall be organized or grouped by the following general guidelines:

- 10.1.E.IV.b(i) Transportation
- 10.1.E.IV.b(ii) MCO Administrative Issues
- 10.1.E.IV.b(iii) Benefit Denial or Limitation

The Contractor may use reports from its existing Member Services system if the system meets the above-stated Department criteria.

10.1.E.V Expedited Internal Appeals

The Contractor shall establish and maintain an expedited review process for internal appeals where either the Contractor or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. Under 42 C.F.R § 438.10(b), the Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports a member's internal appeal.

In instances where the member's request for an expedited internal appeal is denied, the internal appeal must be transferred to the timeframe for standard resolution of internal appeals.

The Contractor shall issue decisions for expedited internal appeals as expeditiously as the member's health condition requires, not to exceed the latter of seventy- two (72) hours from the initial receipt of the internal appeal, or seventy- two (72) hours from receipt of written certification from the MCO or treating medical professional that the member's health condition requires expedited handling of the internal appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to the Department, upon its request, that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, the Contractor shall provide written notice to the member of the reason for the delay. The Contractor shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two calendar days with a written notice of action. The Department reserves the right to conduct random reviews to ensure that enrollees are being notified in a timely manner in accordance with 42 C.F.R §438.228.

10.1.F Continuation of Benefits

Contractor must continue to provide benefits while the Contractor's internal appeal or the State fair hearing is pending, in accordance with 42 C.F.R. § 438.420, when all of the following criteria are met:

10.1.F.I Timely Filing of Appeal

The member or the provider on behalf of the member files the appeal within ten (10) calendar days of the Contractor's mail date of the notice of adverse benefit determination or prior to the effective date of the Contractor's adverse benefit determination; and

10.1.F.II Internal Appeal Content

The internal appeal involves the termination, suspension, or reduction of a previously authorized (as defined in Section 1) course of treatment; and

10.1.F.III The services were ordered by an authorized provider;

10.1.F.IV The original period covered by the initial authorization has not expired; and

10.1.F.V The member requests extension of benefits.

10.1.G Internal Appeal Decisions

All internal appeal decisions must be in writing and shall include, but not be limited to, the following information:

10.1.G.I.a The decision reached by the Contractor;

10.1.G.I.b The date of decision;

10.1.G.I.c For appeals not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so;

10.1.G.I.d The right to request to receive benefits while the State fair hearing is pending and how to make the request, explaining that the

member may be held liable for the cost of those services if the hearing decision upholds the Contractor's decision.

10.2 PROVIDER ,RECONSIDERATIONS, AND APPEALS

10.2.A Provider Grievances

Provider grievances are not appealable to the Department's Appeals Division. A provider who wishes to file a grievance is limited to the process that the Contractor has established for handling these matters, which would be similar that that described in Section 10.1.D.

10.2.B Provider Appeals to the Department

If a provider has rendered services to a member enrolled with the Contractor in a Medicaid program and has either been denied authorization/reimbursement for the services or has received reduced authorization/ reimbursement, that provider can request a reconsideration of the denied or reduced authorization/ reimbursement. Before appealing to the Department, MCO providers must first exhaust all Contractor reconsideration processes. All provider appeals to the Department must be submitted in writing and within thirty (30) days of the Contractor's last date of denial to the Department's Appeals Division, 600 East Broad Street, Richmond, VA 23219. The Contractor's final denial letter must include a statement that the provider has exhausted its internal appeal rights with the Contractor and that the next level of appeal is with the Department of Medical Assistance Services. The final denial letter must include the standard appeal rights to the Department (including the time period and address to file the appeal).

The Contractor is permitted to offer additional types of provider appeal rights at the MCO-level of review only. Network providers may not appeal termination decisions to the Department. The Contractor is required to report on all terminations and credentialing failures to the Department as specified in the MCTM.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern Time. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the Department's Appeal Division after 5:00 p.m. shall be date stamped on the next day the Department is officially open. Any document that is filed with the Department's Appeals Division after 5:00 p.m. on the deadline date shall be untimely. Upon receipt of notice that the Department has received an appeal from a provider involving services provided or to be provided to the Contractor's member, the Contractor must verify that the provider has exhausted all of the Contractor's reconsideration processes. Further the Contractor must verify, based upon the Contractor's records, that the appeal to the Department meets the DMAS timeliness requirements (i.e., within thirty (30) days of the Contractor's last date of denial). The Contractor must notify the Department's Appeals Division within two (2) business days of the receipt of the appeal notice to the Department, of any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal

does not appear to meet the Department's timeliness requirements (based upon the Contractor's records).

Provider appeals to the Department will be conducted in accordance with the requirements set forth in § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.* There are two levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is before an informal appeals agent employed by the Department. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and an administrative hearing representative employed by the Department helps present the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Department Director in issuing the final agency decision.

10.2.B.I Informal Appeal

Providers appealing a Contractor's decision shall file a written notice of informal appeal with the Department's Appeals Division within thirty (30) days of the provider's receipt of the Contractor's final reconsideration decision. The provider's notice of informal appeal shall identify the decision being appealed. Failure to file a written notice of informal appeal within thirty (30) days of receipt of the Contractor's final reconsideration decision shall result in an administrative dismissal of the appeal.

The Contractor shall file a written case summary with the Department's Appeals Division within thirty (30) days of the filing of the provider's notice of informal appeal. The Contractor shall mail a complete copy of the case summary to the Department's MCO Contract Monitor and the provider on the same day that the case summary is filed with the Department's Appeals Division. For each adjustment, patient, and service date or other disputed matter identified by the provider in its notice of informal appeal, the case summary shall explain the factual basis upon which the Contractor relied in taking its action or making its decision and identify any authority or documentation upon which the Contractor relied in taking its action or making its decision. The Contractor shall comply with all state and federal laws, regulations, and policies regarding content and timeframes for appeal summaries. Failure to submit case summaries within the required timeframe and according to the applicable regulatory requirements contained within 12 VAC 30-20-540 shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees.

The Department's informal appeals agent shall conduct the conference within ninety (90) days from the filing of the notice of informal appeal. If the Contractor, the provider, and the DMAS informal appeals agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the DMAS informal appeals agent shall specify the time within which the provider may file written submissions, not to exceed ninety (90) days from the filing of the notice of informal appeal. If a provider submits written submissions after filing the notice of appeal, the Contractor is responsible for submitting a response within the time period set by the informal appeals agent. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

If an informal conference is conducted, the Contractor is required to attend and defend the Contractor's decision at the informal conference with the provider before a DMAS informal appeals agent. If the Contractor's decision was based in whole or part upon a medical determination such as medical necessity or appropriateness, the Contractor shall provide sufficiently qualified medical personnel to attend the conference and defend the decision being appealed. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees. The conference may be recorded for the convenience of the DMAS informal appeals agent. Because the conference is not an adversarial or evidentiary proceeding, no other recordings or transcriptions shall be permitted. Any recordings made for the convenience of the informal appeals agent shall not be released to the Department, the Contractor, or the provider.

Upon completion of the conference, the DMAS informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed thirty (30) days. Only documentation or information filed within the time specified by the DMAS informal appeals agent shall be considered.

The informal appeal decision shall be issued within one hundred and eighty (180) days of receipt of the notice of informal appeal. Providers have the right to appeal the DMAS informal appeal decision in accordance with 12 VAC 30-20-560, as a formal appeal.

10.2.B.II Formal Appeals

Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within thirty (30) days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within thirty (30) days of receipt of the informal appeal decision shall result in dismissal of the appeal.

At the formal level, the Contractor assists the Department's staff counsel in preparing the Department's evidence and acts as a witness at a hearing before a hearing officer appointed by the Virginia Supreme Court.

The Department and the provider shall file with the DMAS Appeals Division all documentary evidence on which the Department or the provider relies within twenty one (21) days of the filing of the notice of formal appeal. Simultaneous with filing, the filing party shall transmit a copy to the other party and to the hearing officer. Only documents filed within twenty one (21) days of the filing of the notice of formal appeal shall be considered. The Department and the provider shall file any objections to the admissibility of documentary evidence within seven days of the filing of the documentary evidence. Only objections filed within seven (7) days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven (7) days of the filing of the objections.

The hearing officer shall conduct the hearing within forty- five (45) days from the filing of the notice of formal appeal, unless the hearing officer, the Department, and the provider all mutually agree to extend the time for conducting the hearing. Notwithstanding the foregoing, the due date for the hearing officer to submit the recommended decision to the Department's Director, shall not be extended or otherwise changed.

If there has been an extension to the time for conducting the hearing, the hearing officer is authorized to alter the due dates for filing opening and reply briefs to permit the hearing officer to be in compliance with the due date for the submission of the recommended decision.

Within thirty (30) days of the completion of the hearing, the Department and the provider shall file their opening briefs with the DMAS Appeals Division. Any reply brief from the Department or the provider shall be filed within ten (10) days of the filing of the opening brief to which the reply brief responds. Simultaneous with filing either the opening brief or the reply brief, the filing party shall transmit a copy to the other party and to the hearing officer.

Hearings shall be transcribed by a court reporter retained by the Department.

The hearing officer shall submit a recommended decision to the Director of DMAS with a copy to the provider within one hundred and twenty (120) days of the filing of the formal appeal notice. If the hearing officer does not submit a recommended decision within one hundred and twenty (120) days, then the Department shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

Upon receipt of the hearing officer's recommended decision, the DMAS Director shall notify the Department and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed with the Department's Appeals Division within fourteen (14) days of receipt of the DMAS Director's letter. Only exceptions filed within fourteen (14) days of receipt of the DMAS Director's letter shall be considered. The DMAS Director shall issue the final agency case decision within sixty (60) days of receipt of the hearing officer's recommended decision.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearing or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the Department's Appeals Division. Contractor travel or telephone expenses in relation to appeal activities shall be borne by the Contractor. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's non-compliance, <u>including but not limited to the amount in dispute together with costs and legal fees</u>. The Contractor shall supply the necessary expertise to

defend its actions and shall assist the formal appeals representative in the preparation of post-hearing matters leading to the Final Agency Decision.

The Department's final administrative appeal decision may be appealed through the court system in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. However, the court review is limited to errors of law only. No new evidence is taken. During the court appeal process, the Department and/or its counsel at the Office of the Attorney General may have a need to confer with the contractor to gain further information about the appealed action. The Contractor must respond to inquiries in a timely fashion. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

10.3 MONITORING AND EVALUATION OF MEMBER AND PROVIDER GRIEVANCES AND APPEALS

The Contractor shall have in place a mechanism to link its member and provider grievances and appeals system, as set forth in Section 10, to the QIP and credentialing process.

The Contractor shall, at a minimum, track trends in grievances and appeals and incorporates this information into the QI process. The Contractor's appeals and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards.
See Section 10 "Grievances and Appeals" for more information.

The grievance and appeals processes must be integrated with the QIP. The grievance and appeals process shall include the following:

- Procedures for registering and responding to grievances and appeals in a timely fashion.
- Documentation of the substance of the grievance or appeal and the actions taken;
- Procedures to ensure the resolution of the grievance;
- Aggregation and analysis of these data and use of the data for quality improvement.
- The Contractor must maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish Medallion 3.0 from commercial members if the Contractor does not have a separate system for Medallion 3.0 members.
- Additionally, in accordance with 42 C.F.R 438.416, the record of each grievance or appeal must contain at a minimum, all of the following information:
    - A general description of the reason for the appeal or grievance
    - The date the appeal or grievance wasreceivedd
    - The date of each review, or if applicable, review meeting
    - The resolution at each level of the appeal or grievance, if applicable
    - The date of resolution at each level, if applicable
    - The name of the covered person for whom the appeal or grievance was filed

The record must be accurately maintained in a manner accessible to the State and available upon request to CMS.

11. Information Systems Management

11.1 SYSTEMS MANAGEMENT

In accordance with 42 C.F.R § 438.242, the Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The Contractor's management information systems must be capable of furnishing the Department with timely, accurate, and complete information. Such information systems shall:

11.1.A Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;
11.1.B Accept and process provider claims as set forth in this Contract;
11.1.C Generate and submit encounter data as set forth in this Contract;
11.1.D Track provider network composition and access as set forth in this Contract;
11.1.E Track grievances and appeals as set forth in this Contract;
11.1.F Perform quality improvement activities, as set forth in this Contract;
11.1.G Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract;
11.1.H Ensure that data received from providers is accurate, and complete by:
11.1.H.I Verifying the accuracy and timeliness of reported data;
11.1.H.II Screening the data for completeness, logic, and consistency; and
11.1.H.III Collecting service information in standardized formats as set forth in this Contract.

Any reference to "systems" in this Section shall mean the Contractor's MIS unless otherwise specified. If the Contractor subcontracts any MIS functions, then these requirements apply to the subcontractor's systems.
The Contractor shall accommodate and modify future system changes/enhancements to claims processing or other, related systems as soon as possible after being notified by the State of the change or enhancement. The Contractor shall advise the Department in writing of the anticipated implementation date of the system changes/enhancements. In addition, the system shall be able to accommodate all future requirements based upon Federal and State statutes, policies and regulations. Unless otherwise agreed by the State, the Contractor shall be responsible for the cost of these changes**.** The Contractor shall make available to the Department and CMS, upon request, all data collected by the Contractor in relation to and in support of the program.[42 C.F.R § 438.242(b)(4)]

11.2 ELECTRONIC DATA SUBMISSION

The Contractor may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 C.F.R. § 142.308(d). If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

11.2.A Electronic Data Interchange (EDI)

Each party will transmit electronic files directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.
Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing, or handling electronic files. Each party is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

11.2.B Test Data Transmission

The Contractor shall be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Contractor shall pass the testing phase for all encounter claim type submissions within twelve (12) calendar weeks from the effective date of the change or start-up of a newly contracted MCO.
The Contractor shall submit the test encounters to the Department's Fiscal Agent electronically according to the specifications of the HIPAA Implementation Guide, DMAS Companion Guide, and the Managed Care Technical Manual.
An MCO (or Vendor) can lose production privileges due to high volume of compliance and/or critical errors (as determined by the Department). Both the Department and its Fiscal Agent can remove production privileges. When an MCO (or Vendor) loses its production privileges, then the MCO (or Vendor) it must actively test with the Department and its Fiscal Agent. Production privileges are expected to be regained within thirty (30) days.

11.2.C Garbled Transmissions

If a party receives an unintelligible transmission, that party will promptly notify the sending party (if identifiable from the received transmission).

11.2.D Enforceability and Admissibility

Any document/file properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be "a writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document/file which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents/files introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

11.3 ENROLLMENT PROCESSING

The Department, or its duly authorized representative, shall provide the Contractor on a monthly basis a listing of all members who have selected or been assigned automatically to the Contractor's plan. The listing, or "enrollment roster," shall be provided to the Contractor sufficiently in advance of the member's enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, as described in this Contract. Should the enrollment report be delayed in its delivery to the Contractor, the applicable

timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment report is delayed. The MMIS eligibility cut-off schedule is documented in the Managed Care Technical Manual. The MCO Enrollment reports shall provide the Contractor with ongoing information about its members and disenrollees and shall be used as the basis for the monthly capitation payments.

11.3.A Enrollment Roster

The enrollment roster (834) will list all of the Contractor's members for the enrollment month who are known on the report generation date. The Enrollment Roster will be provided to the Contractor twice a month per the schedule documented in the Managed Care Technical Manual. The Contractor shall reconcile each enrollment report as expeditiously as is feasible.

11.3.B Capitation Payment File

The 820 payment file will list all of the Contractor's members for the enrollment month who are known on the report generation date. The 820 payment file will be provided to the Contractor the month after the member is enrolled as detailed in the Managed Care Technical Manual.

11.3.C Reconciliation of Enrollment

The Contractor shall work with the Department to ensure that the enrollment databases of the Department and the Contractor are reconciled. The Department may audit the Contractor's Medicaid enrollment database.

11.3.D Retroactive Adjustments

Retroactive adjustments to enrollment and payments shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to enrollment without regard to timeliness of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment update/correction. The Department shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

11.3.E Provider Enrollment Verification

The Contractor must have in place policies and procedures to ensure that in-and out-of-network providers can verify enrollment in the Contractor's plan prior to treating a patient for non-emergency services. The Contractor must provide within five (5) business days of the date on which the Contractor receives the enrollment report from the Department, the ability to verify enrollment by telephone or by another timely mechanism.

11.4 PROVIDER IDENTIFICATION NUMBERS (NPIS,)

In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the Contractor must assign unique identifiers to providers, including physicians, and must require that providers use these identifiers when submitting data to the Contractor.

The Contractor is responsible to ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. Monthly, the Department produces a provider file that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider identification number for the claim and

service date. The Contractor will make best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

11.5 ENCOUNTER DATA

For the purposes of this Contract, an encounter is any service received by the member and processed by the Contractor and/or its subcontractors. The Contractor shall submit encounters for all services it processes with the exception of claims the Contractor or subcontractor has determined to be a duplicate of a previously processed encounter and other exceptions as noted in the Managed Care Technical Manual. The Contractor is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the Contractor by the Department for encounters.

The Contractor must ensure that all electronic encounter data submitted to the Department are timely, accurate and complete. The Contractor shall fully cooperate with all Departmental efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the Department's Fiscal Agent. The Contractor shall comply with all requests related to encounter data monitoring efforts in a timely manner. [42 C.F.R.§§ 438.242(c)(1)-(4) and 438.818]

11.5.A Submission Standards

Approved and denied encounters shall be submitted following the guidelines established by the Managed Care Technical Manual, including the format, data elements, and data values specified. All encounters must be submitted via Virginia's EDI FTP Server as described in that guide.

The encounter submission calendar is documented in the Managed Care Technical Manual. This calendar defines the schedule for submission of encounters by type for each contractor. The Contractor shall adhere to the Department's submission schedule.

Submitted encounter files should only include the normal submission, no backlog, no large sized compliance errors, ST-SE errors or error corrections, unless agreed to in advance by the Department. Files should be submitted to the FTP site before noon on the designated date. Any changes or delays to the submission dates require prior approval by the Department. The Department can, at its discretion, pass through the full cost to the Contractor for encounter processing costs incurred when the Contractor submits a duplicate file to Virginia's EDI FTP server. This pass-through cost will not exceed the amount the Department is charged by its fiscal agent.

11.5.B Data Certifications

All accepted encounter submissions are required to be certified. The Contractor must keep track of every encounter submission made through the State's Fiscal Agent during the month and the MCN assigned to each. At the end of each calendar month, this data must be reported to the Department and certified as specified in the Managed Care Technical Manual. The Encounter Certification form requires the signature of the Contractor's Chief Financial Officer, Chief Executive Officer or a person who reports directly to and who is authorized to

sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. Refer to the Managed Care Technical Manual for additional details about encounter submissions and certification.

The use of the certification form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

11.5.C Timeliness of Encounter Data

The Contractor shall submit to the Department ALL electronic encounter claims within sixty (60) calendar days of the claim payment date in the contractor or subcontractor MIS. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require more frequent submissions, based on file size/volume.

Each month, for each encounter record the Department will calculate the lag days between the MCO's submitted payment date and the date that the encounter was received by Virginia's EDI FTP server. The Department will assess a monetary sanction when more than five percent (5%) of the encounters have a lag of more than sixty (60) days. For purposes of the lag calculation, any encounter record that has a missing or invalid MCO date of payment will be considered as more than sixty (60) days.

11.5.D Completeness of Encounter Data

The Contractor must evaluate the completeness of data from their providers and subcontractors on a periodic basis, in particular providers and subcontractors who are capitated or paid under a global fee arrangement. The Contractor must report the plan used by the Contractor, including frequency of review, to ensure encounter data completeness at start up, when revised, and upon request. Any deficiencies found through the review process must be reported to the Department within sixty (60) calendar days. A corrective action plan to address any deficiencies found must be provided to the Department within thirty (30) calendar days after notification of any deficiencies.

On an annual basis, the Department will reconcile the encounter data submitted to the MMIS by the Contractor against the data submitted to the Department by the Contractor for rate setting purposes. The Department will assess a monetary sanction for each service type where there is more than a five percent (5%) variance between the services reported in the rate data and the encounters submitted to the MMIS.

11.5.E Accuracy of Encounter Data

If it is determined that an error occurred at no fault of the State or its Fiscal Agent, the Contractor is required to submit corrected encounter data. At its discretion, the Department can pass through the full cost to the Contractor for voiding and/or adjusting and replacing the

encounter data in the Virginia MMIS. This pass-through cost will not exceed the amount the Department is charged by its Fiscal Agent.

11.6 REPORTING

The Contractor shall submit all required report deliverables as specified in this Contract and in the current the Managed Care Technical Manual. In the event that report deliverables are returned to the Contractor due to errors, the Contractor agrees to correct the incorrect data and resubmit within ten (10) business days.

Unless otherwise specified, the Contractor shall submit all reports to the Managed Care secure FTP server at: https://vammis-filetransfer.com. All submissions must comply with the *Code of Virginia* § 32.1-325, 12 VAC 30-20-90, §1902(a)(7) of the Social Security Act, and 42 C.F.R. § 431.300.

11.7 DATA QUALITY REQUIREMENTS

11.7.A General Requirements

The Contractor shall meet all data requirements as defined by the Department and in compliance with 42 C.F.R §§ 438.604, 438.606, 438.818, 438.116, and 438.206-207. All data shall be transmitted in a HIPAA-compliant manner. The Department will require all data to be submitted based on Uniform Data Specifications that will be described by the Department in future guidance. This guidance will include, but will not be limited to; electronic data interchange (EDI) companion guides, EDI implementation guides, Managed Care Technical Manual, Medallion 3.0 reporting requirements, or other documents that refer to this section of the Contract. All deadlines and schedules for data submissions shall be as set forth in this Contract, unless a later date is agreed to between the parties.

The Department may require any data inclusive or relevant to the Members from the Contractor within sixty (60) calendar days' notice, in accordance with the format, mode of transfer, schedule for transfer, and other requirements detailed by the Department in its supporting documentation. All supporting documentation may be modified at the discretion of the Department, and the Contractor shall have sixty (60) days from the date of the document's modification to comply. As described by the Department in its supporting documentation, the Contractor shall successfully exchange all required data with the Department no later than one hundred and eighty (180) calendar days after the start of the contract. For newly required data, the Contractor shall have sixty (60) calendar days to implement the exchange of each data set as specified by the Department. The Contractor shall produce any required or requested data according to the specifications, format, and mode of transfer established by the Department, or its designee, within sixty (60) calendar days of notice.

At a minimum, the Contractor shall transmit all data files in the format described in the Uniform Data Specifications guidance documentation including, but not limited to the following:

1) All encounter data;
2) Financial data and reports for payments to providers contracted to provide services to Members;
3) Service authorizations (approved, denied, and pending); and,
4) Provider network data for any providers who are eligible to provide services to the Members.

The Department may also require additional data sets, which shall be defined in supporting documentation at the time requested. The Contractor shall have sixty (60) calendar days from the date of the request to provide such requested additional data, which may include, but is not limited to, the following:

1) clinical data;
2) visit verification data;
3) assessment data;
4) medical record data.

All data submissions are required to be certified. Data certification forms shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall keep track of every record submitted to the Department or its designee and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification.

The Contractor shall disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor shall provide prior notification to the Department of any anticipated changes that may have an impact on the substance or process of data exchanges between the parties, and shall engage with testing in order to ensure continuity of existing data exchanges.

The following requirements shall apply to all submissions. For each data submission, the Contractor shall:

1) Collect and maintain 100% of the data required by the Department.
2) Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which shall include:
   a) Metrics that measure completeness, timeliness, and accuracy of the data;
   b) Benchmarks that describe whether the Contractor's performance is compliant with the Department's requirements;
   c) A description of how each measure is calculated by the Department;
3) Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation;
4) Participate in user acceptance testing with the Department in order to measure the level at which the test submissions meet data and data quality requirements before routine submissions from the Contractor begin;
5) Ensure that Contractor data can be individually linked to Department data at the record level (e.g. Contractor data on Members can be linked to the Department's unique Member identifier); and,
6) Provide any reports on required data as requested by the Department.

11.7.B Data Reconciliation and Potential Audit Requirements

The Department may request a sample extract of previously submitted data from the Contractor that shall be compared to data received by the Department. At the discretion of the Department, the Contractor shall participate in site visits and other reviews and assessments by the

Department, or its designee, for the purpose of evaluating the completeness of the Contractor's data inventory as disclosed to the Department, and to evaluate the collection and maintenance of data required by the Department. Upon request by the Department, or its designee and with thirty (30) calendar days' notice, the Contractor shall provide DMAS-specified Member records in order to permit the Department to conduct data validation assessments.

The Department, or its designee, may investigate suspected data quality issues including, but not limited to, deviations from expected data volume, or expected data corrections, voids or adjustments. Suspected data quality issues discovered by such investigations may result in the addition of metrics to the Data Quality Scorecard or the requirement that the Contractor replace data with suspected data quality issues at no cost to the Department. Any cost incurred by the Department to reprocess replacement data that the Department determines has data quality issues shall be passed through in its entirety to the Contractor. Costs for replacing such data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

11.7.C Data Inventory and Data Quality Strategic Plan Requirement

At least twice yearly, or as otherwise requested by the Department, the Contractor shall submit to the Department a data inventory including, but not limited to:

1) the data's origin (*i.e*. what entity originally generated the data);
2) the business purpose of the data and reason for its existence;
3) a comprehensive description of all metadata elements, including:
    a. a list of all data fields
    b. a business description of the content of each field
    c. the field's format
    d. a list of valid values (where the data field is defined by a limited value set); and,
4) description of the format, schedule, and any other required details regarding how the data is transmitted to DMAS, if that source is required by the Department.

Should the Contractor possess a new data source with data on the Members, the Contractor shall inform the Department sixty (60) calendar days prior to that data source's acquisition or creation.

The Contractor shall provide the Department with an Annual Data Quality Strategic Plan in accordance to the specifications of the Department that addresses:

1) The Contractor's plan for ensuring high quality data that complies with the Department's standards for accuracy, timeliness, and completeness as described in the Data Quality Scorecard or other supporting documentation;
2) Plans and timelines for improving performance on the metrics in the Data Quality Scorecard, unless the Contractor is compliant on all measures;
3) What procedures and automated checks exist in the Contractor's systems to prevent transmission of non-compliant data; and,
4) The compliance actions and data quality standards expected of service providers, billing providers, sub-contractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

11.7.D Data Requirements for Encounters, Financial Transactions, Service Authorizations and Provider Data

11.7.D.I Encounters

The Contractor shall submit encounter data for Member services on which the Contractor incurred a financial liability, and shall include claims for provided services that were eligible to be processed, but where no financial liability was incurred. The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:

a. expected utilizations;
b. actual visits to expected visits;
c. service date lag time benchmarks;
d. expected EDI fail amounts; and,
e. average paid amount per service, by billing code.

2. The Contractor shall also:

a. Collect and maintain one-hundred percent (100%) of all encounter data for each covered service and supplemental benefit services provided to Members, including encounter data from any sub-capitated sources. Such data must be able to be linked to the Department's eligibility data;
b. Develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 USC 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program as directed in Section 7.2.S.VI(Drug Rebates) of this Contract; and,
c. Submit complete, timely, reasonable, and accurate encounter data to the Department within sixty (60) days of the Contractor's payment cycle and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in its supporting documentation.
d. The Contractor's systems shall generate and transmit encounter data files according to the Managed Care Technical Manual and any additional specifications as may be provided by the Department and updated from time to time

In following with 42 CFR §438.602(e), the Contractor shall comply with any audit arranged for by the Department to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by Contractor. The Contractor shall cooperate with the DMAS designated auditor(s) to ensure the audit is completed within the timeframe specified by the Department.

If the Department or the Contractor determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

1) Notify DMAS, prior to encounter data submission and within forty-eight (48) hours of discovery, that the data is not complete or accurate, and provide an action plan and timeline for resolution and approval.
2) Submit for DMAS approval a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level. Timeframe for submission shall be established by the Department, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements.
3) Implement the DMAS-approved corrective action plan within DMAS approved timeframes. Implementation completion shall not exceed thirty (30) calendar days from

the date that the Contractor submits the corrective action plan to the Department for approval.

4) Participate in a validation review to be performed by the Department, or its designee, following the end of a twelve (12) month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. The Department, or its designee, shall determine whether the Contractor is financially liable for such validation review.

11.7.D.II Provider Network

The Contractor shall in accordance 42 C.F.R.§ 438.242(b)(3)(iii):

1. Collect and maintain 100% of all provider data for providers in that Contractor's or sub-contractor's network where the Contractor has incurred a financial liability or denied services for Members; and,

2. Submit complete, timely, reasonable, and accurate provider network data to the Department daily, prior to the Contractor's submission of encounters, and in the form and manner specified by the Department. The Department will use this provider file submission for Medallion 3.0 MCO assignments and encounter processing. The first submission shall be sent sixty (60) days prior to the Department's program implementation. Standard formats, required data elements, and other submission requirements shall be detailed in the Managed Care Technical Manual; and,

3. Submit to the Enrollment Broker a complete provider file in a Department approved electronic format thirty (30) calendar days prior to the effective date of the Contract. An updated file with all of the changes to the network shall be submitted to the Enrollment Broker weekly thereafter or more frequently, if needed, during any program expansions (e.g., upon adding additional populations to the Medallion 3.0 program). Refer to the *Managed Care Technical Manual*; and,

4. Submit to the Department a complete provider file on a monthly basis, or on a more frequent basis as requested by the Department for network analysis. The Medallion 3.0 Network Requirements Submission Manual (NRSM) details the required provider reporting data elements. Additional required elements to be included in this provider file may be identified by the Department.

11.7.D.III Financial Transactions

The Contractor shall:

1. Collect and maintain 100% of all Health Care Claim Payment and Remittance Advice data for payments to providers contracted to provide services to Members; and,

2. Submit complete, timely, reasonable, and accurate financial data to the Department within 48 hours of the Contractor's payment cycle and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

11.7.D.IV Service Authorizations

The Contractor shall:

a. Collect and maintain 100% of all service authorization data for services authorized, pending, or denied for Members.

b. Ensure that service authorization data includes utilization data for all claims associated with services provided pursuant to the specific authorization;

c. Submit complete, timely, reasonable, and accurate service authorization data to the Department no less than weekly, and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

11.7.E Data Quality Penalties

Where DMAS determines that the Contractor has failed to comply with the Departments' data exchange requirements or is non-compliant with data quality benchmarks, DMAS may impose the sanctions set out below effective January 1, 2018. The process for the Department's imposition of sanctions shall comply with the requirements of 42 C.F.R. §§ 438.700(c) and 438.704(b)(1).

The Department shall develop for the Contractor a Data Quality Scorecard, which shall be described in supporting documentation. The Data Quality Scorecard may include up to 40 data quality performance metrics, and performance by the Contractor on the scorecard shall be communicated monthly by the Department to the Contractor. If a new data quality metric is to be added to the Data Quality Scorecard, the Contractor shall have ninety (90) calendar days before data quality withholds may occur based on the Contractor's performance on that metric.

Where DMAS determines that the Contractor has failed to submit required data or meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department shall send a notice of non-compliance. The Department reserves the right to apply penalties for non-compliance.

A Notice of Non-Compliance by the Department to the Contractor shall include:

1. A description of the data quality issue and the Contractor's performance on any metrics that triggered the non-compliance notice;

2. The action that shall be taken by the Contractor in order to cure the performance failure; and,

3. Financial withhold or penalties as a result of non-compliance.

The Department may require the Contractor to replace any non-compliant data with compliant data at no cost to the Department. Any cost incurred by the Department to reprocess replacement data shall be passed through in its entirety to the Contractor. Costs for replacing non-compliant data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

12. Financial Management

The Contractor shall establish and maintain a financial management capability sufficient to ensure that the requirements of Section 2 "Requirements for Operations," are met.

12.1 FINANCIAL STATEMENTS

12.1.A Bureau of Insurance Filings

The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance.

Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

12.1.A.I Annual Audit by Independent Contractor

The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. [42 C.F.R § 438.3(m)] The Contractor shall provide the Department a copy of such an audit within sixty (60) calendar days of completion of the audit.

12.1.B Financial Report to the Department

The Contractor shall agree to work with the Provider Reimbursement Division of the Department to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Medallion 3.0 Program. The Department reserves the right to approve the final format of the report. The report shall be submitted on a quarterly basis to the Department following the same schedule as reports for the BOI. The first quarterly reporting period shall begin on July 1 and end on September 30th. This report is subject to audit and verification by the Department.

For Contractors with multiple Medicaid lines of business in Virginia, the quarterly report should segregate and report data for each program (CCC Plus, Medallion, etc.) and reconcile to the annual BOI reports.

On an annual basis, each contractor shall submit supplemental information related to administrative expenses that (1) identify all non-allowable expenses for Medicaid reimbursement and (2) allocate its administrative expenses across major eligibility groups.

Non-allowable expenses for Medicaid reimbursement include but are not limited to:

- Related party management fees in excess of actual cost;
- Lobbying expenses,
- Contributions,
- State and Federal income taxes,
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs;
- Management fees relating to non-Virginia operations;
- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific MCO enrollees;
- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs.
- Accruals for future losses;
- Reserves based on estimates for bankrupt providers;
- Unsupported medical expenses.

12.2 FINANCIAL RECORDS

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Department prior to making any changes to its basis of accounting.

12.3 FINANCIAL SOLVENCY

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards**. [**Section 1903(m)(1) of the Act and § 438.116(b)]

12.4 CHANGES IN RISK BASED CAPITAL REQUIREMENTS

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in risk based capital requirements imposed by the Bureau of Insurance or any other entity.

12.5 PAYMENT TO MCOS

The Department shall issue capitation payments on behalf of members at the rates established in this Contract and modified during the contract renewal process. Capitation payments may only be made by the State and retained by the Contractor for Medicaid-eligible members as set forth in 42 C.F.R. § 438.3(c)(2). The Contractor shall accept the established capitation rate paid

monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for June enrollment will occur in July, July payment will be made in August, etc.). If an individual is enrolled with the Contractor the first day of any given month, that MCO has the responsibility of providing services to that member no matter if they move to another locality. If the member moves to a locality outside of the MCOs service area, the member will be dropped from the plan's enrollment at the end of the month of change. The capitation payment is based on several factors (e.g., sex, age, aid category and FIPS) and is automatically generated by the system using the information in the system at the time of payment. Individuals who have their FIPS changed even towards the end of the month of enrollment will be disenrolled at the end of the month from the MCO if that individual's FIPS is outside of the MCOs service area/region. Any and all costs incurred by the Plan in excess of the capitation payment will be borne in full by the Plan. The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments.

Under 42 C.F.R. 438.608(c), the Contractor and any subcontractor shall report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.The contractor shall provide the Department with its policies and procedures for identifying excess payments.

12.5.A Schedule of MCO Monthly Payments

Monthly capitation payments to the MCOs shall be paid retrospectively by the Department for the previous monthly MCO enrollment (Payment August enrollment will occur in September). The capitation payment schedule for the current contract year is documented in the Managed Care Technical Manual.

12.5.B Health Insurer Fee

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some Medallion 3.0 health plans that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid line of business. The Department will make an adjustment for the impact of non-deductibility of the health insurer fee on federal and State corporate income taxes but the adjustment shall not exceed the federal or State corporate income taxes reported on the plan's annual financial statement and allocated to the Virginia Medicaid line of business. The health insurer fee for the 2017 fee year was eliminated. If the contractor is required to pay the health insurer fee for the 2018 fee year then the Contractor shall furnish a copy of its Letter 5067C Final Fee Calculation from the IRS to the Department for 2018 by September 15, 2018. Along with a copy of the letter 5067C, the Contractor shall show the methodology for allocating the health insurer fee to the Virginia Medicaid line of business and certify the results. The Department will utilize this information to determine plan specific PMPM adjustments to the FY 2018 capitation rates. There will be separate components for the fee itself and the impact of non-deductibility of the health insurer fee on federal and State corporate income taxes. A health insurance fee adjustment will be determined after the

amounts due are known in the fall after the end of the fiscal year. The Department will make an aggregated retroactive adjustment by January 31, 2019.
The Contractor shall compare its final CY 2018 state and corporate income tax liability for the Medicaid line of business reported to the Bureau of Insurance and the capitation adjustment for the impact of non-deductibility of the health insurer fee and refund the difference, if any, between the capitation adjustment and the actual tax liability to the Department by June 30, 2019.

12.6 RECOUPMENT/RECONCILIATION

The Department shall recoup a member's capitation payment for a given month in cases in which a member's exclusion or disenrollment was effective retroactively. The Department shall not recoup a member's capitation payment for a given month in cases in which a member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of a member, cessation of Medicaid eligibility, inpatient admission to a nursing facility or State mental hospital, approval for the Technology Assisted home and community based waiver service, hospice services or transfer to a non-managed care eligible Medicaid category. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, ninth month and third trimester pregnancy exclusions, etc. In these cases the total capitation payment for the month will be rescinded.
The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or disenrollment.

If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after Contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile newborn payments on a monthly basis; all other payments are reconciled on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter. See the Managed Care Technical Manual for detailed information.

12.7 PAYMENT USING DRG METHODOLOGY

If the MCO has a contract with a facility to reimburse the facility for services rendered to its members, at time of admission, based on a Diagnosis Related Grouping (DRG) payment

methodology, the MCO is responsible for the full inpatient medical hospitalization from time of admission to discharge. This will be effective for any member who is actively enrolled in the MCO on the date of admission regardless if the member is disenrolled from the MCO during the course of the inpatient hospitalization. This is an exception to loss of eligibility rules in Section 5.11.

The Contractor shall provide coverage for payment of practitioner services rendered during the hospitalization for any dates in which the member was enrolled with the contractor on the related date of service.

12.8 PAYMENT FOR NEWBORNS

Until such time that a newborn is assigned a Medicaid identification number, the charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor for the birth month plus two (2) months. Where enrollment errors occur that are later corrected, regardless of the time frame to correct such error, the Contractor is required to cover the newborn member and related charges. The Department will reimburse the Contractor the appropriate capitation payment.

12.9 BILLING MEMBERS FOR COVERED SERVICES

The Contractor, including its network providers and subcontractors, shall not bill a member for any services provided under this Contract. The Contractor shall assure that all in-network provider agreements (Reference Attachment III. Section A. Number 2) includes requirements whereby the member shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor can bill the member for the service.

12.9.A Billing Members for Medically Necessary Services

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a member under the State Plan or under this Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as members are withdrawn from assignment to the Contractor.

Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), and 42 C.F.R § 438.106(a)(b)(1)(2)(c), the Contractor and all of its subcontractors shall not hold a member liable for:

12.9.A.I Debts of the Contractor

Debts of the Contractor in the event of the Contractor's insolvency;

12.9.A.II Payment for services provided by Contractor

Payment for services provided by the Contractor if the Contractor has not received payment from the Department for the services or if the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor.

12.9.A.III Excessive Payments

Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the member if the service had been received directly from the Contractor.

12.9.A.IV Balance Billing

The Contractor shall require that subcontractors and referral providers not bill members, for covered services, any amount greater than would be owed if the entity provided the services directly. [Section 1932(b)(6) of the Act, 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2)]

12.10 THIRD-PARTY LIABILITY

12.10.A Comprehensive Health Coverage

Members enrolled in Medicaid, determined by the Department as having comprehensive health coverage including Medicare, will be assigned to the fee-for-service program, effective the first day of the month following the month in which the coverage was verified. Members will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the MCO is responsible for coordinating all benefits and following Medicaid "payer of last resort" rules. This means that deductibles and coinsurance are covered by the contracted MCO up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage.

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the member was not identified for exclusion prior to enrollment in the MCO, the Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify the Department on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage.

When the other payor is a commercial MCO/HMO organization, the Contractor is responsible for the full copayment amount. The member may not be billed by provider.

12.10.B Workers' Compensation

If a member is injured at his or her place of employment and files a workers' compensation claim, the Contractor shall remain responsible for all services. The Contractor may seek recoveries from a claim covered by workers' compensation if the Contractor actually reimbursed providers and the claim is approved for the workers' compensation fund. The Contractor shall notify the Department on a monthly basis of any members identified during that past month who are discovered to have workers' compensation coverage.

If the member's injury is determined not to qualify as a worker's compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with worker's compensation regulations.

12.10.C Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor shall notify the Department on a monthly basis of any members identified during that past month who have died and are over the age of fifty-five (55).

12.10.D Other Coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

Members with these other resources shall remain enrolled in the MCO. The Contractor shall notify the Department or its designated agent on a monthly basis of any members identified during that past month that are discovered to have any of the above coverage types, including members identified as having trauma injuries. The Contractor shall provide the Department with all encounter/claims data associated with care given to members who have been identified as having any of the above coverage.

12.11 MINIMUM MEDICAL LOSS RATIO (MLR) AND LIMIT ON UNDERWRITING GAIN

The Contractor shall be subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a contract specific basis and will only include revenue and expense experience applicable to members included under the contract. The MLR is calculated first followed by the calculation of the Underwriting gain limit.

The Contractor shall be subject to a minimum MLR of eighty-five percent (85%). The MLR shall be determined as the ratio of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue. If the MLR for a reporting year is less than eighty-five percent (85%) then the Contractor shall make payment to the Department equal to the deficiency percentage applied to the amount of adjusted premium revenue.

The Contractor is required to report a MLR annually based on 42 CFR § 438.8 including any credibility adjustment. The Contractor shall submit to the Department, in the form and manner prescribed by the Department, the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year. The MLR reporting year shall be the contract year.

The Contractor shall report to the Department the following information for each MLR reporting year based on data through the ninth (9th) month following the MLR reporting year:

a. Total incurred claims;

b. Expenditures on quality improving activities;
c. Expenditures on activities related to program integrity compliance;
d. Non-claims costs;
e. Premium revenue;
f. Taxes, licensing and regulatory fees;
g. Methodology for allocation of expenditures;
h. Any credibility adjustment applied;
i. The calculated MLR;
j. Any remittance owed to the State;
k. A reconciliation of the information reported in this report with the audited financial report;
l. A description of the aggregation method by covered population; and,
m. The number of Member months.

If the Contractor is required to make a payment to the Department the payment shall be due to the Department no later than twelve (12) months following the MLR reporting year.

The Contractor shall be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid premium income. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year developed in the same manner as the MLR (i.e. with data through the ninth (9th) month following the MLR reporting year). Such amounts shall be determined consistent with the reporting requirements for the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance with two exceptions. First, the non-claims costs should exclude the amount, if any, of non-allowable expenses as described in section 12.1.B. Second, the Health Insurer Fee (HIF) shall be excluded from the non-claims costs and the reimbursement from DMAS under section 12.5.B shall be excluded from revenue.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds three percent (3.00%) then the Contractor shall make payment to the Department equal to the sum of fifty percent (50%) of the excess of the percentage over three percent (3.00%) plus fifty percent (50%) of the excess of the percentage over ten percent (10.00%) applied to the amount of Medicaid premium income attributable to the contract. Such amount will be remitted to the Department as a refund of an overpayment. To illustrate, if the underwriting gain is nine percent (9%) then the Contractor shall refund to the Department three percent (3.0%) of Medicaid premium income. If the underwriting gain is eleven percent (11%) then the Contractor shall refund to the Department 4.5% of Medicaid premium income. If the underwriting gain is four percent (4.0%) then the Contractor shall refund to the Department 0.5% of Medicaid premium income.

All of the variables used in the calculation of the underwriting gain limit and the amount of any resulting payment shall be determined as if the limit did not exist but shall reflect any refund amount required due to the MLR contract provision. Contractors are required to notify the Department and provide supplemental information in the event that this limit impacted the financial results reported for a quarter. This supplemental financial information should include

revised values for Medicaid underwriting gain and Medicaid premium income determined without application of the limit.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 member months during the calendar year. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than twelve (12) months of experience in the program at the beginning of the calendar year.

If the Contractor is required to make a payment to the Department under this Contract provision, the payment shall be due to the Department no later than December 1 of the following calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based in whole or in part on the applicability of this contract provision.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than one hundred and twenty thousand (120,000) member months during the calendar year. The number of member months for a given calendar year shall be the amount reported on the Exhibit of Premiums, Enrollment and Utilization line six (6) under the column entitled Title XIX Medicaid attributable to the Medallion 3.0 contract. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than twelve (12) months of experience in the program at the beginning of the calendar year.

If the Contractor is required to make a payment to the Department under this Contract provision, the payment shall be due to the Department no later than June 1 of the following calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based upon the applicability of this contract provision.

The Contractor shall report a medical loss ratio (MLR) annually for Medallion 3.0 for each contract/reporting year based on 42 C.F.R. § 438.8 and any additional CMS guidance. Reporting specifications will be included in the MCTM.

12.12 REINSURANCE

12.12.A Pharmacy Reinsurance

Reinsurance is a stop-loss program provided by the Department to the Contractor. Reinsurance is available to cover ninety percent (90%) of a member's prescription drug costs above an attachment point. The cost to the Department of providing reinsurance coverage will be offset by a reduction to the capitation rate otherwise payable during the contract year. The amount of the reduction shall be determined prospectively and shall be applied to all capitation payments.

The amount to be used in the computation of reinsurance will be the Contractor paid amount. The Contractor must notify the Department quarterly of all members whose prescription drug costs have exceeded the attachment point during the contract year. All reinsurance claims are

subject to medical review by the Department. The attachment point varies by population group as follows: (1) HAP Members - $50,000, (2) Other Aged, Blind and Disabled (ABD) Members - $100,000, and (3) Low Income Family and Children (LIFC) Members including Foster Care and Adoption Assistance - $225,000.

The Department will reimburse a Contractor for ninety percent (90%) of the costs of prescription drug coverage (including prescription drugs administered in a physician's office or outpatient hospital setting) in excess of the attachment point for any member whose total costs of prescription drug claims incurred under the contract, less any Medicare/TPL payment, exceed the attachment point. Such reinsurance reimbursements shall be made quarterly for the preceding three (3) month period during the contract. Contractors are required to submit documentation for reimbursable claims along with an invoice within thirty (30) days of each quarter end. The quarterly periods end on September 30, December 31, March 31 and June 30 of the contract year. The deadline for final quarter will be 90 days after the final quarter ends , to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will make reinsurance reimbursements within sixty (60) days of receipt of such list/invoice or provide notice to the Contractor if additional information is required.

The Department reserves the right to perform audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

12.12.B ARTS Stop Loss

Contractors are responsible for Addiction and Recovery Treatment Services (ARTS) in Section 7.2.AA. Given the uncertainty of the potential cost of these services, the Department will implement a stop loss arrangement across all managed care programs that the contractor participates in with the Department. The stop loss time frame shall cover services with dates of service beginning April 1through June 30Under this arrangement, the Department shall reimburse the Contractor for one hundred (100%) of the costs for ARTS that exceed one hundred and twenty percent (120%) of the capitation payment for ARTS. Only ARTS services in the table are eligible for stop loss. The table includes the documentation necessary to identify the services eligible for stop loss and the method that will be used to value eligible costs. The services must be furnished consistent with the requirements in Section 7.2.AA.

New Services	**Method of Identification**	**Stop Loss Pricing**	**Per Unit**
Inpatient Hospital Services	Inpatient Claims for Individuals Age 21 or older with a Principal SUD Diagnosis	MCO Paid Amount	Discharge/Day
Residential Treatment Services	Claims for Inpatient Residential Treatment Services based on Provider List furnished by DMAS for Individuals Age 21 or Older	MCO Paid Amount	Day
Residential Group Home (currently covered only for pregnant women)	H2034	$175.00	Day

Peer Support Services-individual (eff July 1, 2017)	T1012	$6.50	15 minutes
Peer Support Services-group (eff July 1, 2017)	S9445	$2.70	15 minutes
Medication Administration	H0020		
Medication Costs in Clinics	S0109, J0571, J0572, J0573, J0574, J0575, J2315	See DMAS rate structure	See DMAS rate structure
Services with Higher Rates			
Substance Use Care Coordination	G9012	$243.00	month
Substance Use Case Management	H0006	$243.00	month
Intensive Outpatient	H0015	$250.00	day (min 3 hours)
Partial Hospitalization	S0201 (CMS 1500 claim); Revenue Code 0913 (UB04 claim)	$500.00	day (min 6 hours)
Opioid Treatment Services-Individual	H0004	$24.00	15 minutes
Opioid Treatment Services-Group	H0005	$7.25	15 minutes

The amount of the capitation payment for Medallion 3.0 shall be determined using the adjustment by eligibility group in Exhibit 8 of the rate book times the number of member months for which capitation payments are made in SFY18. These payments will be combined with other capitation payments for ARTS for other Medicaid programs that the Contractor participates in.

Stop loss reimbursements shall be made annually. Contractors are required to submit documentation for reimbursable claims minus any Medicare/TPL along with an invoice by September 30, 2018 (ninety (90) calendar days after the end of the state fiscal year). The Department will make stop loss reimbursements within sixty (60) calendar days of receipt of the documentation and invoice or provide notice to the Contractor if additional information is required.

12.13 "NEVER EVENTS" AND HEALTH CARE ACQUIRED CONDITIONS

The Contractor shall comply with 42 CFR § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The Contractor's reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR § 447.26.

12.13.A Hospital Acquired Conditions Adjustments

Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor (Thomas Reuters) used by the Department. For example, an inpatient claim with forty-five (45) covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to forty-two (42) covered days.

12.13.B Services which shall receive no payment

No payment shall be made for services for inpatients for the following Never Events: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or otherwise invasive procedure performed on the wrong patient.

12.13.C Provider Preventable Conditions

No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Under 42 C.F.R. §§ 438.3(g), 434.6(a)12(i), and 447.26(b), the Contractor is prohibited from making a payment to a provider for provider-preventable conditions that meet the following criteria:

- Is identified in the State Plan.
- Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
- Has a negative consequence for the beneficiary.
- Is auditable.
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additionally, the Contractor must require all providers to report provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Further, the Contractor must report all identified provider preventable conditions to the Department.

12.13.D Reduction Limits for Provider Payments

Reductions in provider payment may be limited to the extent that the following apply:

12.13.D.I The identified provider-preventable conditions would otherwise result in an increase in payment.

12.13.D.II The Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

12.13.E Nonpayment shall not Prevent Access

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

12.13.F Adjustments

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

12.14 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) & RURAL HEALTH CLINICS (RHCS)

Prior to FQHC or RHC contract signature, the Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Contractor must establish the following type of contractual arrangement:

If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHC's or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of Medallion 3.0 members.

The Contractor must provide assurances that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the Contractor shall provide supporting documentation at the Department's request.

Within ten (10) business days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of arrangement it has established.

12.15 CERTIFICATION (NON-ENCOUNTERS)

Any payment information from the Contractor that is used for rate setting purposes or any payment related data required by the state must be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor must use Attachment XIII, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

12.16

12.17 INCREASED PAYMENTS TO ENSURE ACCESS IN EASTERN VIRGINIA/TIDEWATER

12.17.A Increased Payments to Qualifying Physicians

Pursuant to Item 301, Section DDDD(2)(b) of the 2015 Appropriation Act, the Contractor must use funds received from the Physician Access Adjustment component of the rates to increase payments to physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth.

The Physician Access Adjustment PMPM of $1.84 has been calculated to raise total reimbursement to the affected physicians to a level consistent with the average commercial rate in aggregate. The increased payments only apply to the Tidewater region, and as such, only the Tidewater LIFC and ABAD rates will be affected. The Contractor must provide documentation to the Department, as specified in the MCTM, that all funds received from the Physician Access Adjustment component of the capitation rate are used in accordance with this Subsection.

12.17.B Claims Processing Requirements

Payments under this subsection shall meet all requirements of Section 4.4 "Provider Payment."

12.18.C Subject to CMS Approval

No payment shall be made under this subsection without approval of the Physician Access Adjustment rate component by the Centers for Medicare & Medicaid Services.

13. ENFORCEMENT, REMEDIES, & COMPLIANCE

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations including, but not limited to, the requirements of or pursuant to Section F of 12 VAC 30-120-380, as amended, the following remedies may be imposed.

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

The Department's administrative procedures shall not supersede the administrative procedures set forth in herein and those required by the Federal government.

Remedial Actions

The Department may pursue all remedial actions with the Contractor that are taken with Medicaid fee-for-service providers. The Department will work with the Contractor and the Contractor's network providers to change and correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner, as determined by the Department.

Remedies not Exclusive

The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable, and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

13.1 REMEDIES

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

13.1.A Federally-Prescribed Sanctions for Noncompliance

13.1.A.I Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions

Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. The Department will provide the Contractor with timely written notice before imposing an intermediate sanction (other than required temporary management) that explains the basis, nature of the sanction, and any applicable appeal

rights. Such sanctions may include any of the ones described in subparagraph 13.1.a.ii through 13.1.a.vii below, and may be imposed if the managed care organization:

13.1.A.I.a Fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to a member covered under the Contract;

13.1.A.I.b Imposes premiums or charges members in excess of the premiums or charges permitted under Title XIX of the Act;

13.1.A.I.c Acts to discriminate among members on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll a member, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible members whose medical condition or history indicates a need for substantial future medical services.

13.1.A.I.d Misrepresents or falsifies information that is furnished-

- To the Secretary of the State under this title; or
- To a member, a potential member, or a health care provider under such title.

13.1.A.I.e Fails to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Act.

In addition, the State may impose sanctions against a Managed care organization if the State determines that the entity distributed directly or indirectly through any agent or independent Contractor marketing materials that have not been approved by the Department or that contain false or misleading information. [42 C.F.R. §§ 438.700(c) and 438.704(b)(1)]

13.1.A.II Section 1932(e)(2)(A) of the Act allows the State to impose the following civil money penalties:

13.1.A.II.a For each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of $25,000.

13.1.A.II.b For each determination that the MCO discriminates among members on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible members based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, a maximum of $100,000. For each determination that the MCO misrepresents or falsifies information furnished to member, potential member, or health care provider, a maximum of $25,000.

13.1.A.II.c For each determination that the MCO has discriminated among members or engaged in any practice that has denied or discouraged

enrollment, the money penalty may be as high as $15,000 for each member not enrolled as a result of the practice, up to a maximum of $100,000.

13.1.A.II.d With respect to a determination that the MCO has imposed premiums or charges on members in excess of the premiums or charges permitted, the money penalty may be a maximum of $25,000 or double the amount of the excess charges; whichever is greater. The excess amount charged must be deducted from the penalty and returned to the member concerned.

All civil money penalties shall be imposed in accordance with 42 CFR § 438.706.

13.1.A.III Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management:

13.1.A.III.a Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the members. Temporary management may also be imposed if there is a need to assure the health of the organization's members during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.

13.1.A.III.b Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur**.** [42 C.F.R. §438.706]

13.1.A.IV Sections 1932(e)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed:

13.1.A.IV.a The State may permit members enrolled in a Managed care organization to disenroll without cause.

13.1.A.IV.b The State may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932(e) of the Act.

13.1.A.IV.c The State may suspend payment to the entity under Title XIX for individual members after the date the Secretary of Health and Human Services or the State notifies the entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur. [42 C.F.R. §§438.700(d)(1) and 438.702(a)(3)-(5)]

13.1.A.V Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and notify and allow members to disenroll without cause. [42 C.F.R. §438.706(b)-(d)]

13.1.A.VI Section 1932(e)(4) of the Act allows the State to terminate contracts of any Managed care organization that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity's members with other managed care entities or allow members to receive medical assistance under the State Plan other than through a Managed care organization.

13.1.A.VII Title 42 C.F.R. § 438.730 allows the State to recommend that CMS impose the denial of payment sanction for new members of the managed care organization when, and for so long as, payment for those members is denied by CMS:

13.1.A.VII.a The Contractor fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under this Contract to a member covered by this Contract.

13.1.A.VII.b The Contractor imposes on the member premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

13.1.A.VII.c The Contractor acts to discriminate among members on the basis of their health status or need for health care services;

13.1.A.VII.d The Contractor misrepresents or falsifies information that it furnishes to CMS or to the Department.

13.1.A.VII.e The Contractor misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider.

[42 C.F.R. §§438.700(b)(1)-(6), 438.726(b), and 438.730(e)(1)(i)]

13.1.A.VIII The State must give the Managed care organization a hearing before termination occurs, and the State must notify the members enrolled with the Managed care organization in writing of the hearing and allow the members to disenroll if they choose without cause.

13.1.B Other Specified Sanctions

If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the Contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

13.1.B.I Suspensions of New Enrollment

The Department may suspend the Contractor's right to enroll new Medicaid members (voluntary, automatically assigned, or both) under this Contract. The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option, must notify the Contractor in writing of its intent to suspend new Medicaid enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid enrollment or disenroll Medicaid members in anticipation of the Contractor not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify members of Contractor non-compliance and provide such members an opportunity to enroll with another MCO.

13.1.B.II Department-Initiated Disenrollment

The Department may reduce the number of current members by disenrolling the Contractor's Medicaid members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

13.1.B.III Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid members. The Contractor shall be given at least thirty (30) calendar days' notice prior to the Department taking any action set forth in this paragraph.

13.1.B.IV Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities which are geared toward potential members. The Contractor shall be given at least ten (10) calendar days' notice prior to the Department taking any action set forth in this paragraph.

13.1.B.V Additional Sanctions

In accordance with 42 C.F.R. §438.702(b), the Department may impose additional sanctions provided for under Virginia statutes or regulations to address noncompliance.

13.2 COMPLIANCE MONITORING PROCESS (CMP)

The Department shall be responsible for conducting an ongoing contract monitoring process. As part of this monitoring process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract. The Department may, at its sole discretion, conduct any or all of the following activities, as part of the contract monitoring process:

- Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;
- Conduct Contractor, network provider, and subcontractor site visits; and
- Review Contractor policies, procedures, and other internal documents.

13.2.A Compliance Monitoring Process (CMP), Generally

The purpose of the Department's Compliance Monitoring Process (CMP) is to detect and respond to issues of noncompliance and remediate contractual violations when necessary. The CMP uses a tiered points system to achieve the Department's goal of Contract Compliance. Furthermore, the CMP is comprised of a six (6) level deficiency identification system described below.

13.2.A.I CMP Point System, Generally

Points the Contractor incurs due to issues of non-compliance accumulate over a rolling twelve (12)-month schedule. The Department shall carry over all active points from the previous contract cycle, however, points more than twelve (12) months old expire and will no longer be counted. No points will be assigned for a violation the Contractor is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (i.e., natural disasters, a lightning strike disables a computer system, etc.).

13.2.A.II CMP Point System, Waiving Points

In cases where the Contractor is believed to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), the Department may assess or levy points on the Contractor.

- The Department will mitigate or consider waiving sanctions solely at its discretion for the following reasons: 1) for an infraction due to an unforeseen

circumstance (including but not limited to acts of nature, DMAS IM issues, etc.) beyond the Contractor's control; 2) during the first year of the Contractor's operation; 3) for instances when the Contractor identifies and self-reports infractions. The Contractor must communicate these infractions to the Department in writing within thirty (30) business days of discovery; and, 4) the first time the Contractor incurs the infraction.

13.2.B CMP Deficiency Identification System - Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent compliance violation/incident. A compliance violation, unless otherwise defined, will be at the Department's discretion based on the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident. Financial sanctions shall be imposed per infraction type. A Corrective Active Plan (CAP), MCO Improvement Plan (MIP), or other sanctions may be imposed in addition to the fines listed below. The Department has a six (6) level compliance deficiency identification system within its CMP. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

Level	**Point Range**	**Corrective Mechanism**	**Financial Sanctions/Fines**
1	0-15.5	MIP	None
2	16-25.5	CAP	$5,000
3	26-50.5	CAP	$10,000
4	51-70.5	CAP	$20,000
5	71-100.5	CAP	$30,000
6	> 100.5	Possible Agreement Termination	N/A
Other	Specific Pre-Determined Sanctions	See Section 13.C.III, As the situation requires.	See Section 13.C.III. Up to $20,000/day

13.2.C Compliance Violation Types

13.2.C.I One (1) Point Violations

The Department may, at its discretion, assess one (1) point when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts:

- Impairs the Department's ability to properly oversee and/or analyze Contractor performance, including but not limited to reporting errors.

Examples of one point violations include, but are not limited to, the following:

- **Noncompliance with Encounter Submissions – Critical Errors -** If the Department finds that the Contractor is unable to comply with the critical error standards in Section 11.5 of this Contract relating to encounter data submissions, as set forth in Managed Care Technical Manual (MCTM §1.5).

- Failure to use the most current Medallion 3.0 Contract as the basis for submissions, including all Contract Amendments to date at the time of submission.
- Failure to use the most current Managed Care Technical Manual (MCTM).
- Failure to return Contract Amendments on or before due date, in the absence of a minimum of forty-eight (48) hour notice to the Department. The Contractor must provide a legitimate reason for the delay, as determined by the Department, to avoid incurring a one (1)point violation.
- Failure to comply with the Department's defined critical encounter submission requirements (e.g., timeliness, failed voids, rebate date, etc.). Each critical issue will be identified and documented in the MCTM.

13.2.C.II Five (5) Point Violations

The Department may, at its discretion, assess five (5) points when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts:

- Impairs a member's or potential enrollee's ability to obtain accurate information regarding the Contractor services,
- Violates a care management process,
- Impairs a member's or potential enrollee's ability to obtain correct information regarding services, or
- Infringes on the rights of a member or potential enrollee.

Examples of five (5) point violations include, but are not limited to, the following:

- Failure to provide accurate provider panel information.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance**,** or state hearing requirements, including the failure to notify a member of his or her right to a state hearing when the Contractor proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to staff a twenty-four (24)-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the twenty-four (24)-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to health care providers, the Contractor's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify the Department, or members, of provider panel terminations.
- Failure to comply with a CAP (Corrective Action Plan) or MIP (MCO Improvement Plan).
- Failure to actively participate in quality improvement projects or performance improvement projects facilitated by the Department and/or the EQRO.
- Failure to meet provider Access to Care & Network Standards as defined in Section 3.

• Failure to comply with the Department's defined critical encounter submission requirements (e.g., timeliness, failed voids, rebate date, etc.). Each critical issue will be identified and documented in the MCTM.

•Noncompliance with Encounter Submissions may incur additional processing costs (See Section 11.5.E)

•Noncompliance with Claims Adjudication Requirements may incur additional fines (See *13.2.C.IV.c*, below).

13.2.C.III Ten (10) Point Violations

The Department may assess ten (10) points when the Contractor fails to meet a program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts:

- Affects the ability of the Contractor to deliver, or a member to access, covered services;
- Places a member at risk for a negative health outcome; or
- Jeopardizes the safety and welfare of a member.

Examples of ten (10) point violations include, but are not limited to, the following:

• Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).

• Failure to assist a member in accessing needed services in a timely manner after receiving a request from the member.

• Failure to provide medically-necessary Medicaid covered services to members.

• Failure to comply with the substantive MCO oversight requirements set forth in Section 3.16 Subcontractor Management and Monitoring. Late deliverables under this section will be treated under 13.2.C.IV.b.

• Failure to comply with the Program Integrity Requirements set forth in Section 9.2 Program Integrity Plan, Policies and Procedures. Late deliverables under this section will be treated under 13.2.C.IV.b.

• Failure to participate in transition of care activities or discharge planning activities.

• Failure to process prior authorization requests within the prescribed time frames.

• Repeated failure to comply with a CAP (Corrective Action Plan) or MIP (MCO Improvement Plan).

• The imposition of cost-sharing or copays on members that are in excess of the cost-sharing limits or copays permitted under the Medicaid program.

• Misrepresentation or falsification of information that the Contractor furnishes to the Department.

• Misrepresentation or falsification of information that the Contractor furnishes to a member, potential member, or health care provider.

• Failure to comply with the requirements for physician incentive plans, as set forth in 42 C.F.R. §§ 422.208 and 422.210.

• Failure to comply with the Quality Improvement & Oversight Requirements set forth in Section 8.1.

13.2.C.IV Other – Specific Pre-Determined Sanctions

13.2.C.IV.a **Adequate network-minimum provider panel requirements**

Any deficiencies in the Contractor's provider network, as specified in Section 3 of this Contract, may result in the assessment of a $1,000 nonrefundable fine for each provider category (e.g., PCP, pediatricians, OB/GYN). Compliance will be assessed at least quarterly.

The Department may assess additional sanctions (e.g. CAPs, points, fines) if (1) the Contractor violates any other provider panel requirements or (2) an Contractor's member has experienced problems accessing necessary services due to lack of an adequate provider panel.

13.2.C.IV.b **Submissions of Reporting Deliverables**

All submissions, data, and documentation submitted by the Contractor must be received by the Department as specified in Section 11.6 and must represent the Contractors in an honest and forthright manner. If the Contractor fails to provide the Department with any required submission, data or documentation (including failure to use the proper templates contained in the Managed Care Technical Manual), the Department may assess points on a "per report" basis, as outlined in the chart below, unless the Contractor requests and is granted an extension by the Department. Assessments for late submissions will be done based on the frequency requirement of the submission (i.e. monthly, quarterly, and annually). Grading is based on §3.1.2 "Deliverable Scoring" in the Managed Care Technical Manual.

Grading Scale in MCTM §3.1.2	**Points Assessed, (Per Report)**
A: >=91	0
B: >=81 and <91	0.5
C: >=71 and <81	1
D: >=61 and <71	1.5
F: <71	2

13.2.C.IV.c **Noncompliance with Claims Adjudication Requirements- 5 points**

If the Department finds that the Contractor is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance. If the Department has identified specific instances where an Contractor has failed to take the necessary steps to comply with the requirements specified in this Contract by (1) failing to

notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance.

13.2.D Corrective Action Plans and MCO Improvement Plans

In addition to sanctions, as described above, the Department may require the Contractor to submit MCO Improvement Plans and Corrective Action Plans.

13.2.D.I MCO Improvement Plans (MIPs)

The Department may require the MCO to submit an MCO improvement plan to address minor compliance violations/failures/deficiencies.

A MIP is only used for issues that do not rise to the level of a formal corrective action plan and are not intended to be disclosed by the Contractor in its business outside of the Commonwealth of Virginia. For all other purposes, a MIP functions as a Corrective Action Plan. MIPs must always include the necessary information and be submitted in the method as required the MCTM. If a MIP does not contain the necessary information, an additional sanction or violation point value may be assessed.

13.2.D.II Corrective Action Plans (CAPs)

When necessary, a corrective action plan (CAP) shall be initiated to address findings and observations that have been identified by the Department. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and state/federal regulations.

The Contractor's first step in preparing a CAP is to review the specific findings/observations noted in the communication received from the Department and determine the root cause of the deficiency.

CAPs must always include the necessary information and be submitted in the method as required in the MCTM. If a CAP does not contain the necessary information, an additional sanction or violation point value may be assessed.

13.2.E Other Financial Sanctions

The Department may impose financial sanctions/penalties upon the Contractor of at least the amount of payment required in the Contractor's contract with the disputing party.

13.2.E.I Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department must submit to the Contractor a list of the members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold

portions of capitation payments or otherwise recover damages from the Contractor in the following situations.

13.2.E.I.a Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary covered contract services, the Department may direct the Contractor to provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days' written notice prior to the withholding of any capitation payment.

13.2.E.I.b Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

13.2.E.II Procedure

In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

13.2.E.II.a The Department shall notify the Contractor of the Contractor's failure to perform required administrative functions under the Contract.

13.2.E.II.b The Department shall give the Contractor thirty (30) calendar days' notice to develop an acceptable plan for correcting this failure.

13.2.E.II.c If the Contractor has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.

13.2.E.II.d The Department shall notify the Contractor when it is determined that the Contractor is not in compliance with a provision in this Contract. Notice shall be sent requesting a corrective action plan to resolve the error. If the Contractor fails to respond to the Department's request in three (3) business days, the Department shall notify the Contractor in writing of its failure to respond to the Department is a violation of this Contract. If the Contractor continues to withhold corrective action within one (1) week of the date of the letter, the Department's Director shall notify the Contractor that its continued failure to act will result in one or a combination of the following remedies to the Department:

13.2.E.II.d(i) withhold of capitation;

13.2.E.II.d(ii) withhold/suspension of future enrollment;

13.2.E.II.d(iii) fines for violation not to exceed $10,000 per occurrence; and/or termination of the Contract.

13.2.E.III Suspension of Medicaid Payments in Cases of Fraud

In accordance with 42 C.F.R. § 455.23, Managed Care Organizations are subject to payment suspensions. States should suspend payments to managed care entities after the Department determines there is a credible allegation of fraud for which an investigation is pending. Credible allegation of fraud is defined under 42 C.F.R. § 455.2 as any allegation, which has been verified by the State, from any source, including: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. The Department does not have to notify the Contractor first of suspension of payments. The Contractor must be granted an administrative review where state law requires this.

13.2.E.IV Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid members and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor Medicaid activities.

13.3 PROHIBITED ACTIONS

13.3.A Prohibited Affiliations with Entities Debarred by Federal Agencies

In accordance with requirements described in 42 C.F.R. §§ 438.610, 438.214(d)(1), and 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at http://www.cms.gov/smdl/downloads/SMD061208.pdf), the Contractor shall comply with all of the following Federal requirements. Failure to comply with accuracy, timeliness, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

13.3.A.I Contractor Owner, Director, Officer(s) and/or Managing Employees

13.3.A.I.a The Contractor and or its subcontractors may not knowingly have a relationship of the type described in paragraph (b) of this section with:

13.3.A.I.a(i) An individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or 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.

13.3.A.I.a(ii) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

13.3.A.I.b The relationships described in this paragraph are as follows:

13.3.A.I.b(i) A director, officer, or partner of the Contractor

13.3.A.I.b(ii) A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.

13.3.A.I.b(iii) A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

13.3.A.I.c Consistent with Federal disclosure requirements described in 42 C.F.R. §§ 455.100 through 42 C.F.R. 455.106 and 438.610, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)* included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing.

13.3.A.II Provider & Contractor Disclosure of Ownership and Control, Business Transaction, and Criminal Conviction Information

In accordance with Federal regulations contained in 42 C.F.R. §§ 455.100 through 455.106, 438.608, and 438.610 the Contractor shall provide written disclosure for all of the following:

- Information on ownership and control (42 C.F.R. § 455.104),
- Information related to business transactions (42 C.F.R. § 455.105), and
- Information on persons convicted of crimes against Federally related health care programs (42 C.F.R. § 455.106)

The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)*, included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing. Additionally, the Contractor shall submit this completed form upon request to the Department within thirty- five (35) calendar days of the Department's request. The Department will review the ownership and control disclosures submitted by the Contractor and any of the Contractor's subcontractors in accordance with 42 C.F.R. §§ 438.602(c) and 438.608(c). Additionally, all disclosures must also be made in the timeframe and manner specified in accordance with 42 C.F.R §455.104.

The Contractor shall conduct monthly checks for all of the Contractor's owners and managing employees against the Federal listing of excluded individuals and entities (LEIE) database. Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this

Contract, sanction as described in Section 13 of the Contract and/or termination of this Contract by the Department.

The Contractor shall comply with § 1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, et seq.), as amended, which requires the disclosure and justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. § 300e, et seq., as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness.

13.3.A.II.a The information provided for transactions between the Contractor and a Party in Interest will include the following:

13.3.A.II.a(i) The name of the Party in Interest in each transaction;

13.3.A.II.a(ii) A description of each transaction and, if applicable, the quantity of units involved;

13.3.A.II.a(iii) The accrued dollar value of each transaction during the calendar year; and

13.3.A.II.a(iv) A justification of the reasonableness of each transaction.

13.3.A.II.b The Department requires review of any proposed acquisition or purchase of an existing Medicaid health plan. The proposed acquisition must benefit both the Commonwealth and the Department and must assure minimal disruption to Medicaid members and providers. As part of the review process, the Department requires the contractor to provide with its written notice, and the following additional items to include from the potential purchaser within 180 days or upon reasonable certainty of, the proposed acquisition date, but in no case less than 90 days fo the proposed acquisition taking effect:

- A letter of intent which describes the purpose and manner of the sale.
- The letter must include the acquisition plan, method and terms (e.g. stock or asset transfer), a proposed effective date, copies of BOI and VDH approval, and NCQA certification,
- A detailed description of the parent/acquiring company to include health insurance history and experience, Medicaid managed care experience (including state medicaid recommendations and sanctions, if any),
- A project plan including completion of any network development, information technology changes and requirements, and communications,
- An organizational chart indicating the retention of curent and key personnel, as well as any staff changes,
- A list of the acquisition/implementation team at the MCO with their title and role on the team including a project lead,
- Profit and enrollment projections,
- A member and provider education and outreach plan, and
- A transition plan detailing (i) how the acquisition will or will not impact the MCOs current processes, certifications and programs, including NCQA accreditation (ii) a list of subcontractors impacted or

not impacted, and (iii) a communication plan for notifying the subcontractor(s) of changes (A detailed operational transition plan).

The Department reserves the right to request additional information concerning a proposed acquisition of an existing Medicaid health plan. Pursuant to 42 C.F.R. § 438.66(d) the department reserves the right to conduct a readiness review upon receipt of change of ownership notification when deemed necessary. The department shall review the proposed acquisition when it has verified that all of the requested information is submitted and shall make every effort to issue a written response within 90 days of the commencement of its review. Additionally, the contractor shall notify the department of business transactions associated with the contractors change of ownership. Business transaction to be disclosed include but are not limited to [42 U.S.C. § 300e-17]:

13.3.A.II.b(i) Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

13.3.A.II.b(ii) Any lending of money or other extension of credit between the Contractor and a Party in Interest; and

13.3.A.II.b(iii) Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

13.3.A.II.c At least ninety (90) days or upon reasonable certainty, but no less that thirty-five (35) days prior to any change in ownership, the Contractor must provide to the Department information concerning each Person with Ownership or Control Interest as defined in this Contract [42 U.S.C. § 300e-17] <u>This information includes but is not limited to the following</u>:

13.3.A.II.c(i) Name, address, and official position;

13.3.A.II.c(ii) The date of birth and Social Security Number;

13.3.A.II.c(iii) A biographical summary;

13.3.A.II.c(iv) A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling.

13.3.A.II.c(v) The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request; and

13.3.A.II.c(vi) The identity of any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason. This disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 U.S.C. § 1320a-7, as amended, and 42 C.F.R. § 455.106, as amended, and must be submitted on behalf of the Contractor and any subcontractor as well as any provider of health care services or supplies.

The Contractor shall advise the Department, in writing, at least ninety (90) days or upon reasonable certainty, but no less that thirty-five (35) days prior to the effective date of any organizational change or major decision affecting its Medicaid managed care business in Virginia or other states. This includes but is not limited to sale of existing business to other entities or a complete exit from the Medicaid managed care market in another state or jurisdiction.

The Contractor shall require its non-Medicaid enrolled providers and all subcontractors, at the time of application, credentialing, and/or recredentialing, to disclose the required information in accordance with 42 C.F.R. 455 Subpart B as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. See 42 C.F.R. § 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 program under Medicare, Medicaid, or CHIP.

13.3.A.II.c(vii) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

13.3.A.II.d The Contractor must report to the Department within five business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.

Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

13.3.A.II.e The Contractor and subcontractor shall disclose to the Department any persons or corporations with an ownership or control interest in the MCO that:

- Has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity;
- Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%)of the Contractor's assets;
- Is an officer or director of an MCO organizations; or
- Is a partner in an MCO organized as a partnership.

[Section 1124(a)(2)(A) of the Act, section 1903(m)(2)(A)(viii) of the Act; 42 C.F.R. §438.608(c)(2); 42 C.F.R. § 455.100-104]

13.3.A.II.f The Contractor shall disclose information on individuals or corporations with an ownership or control interest in the MCO to the Department at the following times:

- When the Contractor submits a proposal in accordance with the Department's procurement process.
- When the Contractor executes a contract with the Department.
- When the Department renews or extends the Contractor's contract.
- Within thirty- five (35) days after any change in ownership of the MCO.

[Section 1124(a)(2)(A) of the Act, section 1903(m)(2)(A)(viii) of the Act; 42 C.F.R. §438.608(c)(2); 42 C.F.R. § 455.100-103]

13.3.B Other Categorical Prohibited Affiliations with Entities:

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

13.3.B.I Entities which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has:

13.3.B.I.a Been convicted of any of the following crimes:

13.3.B.I.a(i) Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);

13.3.B.I.a(ii) Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);

13.3.B.I.a(iii) Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (as provided in § 1128(b)(1) of the Act, as amended);

13.3.B.I.a(iv) Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended);or

13.3.B.I.a(v) Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in §1128(b)(3) of the Act, as amended.

13.3.B.I.b Been excluded from participation in Medicare or a State health care program;

13.3.B.I.c Been assessed a civil monetary penalty under Section1128A of the Social Security Act [42 U.S.C. § 1320a-7(a)-(f)]; or (Civil monetary penalties can be imposed on an individual provider, as well

as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General and may be imposed in the event of false or fraudulent submittal of claims for payment and certain other violations of payment practice standards.)

13.3.B.I.d Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 C.F.R. Part 76 or under guidelines implementing such an order or is an affiliate (as defined in such Act) of a person described in clause (a).

The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

13.3.B.II Entities which have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

13.3.B.II.a The administration, management, or provision of medical services;

13.3.B.II.b The establishment of policies pertaining to the administration, management, or provision of medical services; or

13.3.B.II.c The provision of operational support for the administration, management, or provision of medical services. [42 C.F.R. § 431.55(h)(3)]

The Contractor attests by signing this Contract that it excludes from participation in the Contract activities all entities which could be included in the categories listed in b. i. through iii. above.

13.3.B.III Entities who are to be excluded per *Code of Virginia* § 32.1- 325.

13.3.B.IV Prohibited Affiliations with Entities Debarred by Federal Agencies, see §13.3(a).

13.3.C Prohibited Affiliations with Contractor and Subcontractor Service Providers

13.3.C.I In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 C.F.R. § 438-610 and § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by the Department for fraud, waste and abuse. Additional guidance may be found in the Department's 4/7/09

Medicaid Memo titled Excluded Individuals/Entities from State/Federal Healthcare Programs.

13.3.C.II The Contractor must inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s), have written policies and procedures outlining provider enrollment and/or credentialing process.

13.3.D Nonpayment

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items for services furnished in an emergency room of a hospital):

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVII, or XX or under this title pursuant to sections 1128,1128 A, 1156, or 1842(j)(2) of the Act.
- Furnished at the medical directions or on the prescription of a physician, during the period when such physician is excluded under participation under title V, XVII, or XX or under this title pursuant to sections 1128,1128 A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments.
- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
- With respect to the amount expended for roads, bridges, stadiums, or any other item or service not covered under the MSP.

13.4 APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in both 42 C.F.R. § 438.700 (a) and 12 VAC 30-120-400, the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 12 VAC 30-120-410- and 42 C.F.R. §§ 438.700 through 724 allowing them to impose the sanctions provided therein.
The Contractor shall have all the appeal rights provided for in 42 C.F.R. § 438.710 and 12 VAC 30-120-410.

13.4.A Right to Appeals

The Contractor shall have the right to appeal any adverse action taken by the Department. All appeals arising out of a sanction or remedy levied pursuant to Section 13 of this Contract shall be handled in accordance with Section 13.

The Contractor may not submit to the Department for resolution under this section disputes relating to Medicaid eligibility requirements or covered services.

13.4.B Disputes Arising Out of the Contract

As provided for in *Code of Virginia* §2.2-4363, as amended, disputes arising out of the Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

13.4.C Informal Resolution of Contract Disputes

For any dispute arising out of the Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

13.4.D Presentation of Documented Evidence

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

13.5 HIPAA COMPLIANCE: SECURITY AND CONFIDENTIALITY OF RECORDS

13.5.A HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the Contractor with this agreement or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the Contractor

from the Department or from any other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

To the extent that the Contractor uses one or more providers and/or subcontractors to render services under this Contract, and such providers/subcontractors receive or have access to protected health information (PHI), each such provider/subcontractor shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers/subcontractors to whom it provides PHI received from the Department (or created or received by The Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract.

13.5.B Use of Disclosure of Information

The use or disclosure of information concerning Contract services or members obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, and provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

For purposes of this Contract, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this Contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member.

Except as otherwise limited in this Contract, Contractor may use or disclose protected health information (PHI) to perform functions, activities, or services for, or on behalf of, the Department as specified in this Contract. In performance of Contract services, Contractor agrees to:

- Not use or further disclose protected health information (PHI) other than as permitted or required by the terms of this Contract or as required by law;
- Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Contract;
- Report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Department as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164 and the American Recovery and Reinvestment Act (P.L. 111-5) when effective;

- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it;
- Report to the Department any security incident of which it becomes aware;
- Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to members, and protect against any future breaches.
- In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

For purposes of this paragraph, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member.

- Impose the same requirements and restrictions contained in this Contract on its subcontractors and agents to whom Contractor provides PHI received from, or created or received by a Contractor on behalf of the Department;
- Provide access to PHI contained in a designated record set to the Department, in the time and manner designated by the Department, or at the request of the Department, to a member in order to meet the requirements of 45 C.F.R. § 164.524.
- Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the Department;

- Document and provide to the Department information relating to disclosures of PHI as required for the Department to respond to a request by a member for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528;
- Make its internal practices, books, and records relating to use and disclosure of PHI received from, or created or received by a Contractor on behalf of the Department, available to the Secretary of the U.S. Department of Health and Human Services Secretary for the purposes of determining compliance with 45 C.F.R. Parts 160 and 164, subparts A and E;
- At termination of the Contract, if feasible, return or destroy all PHI received from, or created or received by a Contractor on behalf of the Department that the Contractor still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the Contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Contractor may use or disclose PHI received from the Department, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Contractor may disclose PHI for such purposes if the disclosure is required by law, or if Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and that person will notify the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

Written notices regarding any impermissible use or disclosure by the Business Associate shall be sent to the Department through general mail to:

Contact: Theresa Fleming, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

13.5.B.I Disclosure and Confidentiality

The Contractor must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Attachment I of this Contract. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

13.5.B.II Disclosure to Workforce

The Contractor shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contractor, therefore,

must ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

13.5.B.III Safeguards – Business Associate Agreement

If applicable, the Contractor shall be required to enter into a DMAS-supplied Business Associate Agreement (BAA) with the Department to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all state and federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 C.F.R. Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement. The Contractor shall keep abreast of any future changes to the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to the Department. The current DMAS BAA template is attached to this Contract, but Contractor's should reference the version available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx .

13.5.B.IV Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the member's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 C.F.R. § 164.528. The Contractor shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

13.5.B.V Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this Contract.

13.5.B.VI Reporting

The Contractor shall report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware. Moreover, the Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known

by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to members, and protect against any future breaches.

In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

13.5.B.VII Access to PHI

The Contractor shall provide access to PHI contained in a designated record set to the Department, in the time, manner, and format designated by the Department, or at the request of the Department, to an individual in order to meet the requirements of 45 C.F.R. Part 164.

13.5.B.VIII Amendment to PHI

The Contractor shall make PHI available for amendment and incorporate any amendments to PHI in its records at the request of the Department in a time and manner as designated by the Department.

Further, the Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement, Attachment IV.

13.5.C Access to Confidential Information

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 C.F.R. Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance, and 42 C.F.R. Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

The Contractor will not be held accountable to provide care coordination under Addiction and Recovery Treatment Services (ARTS) if it has not received written disclosure from the member's provider.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records and member information and appointment records for treatment of sexually transmitted diseases and submit prior to signing the initial contract, upon revision or on request to the Department.

The Contractor shall comply with the Department's Security Requirements for vendors.

13.5.D Audits, Inspections, and Enforcement

With reasonable notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA. The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any member who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any

rights such individual may have under this HIPAA, the Agreement, or any other law relating to or arising out of the Contractor's violation any provision of HIPAA.

14. Terms and Conditions

Through submittal of the response of the Department's request for Proposals and by signing this Contract, the Contractor shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their Attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the Contractor as to the contents of the Department's RFP and this Contract.

Delegation of Primary Authority to Manage Networks and Maintain Operational Consistency: The Director of the Department hereby delegates most of the Department's authority to establish, maintain, monitor, sanction, credential, re-credential, and terminate network providers to the Contractor. The Department maintains oversight capacity on the Contractor's provider networks as necessary to enforce the provisions and terms contained herein this Contract. In order to maintain operational consistency, any area where the Contract and all sources of law/guidance described in Section 14.3 "Applicable Laws, Regulations& Interpretation," are silent, reflects the Department's intent for the Contractor to follow its own clearly delineated policies and procedures.

Contract Requirement Exemptions Process:
The Contractor may request to be exempted from any contract requirement; however, such request for exemption must be requested in writing as required in Section 13.2.A.II and the MCTM. Any release by the Department of any contractual requirement must be approved by the Department's management and the Health Care Services Compliance Unit. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

14.1 ACCESS TO PREMISES

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, at any time, access to the Contractor's premises, subcontractor's premises, or the premises of the Contractor's network providers to inspect, audit, monitor or otherwise evaluate the performance of the Contractor, subcontractor, or network provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. Further, duly authorized agents or representatives of the State or Federal Government, shall have the right to audit and inspect any books or record of the Contractor or its subcontractor pertaining to: the ability of the Contractor to bear the risk of financial losses and services performed or payable amounts under the Contract. In the event "right of access" is requested under this section, the Contractor, subcontractor, or network provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor's or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall

finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 C.F.R § 438.3(h)]

The Contractor must retain, and require subcontractors to retain, as applicable, the following information: enrollee grievance and appeal records in 42 C.F.R § 438.416, base data in § 438.5(c), MLR reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years. [42 C.F.R § 438.3(u)]

14.2 ALL PAYERS CLAIM DATABASE

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia* for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contactor shall be responsible for the submission of claims data related to services provided under this contact. Such data submission, pursuant to §32.1-276.7:1 of the *Code of Virginia*, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the *Social Security Act*.

14.3 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS

The documents listed herein shall constitute the entire Contract between the parties, and no other expression, whether oral or written, shall constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the Contract documents shall be resolved by giving legal order of precedence in the following order:

- Federal Statutes
- Federal Regulations
- State Statutes
- State Regulations
- Virginia State Plan
- Managed Care Waiver
- Managed Care Contract, including all amendments and attachments including Medicaid memos and relevant manuals, as well as the Managed Care Technical Manual, as updated.

Any ambiguity or conflict in the interpretation of this Contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals.

Services listed as covered in any evidence of coverage or any member handbook shall not take precedence over the services required under this Contract or the State Plan for Medical Assistance.

14.3.A Additional Sources of Law

14.3.A.I Governing Law (Virginia)

The Contract shall be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

14.3.A.I.a Specific State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including, but not limited to: (1) the *Code of Virginia* Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 211; (3) Virginia Administrative Code, 12 VAC 30-120-360 through 12 VAC 30-120-420; and (4) *Code of Virginia*, Title 32.1, Chapter 10.

14.3.A.II Governing Law (Federal)

14.3.A.II.a **Uniform Administrative Requirements**

In accordance with 45 C.F.R. § 74, the Contractor shall comply with all of the following Federal regulations.

14.3.A.II.b **Environmental Protection Rules**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under § 306 of the Clean Air Act (42 U.S.C. § 7606, § 508 of the Clean Water Act [33 U.S.C. § 1368]), which prohibits the use, under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

14.3.A.II.c **Copeland "Anti-Kickback" Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 18 U.S.C. § 874 and 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 3. See also 48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

14.3.A.II.d **Davis-Bacon Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 5. See also 48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency

14.3.A.II.e **Contract Work Hours and Safety Standards Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C §§ 327-333, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 5. See also 48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

14.3.A.II.f **Rights to Inventions Made Under a Contract or Agreement**

Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and State of Virginia in any resulting invention in accordance with 37 C.F.R. Part 401 "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements, and any further implementing regulations issued by U.S. Department of Health and Human Services.

14.3.A.II.g **Byrd Anti-Lobbying Amendment**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. § 1352 and 45 C.F.R. Part 93. No appropriated funds may be expended by the member of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting 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 any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

14.3.A.II.h **Debarment and Suspension**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under Executive Orders 12549 and 12689 and 45 C.F.R. part 76. Executive Order (E.O.) 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for non-procurement debarment and suspension. A person who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect.

14.3.A.II.i **Energy Policy and Conservation Act**

The Contractor shall comply with any mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act, Public Law 94-163.

14.4 ATTORNEY FEES

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Contractor shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

14.5 AUDIT FINDINGS

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the Contractor to the Department. If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department as provided for in Section 13.4.

14.6 CHANGES IN KEY STAFF POSITIONS & ORGANIZATION

To promote continual effective communications, the Contractor must notify in writing the Department of changes in key staff positions, particularly the Chief Executive Officer (CEO), President (corporate or Commonwealth business),Contract Administrator, Chief Financial Officer (CFO), Chief Medical Director/ Officer (CMO), Pharmacy Director, Medical Management Director, Member Services/Operations Manager, Information Technology staff, Quality Improvement Manager, Project Executive, Compliance Manager/Director, Compliance Officer, and anyone key to the Contractor's operations per the timelines listed below. Reporting requirements are as specified in the MCTM. The notification requirement also applies to specific program or project leads assigned to participate in or serve on the Department's Meetings and/or Board, as referenced in Section 14.20.

Departure:	The Contractor must provide notification to the Department within five (5) calendar days from receipt of formal written *knowledge* of departure
New Hire:	The Contractor must provide notification, a resume, and an updated organizational chart to the Department within five (5) calendar days of the start date.

In addition, the following information is to be reported annually and also within five (5) calendar days when individuals either leave or are added to these key positions:

14.6.A Organizational Chart

The Contractor shall provide the Department with an organizational chart showing the staffing and lines of authority for the key personnel to be used. The organizational chart should include:

14.6.A.I The relationship of service personnel to management and support personnel

14.6.A.II The names of the personnel and the working titles of each, and

14.6.A.III Any proposed subcontractors including management, supervisory, and other key personnel. It is recommended that these organizational charts also reflect any current internal reporting structures.

14.6.B Resumes

The Contractor shall provide the Department with resumes for any key positions within five calendar (5) days of a staffing change, or at the Department's request. Resumes, limited to two (2) pages, shall include qualification, experience, and relevant education and training.

14.6.C Department Authority to Remove Staff

The Department reserves the right to direct the Contractor to remove any staff from this Contract when the Department determines the removal to be in the best interest of the Contract and the Commonwealth.

14.6.D Company Background History

The Contractor shall submit annually an updated company background history that includes any awards, major changes (such as entering or leaving another State Medicaid Program), or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors. This report must be submitted electronically.

14.7 CONFLICT OF INTEREST

Nothing in this Contract shall be construed to prevent the Contractor from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this Contract, provided, however, that the Contractor furnishes the Department with full prior disclosure of such other activities, or upon discovery of a conflict of interest. The Contractor shall comply with Federal conflict of interest provisions and requirements described in 42 C.F.R. § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

In accordance with 1932(d)(3) of the Social Security Act and 42 C.F.R. 438.3 (f)(2), the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Department having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. Section 423) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

14.7.A Use of Third Party Administrator (TPA)

The Contractor may utilize subcontracts with third party administrators (TPAs) for the purpose of processing claims, "back office", and other purely administrative functions. All contracts between the Contractor and its chosen TPA must be submitted to the Department for initial approval ten (10) days prior to execution, and then annually or upon amendment thereafter.

14.7.B Firewalled Staff & Facilities

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a Third Party Administrator (TPA) for additional services beyond those referenced in Section 14.7.A, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent contractor/third party, that demonstrates proper interconnectivity with the Department and

that firewalls meet or exceed the industry standard. Contractors and TPAs must provide assurances that all service level agreements with the Department will be met or exceeded.

Contractor staff must be solely responsible to the single health plan entity contracted with the Department.

14.8 CONTRACT TERM AND RENEWAL

The effective date of this Contract is July 1, 2017. This Contract will be effective until December31, 2018.

The service areas and capitation rates for this Contract are referenced the Attachments.

The Contract shall automatically renew for six (6) additional months if, on the ending date of this Contract, the Contractor and the Department are actively involved in good faith renegotiations of this Contract or negotiation of another risk based Contract. The capitation rates for this automatic renewal period will be set at the discretion of the Department.
The Contractor may opt out of the above automatic renewal clause. In order to do so, the Contractor must notify the Department in writing at least twelve (12) full calendar months prior to the renewal. If the Contractor fails to notify the Department of non-renewal on or before this date, the Contract will be automatically renewed.

14.9 CONTRACTOR LIABILITY

The Contractor assumes full financial liability for developing and managing a health care delivery system that will arrange for or administer all covered services outlined in this Contract.

14.10 COVENANT AGAINST CONTINGENT FEES

The Contractor shall warrant that no person or selling agency has been employed or retained to solicit and secure the Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency, excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the Contract without liability or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

14.11 DELIVERY DATES FOR INFORMATION REQUIRED BY THE DEPARTMENT

When the last day for submission of any contractually required information or reports to the Department by the Contractor falls on a Saturday, Sunday, or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday, or legal holiday.

14.12 DEPARTMENT OVERSIGHT

The Department reserves the right to review the Contractor's policies and procedures and determine conditions for formal notification to the Department of situations involving quality of care.

During the conduct of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this Contract and in the documents referenced herein. The Department reserves the right to audit, formally and/or informally, for compliance with any term(s) of this Contract, for compliance with the laws and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of any term(s) of this Agreement. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Department shall be responsible for the administration of this Contract. Administration of the Contract shall be conducted in good faith within the resources of the State, but in the best interest of the members. The Department shall retain full authority for the administration of the Medicaid Program in accordance with the requirements of Federal and State laws and regulations, including the requirements of 32.1-330(B) of the *Code of Virginia*. See Section 14.3 regarding conflicts between the Department's administration of the Medicaid program and the Contractor's policies and its subcontractor's contracts.

14.13 DRUG-FREE WORKPLACE

The Contractor shall acknowledge and certify that it understands that the following acts by the Contractor, its employees, and/or agents performing services on State property are prohibited from:

- The unlawful manufacture, distribution, dispensing, possession, or use of alcohol or other drugs; and
- Any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

The Contractor shall further acknowledge and certify that it understands that a violation of these prohibitions constitutes a breach of contract and may result in default action being taken by the Commonwealth in addition to any criminal penalties that may result from such conduct.

14.14 INDEMNIFICATION

The Contractor hereby agrees to defend, hold harmless, and indemnify the Department, its officers, agents and employees from any and all claims by third parties, regardless of their nature or validity, arising out of the performance of this Contract by the Contractor or its agents, employees, or subcontractors including, but not limited to, any liability for costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this Contract or based on any libelous or other unlawful matter contained in such data.

The Contractor is not required to defend, hold harmless or indemnify the Department, its officers, agents, and employees from claims resulting from services provided by an Agency of

the Commonwealth of Virginia or its officers, agents, and employees when and if the Agency is expressly serving as a subcontractor under the provisions of this Contract.

14.15 INDEPENDENT CAPACITY

The Contractor and the agents and employees of the Contractor, in the performance of this Contract, shall act as independent Contractors and shall not act or represent themselves as officers, employees or agents of the Department or of the Commonwealth.

14.16 INSURANCE

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using the Department or to failure of the using the Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

Before delivering services under this Contract, the Contractor shall obtain the proper insurance coverage during the term of the Contract and ensure that all insurance coverage shall be provided by insurance companies authorized by the Virginia State Corporation Commission to sell insurance in the Commonwealth of Virginia. The Contractor shall have the following insurance coverage at the time the Contract is awarded and during the Contract period and submit documentation verifying coverage to the Department prior to initial contract signature, upon revision by the Contractor, or at the Department's request:

14.16.A Professional Liability Insurance for the Contractor's Medical Director

Insurance in the amount of at least one million dollars ($1,000,000) for each occurrence shall be maintained by the Contractor for the Medical Director.

14.16.B Workers' Compensation

The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees working in the Commonwealth of Virginia. In the event any work is subcontracted, the Contractor shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working in the Commonwealth. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the Commonwealth of Virginia.

14.16.C Employer's Liability

The Contractor shall maintain at least one hundred thousand dollars ($100,000) in liability coverage.

14.16.D Commercial General Liability

The Contractor shall maintain one million dollars ($1,000,000) in combined single-limit liability coverage. The Commonwealth of Virginia is to be named as an additional insured with respect to the services to be procured. This coverage is to include Premises/Operations

Liability, Products and Completed Operations Coverage, Independent Contractor's Liability, and Personal Injury Liability.

14.16.E Automobile Liability

The Contractor shall maintain five hundred thousand dollars ($500,000) per occurrence in automobile liability insurance for its corporate employees who use an automobile for business purposes.

14.17 LIABILITY NOTIFICATION

The Contractor shall notify the Department immediately in writing when it or one of its subcontracts is involved in a situation where the Contractor or its subcontractor may be held liable for damages or claims against the Contractor. Such situations include automobile accidents caused by an employee of the Contractor or subcontractor where a third party is injured or dies.

14.18

14.19 MANAGED CARE TECHNICAL MANUAL – USE OF MOST CURRENT VERSION

The Department will post the current version of the Managed Care Technical Manual on the Virginia Medicaid Medallion 3.0 website, and also in the report directory of the DMAS secure FTP server. The version number of the Managed Care Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

The Managed Care Technical Manual will be updated no more frequently than monthly. The revised Managed Care Technical Manual will be posted to the Managed Care website (http://www.dmas.virginia.gov/Content_atchs/mc/MCTM%202%205.pdf) and to the FTP server no later than the last calendar day of each month. The MCOs must check the website or server at the beginning of each month to ensure use of the most current version of the program specs for the next submission to the Department. The Contractor is required to use the most current version of the MCTM before the due date of each individual submission, including any reports (annual or other reports) due after the end of the Contract year.

14.20 MEDICAL RECORDS: ACCESS TO AND RETENTION OF RECORDS

The Contractor shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled members. The Contractor shall require compliance of all providers and subcontractors with HIPAA security and confidentiality of records standards, as detailed in Section 13.5 of this Contract. Each report must contain the valid member Medicaid identification number. If the ID number is not valid, the report will be returned to the Contractor for correction. Additionally, the Contractor shall maintain standards for medical records that are congruent with current NCQA guidelines.

14.20.A Access and Retention Requirements

The requirements shall:

14.20.A.I Include written policies

Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The Contractor shall have written procedures for release of information and obtaining consent for treatment.

14.20.A.II Include procedures to ensure individual medical records are available to the Department

Include procedures maintained by the Contractor or maintained by network provider(s) so that individual medical records for each member are made readily available to the Department, the contracted External Quality Review Organization (EQRO), and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- network or out-of-network providers for the medical management of the member. The Contractor shall use its best efforts to assist members and their authorized representatives in obtaining records within ten (10) business days of the record request. The Contractor will identify an individual who can assist members and their authorized representatives in obtaining records. The Contractor shall use its best efforts, when a member changes PCPs, to assure that his or her medical records or copies of medical records are made available to the new PCP within ten (10) business days from receipt of request from the member.

14.20.A.III Include procedures to ensure timely access

Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider; Contractor-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the Contractor shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all members' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The Contractor may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week notice, with the remaining list of records presented at the time of audit.

14.20.A.IV Provide transfer procedures to provide continuity of care

Provide for adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

14.20.B HIPAA Security and Confidentiality of Records Standards

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards, detailed in this Contract. See also Section 13.5 "HIPAA Compliance: Security and Confidentiality of Records."

14.20.B.I Access to Records

The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors or network providers.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any medical and/or financial records of the Contractor, its subcontractors and its network providers.

14.20.B.II Retention of Records

All records and reports relating to this Contract shall be retained by the Contractor for a period of ten (10) years after final payment is made under this Contract or in the event that this Contract is renewed, ten (10) years after the renewal date. When an audit, litigation or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of ten (10) years following resolution of such action. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

14.20.C Content of Medical Records

The Contractor must ensure that each member's medical record(s) include(s) the required elements pursuant to 42 C.F.R. §§ 456.111 and 456.211, including but not limited to: member ID, physician name, admission dates, and dates of application for and authorization of Medicaid benefits if application is made after admission, plan of care as required under 42 C.F.R. §§ 456.80 and 456.180, initial and subsequent continued stay review dates as required by 42 C.F.R. §§456.128 456.133,456.233, and 456.234 date of operating room (if applicable), justification of emergency admission (if applicable), reasons and plan for continued stay (if physician believes continued stay is necessary), and other supporting material as necessary and appropriate.

14.21 MEETINGS

The Contractor shall participate in meetings with the Department of Medical Assistance Services, including the Case Manager's meetings, DMAS Managed Care Advisory Committee meetings, MCO Work-Group meetings, Quality Collaborative meetings, Financial Workgroup meetings, Program Integrity meetings, or any other groups as necessary when requested to do so by the Department. Each meeting is comprised of MCO staff members in regular attendance. Any substitutions of regularly attending staff at a specific meeting require informal notification twenty-four (24) hours in advance to the Department.

14.21.A Meetings with State Government Agencies

The Contractor shall not request any meetings with other Commonwealth agencies to discuss exclusive Virginia Medicaid business without prior Departmental knowledge.

14.22 MISREPRESENTATION OF INFORMATION

Misrepresentation of a Contractor's status, experience, or capability in the performance of this Contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate Contract termination and/or replacement.

14.23 NON-DISCRIMINATION

The Contractor shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to individuals with disabilities pursuant to persons § 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 C.F.R. Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act of 1990 as amended, title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1967, the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, sexual orientation, gender identity, physical condition, developmental disability, or national origin. The Contractor shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 C.F.R. Chapter 60).

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the Contractor setting forth the provisions of the non-discrimination clause.

14.24 OMISSIONS

Professional Liability/Errors and Omission insurance in the amount of at least one million dollars ($1,000,000) per occurrence, three million dollars ($3,000,000) aggregate shall be maintained by the Contractor.

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.25 PRACTICE GUIDELINES

The Contractor shall establish practice guidelines as described in this section, in accordance with 42 C.F.R. § 438.236(d), and that are congruent with current NCQA Standards for establishing guidelines.

14.25.A Adoption of Practice Guidelines

In accordance with 42 C.F.R. § 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:

14.25.A.I Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

14.25.A.II Consider the needs of the members;

14.25.A.III Are adopted in consultation with contracting health care professionals; and
14.25.A.IV Are reviewed and updated periodically, as appropriate.

14.25.B Dissemination of Guidelines

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Additionally, the Contractor shall provide a copy of its practice guidelines prior to signing the initial contract, upon revision, or on request to the Department. [42 C.F.R. § 438.236(c)]

14.25.C Application of Guidelines

Contractor decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

14.26 RESPONSIVENESS TO THE DEPARTMENT

The Contractor shall acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including case management evaluation requests and requests to change MCO (good cause), involving members or providers as expeditiously as the member's health condition requires or no later than two (2) business days of receipt of the request from the Department. The Contractor's acknowledgement must include a planned date of resolution. A detailed resolution summary advising the Department of the Contractor's action and resolution shall be rendered to the Department in the format requested. The Department's requests for case management services and/or requests for the Contractor to contact the member/provider must occur within the time frame set forth by the Department.

The Department's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Department, must be given priority by the Contractor and completed in accordance with the instructions from the Department. The Department shall provide guidance with respect to any necessary deadlines and resolution requirements, including dates of resolution. A resolution summary, as described by the Department, shall be submitted to the Department.

14.26.A Records & Litigation Holds Requested by the Commonwealth

Pursuant to a request from the Department, the Medicaid Fraud Control Unit, or other relevant Commonwealth entity, or when the Department is served a Request for Discovery, the Contractor must make any and all records and documents available, whether maintained in electronic or hard copy format. The Contractor must also have the ability to implement a litigation hold to preserve such records and search for relevant documents, if so directed by the Commonwealth.

14.27 RIGHT TO PUBLISH

The Department agrees to allow the Contractor to write on subjects associated with the work under this Contract and have such writing published, provided the Contractor receives prior written approval from the Department before publishing such writings.

14.27.A Presentations & Publications Involving Virginia Data and Information

The Contractor shall submit for review any presentation or publication that will be given to outside parties and contains Virginia data and information at least thirty (30) days in advance.

14.28 RIGHT TO RECOVERY IN ALL MATTERS ARISING UNDER THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT

The Contractor hereby acknowledges that it has no course of action pursuant to the Virginia Fraud Against Taxpayers Act (Va. Code §§ 8.01-216.1 through 8.01-216.19) for fraud matters pursued by the Virginia Medicaid Fraud Control Unit (MFCU) and/or Office of the Attorney General of the Commonwealth (OAG). The Contractor is not entitled to any portion of the recoveries or penalties and the funds will be returned to the Department unless the Contractor qualifies as a person under Va. Code § 8.01-216.2 and brings an action on behalf of the Commonwealth under Va. Code § 8.01-216.5, in which case the Contractor would be entitled to an award of the proceeds from such action as set forth in § 8.01-216.7.

14.29 SEVERABILITY, ASSIGNABILITY, AND INTERPRETATION

All provisions contained in this Contract are contingent upon Federal approval unless explicitly stated otherwise. If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

Except as allowed under subcontracting, the Contract is not assignable by the Contractor, either in whole or in part, without the prior written consent of the Department.

Any article, section, or subsection headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.30 TERMINATION OF CONTRACT

14.30.A Pre-Termination Hearing

In accordance with 42 C.F.R. § 438.710(b) and 438.710(b)(2)(i)-(iii), the Department:

- Will provide the Contractor with a pre-termination hearing before terminating the Contractor's contract.
- Must give the Contractor written notice of its intent to terminate and the reason for termination.
- Must provide the Contractor with the time and place of the pre-termination hearing.
- Must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

- For an affirming decision, the Department will give enrollees of the Contractor notice of the termination and information, consistent with § 438.10, on their options for receiving Medicaid services following the effective date of termination.

14.30.B Suspension of Contractor Operations

The Department may suspend a Contractor's operations, in whole or in part, if the Department determines that it is in the best interest of Medallion 3.0 members to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

14.30.C Terms of Contract Termination

This Contract may be terminated in whole or in part:

14.30.C.I By the Department or the Contractor, for convenience, with one hundred and eighty (180) days advance written notice;

14.30.C.II By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of Medallion 3.0 services and continued performance of the Contractor's responsibilities; or

14.30.C.III By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for Contract termination is described in the following paragraphs.

14.30.C.IV Termination for Convenience

The Contractor or the Department may terminate this Contract with or without cause, upon 180 days advance written notice. In addition, the Contractor may terminate the Contract, as provided in Section 14.8 of this Contract, by opting out of the renewal clause.

14.30.C.V Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are withdrawn, restricted, limited, or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. Determinations by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

14.30.C.VI Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

14.30.C.VII Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract has been terminated, in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, and liability for medical claims.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of

termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling Contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

14.30.D Termination Procedures

14.30.D.I Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for members hospitalized at the time of termination.

14.30.D.II Refunds of Advanced Payments

If the Contract is terminated under this Section, the Contractor shall be entitled to be paid a pro-rated capitation amount for the month in which notice of termination was effective to cover the services rendered to members prior to the termination. The Contractor shall not be entitled to be paid for any services performed after the effective date of the termination. The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

14.30.D.III Notification of Members

In all cases of termination, the Contractor shall be responsible for notifying members about the termination and the Department shall be responsible for reassigning members to new MCOs, as appropriate. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

14.30.D.IV Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the Contract and about the reassigning of its members to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

14.30.D.V Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

14.30.D.V.a Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;

14.30.D.V.b Place no further orders or subcontracts for materials, services, or facilities;

14.30.D.V.c Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

14.30.D.V.d Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

14.30.D.V.e Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;

14.30.D.V.f Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;

14.30.D.V.g Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and,

14.30.D.V.h Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.

The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

14.31 TRANSITION

The Contractor shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its Medicaid population. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this Contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The Contractor shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively affect an orderly and efficient transition to a successor.

14.32 WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.33 QUALIFIED SIGNATORY

The Contractor must, in order to meet the necessary requirements to qualify as a signatory to this Contract, meet all the requirements required in Section 2 and Attachment XVI to the Department's satisfaction, including but not limited to the following subject areas: credentialing, policies and procedures for member and provider treatment, readiness reviews, enrollment verification, encounters, data security plans, insurance verification requirements, and NCQA Accreditation (or already be in progress of achieving NCQA accreditation for the Virginia Medicaid Program).

14.33 TERMS AND CONDITIONS OF THE FAMIS CONTRACT

By accepting the terms and conditions of the Medallion 3.0, the Contractor also agrees to accept the terms and conditions of the Family Access to Medical Insurance Security (FAMIS) Contract in the absence of a legitimate fiscal concern, as determined by the Department.

ATTACHMENTS

ATTACHMENT I - AUTHORIZED WORKFORCE CONFIDENTIALITY AGREEMENT

This Agreement between _____ [Business Associate name] and _____ (please print), an employee of _____ hereby acknowledges that [the Entity's] records and documents are subject to strict confidentiality requirements imposed by state and federal law including 42 C.F.R. § 431 Subpart F, *Code of Virginia* §2.2-3800, *et. seq.*, and 12 VAC 30-20-90, *et. seq.*

I (initial) _____ acknowledge that my supervisor, or whoever administers the data, has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality.

I (initial) _____acknowledge that my supervisor or, whoever administers the data, has reviewed with me the confidentiality and security policies of our organization.

I (initial) _____acknowledge that unauthorized use, dissemination or distribution of Virginia Department of Medical Assistance Services (DMAS) confidential information is a crime.

I (initial)_____hereby agree that I will not use, disseminate or otherwise distribute confidential records or said documents or information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I (initial) _____also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with [the entity] and may subject me to penalties both civil and criminal.

Signed _____ Date _____

ATTACHMENT II - SUMMARY OF COVERED MEDALLION 3.0 and MEDICAID SERVICES

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the appropriate DMAS Provider Manual.

* Indicates Carved-Out Services – contact the Department for information on how to obtain services

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Abortions, induced*	12 VAC 30-50-100 and 12 VAC 30-50-40	No, except in those cases where there would be substantial danger to life of mother	No	The Contractor shall not cover services for elective abortion. Requests for abortions that are referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and federal law. The Commonwealth will be responsible for payment of abortion services meeting state and federal requirements under the fee-for-service program.
Case Management Services for members of Auxiliary Grants*	12 VAC 30-50-470	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.
Christian Science Nurses	12 VAC 30-50-300	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.
Christian Science Sanatoria	12 VAC 30-50-300	Yes	Yes	The Contractor is required to cover this service with no limitations.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor is required to cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	*Code of Virginia* Section 37.1-67.4	Yes	Yes	The Contractor is required to cover all medically necessary court ordered Medallion 3.0 services.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Dental Services*	12 VAC 30-50-190	No except for certain circumstances.	No except for certain circumstances.	The Contractor is required to cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover CPT and other "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain members when determined such services are required to provide dental care.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover EPSDT screenings **(including lead screenings)** and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions. (Some services may require service authorization) The Contractor shall screen and assess all children. The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Behavioral Therapy Services under EPSDT	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000	Yes	No	The Contractor is not required to provide coverage for Behavioral Therapy Services as defined by 12 VAC 30-50-130 and 12 VAC 30-130-2000. BT services for children enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines.
Early Intervention Services*	20U.S.C. § 1471 34 C.F.R.§ 303.12 *Code of Virginia* § 2.2-5300	Yes	No	***The Contractor is not required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines. Early Intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at*** http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx. The Contractor shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395	Yes	Yes	The Contractor is required to cover all emergency services without service authorization. The Contractor is also required to cover the services needed to ascertain whether an emergency exists. The Contractor may not restrict a member's choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. § 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Experimental and Investigational Procedures*	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor may not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor is required to cover all family planning services and supplies provided to its members by network providers and by out-of-network providers.
HIV Testing and Treatment Counseling	*Code of Virginia* Section 54.1-2403.01	Yes	Yes	The Contractor is required to comply with the State requirements governing HIV testing and treatment counseling for pregnant women.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Home Health Services	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity. The MCO must continue to manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term. This includes those instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. B-12 shots Insulin injections Central line and porta cath flushes Blood draws, for example where the member is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance Changing of indwelling catheter
Hospice Services	12 VAC 30-50-270	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor is required to cover inpatient stays in general acute care and rehabilitation hospitals for all members. The Contractor is required to comply with maternity length of stay requirements. Contractor is required to comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The Contractor is required to cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor is required to cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.
Lead Investigations	12 VAC 30-50-227	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover low-dose screening mammograms for determining presence of occult breast cancer.
Medical Supplies and Equipment	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover all medical supplies and equipment at least to the extent they are covered by DMAS. The Contractor is required to cover related supplies for children and nutritional supplements for adults over 21. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Mental Health Services (See last page of this table)				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor is required to cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation (Reference Table of Coverage shown in Section 7.)	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Contractor shall cover necessary procurement/donor related services. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-580.
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor is required to cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor is required to cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover annual pap smears.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225	Yes	Yes	The Contractor is required to cover physical therapy, occupational therapy, and speech pathology and Audiology services that are provided as an inpatient or outpatient hospital service or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.
Physician Services	12 VAC 30-50-140	Yes	Yes	The Contractor is required to cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor is required to cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410	Yes	Yes	The Contractor is required to cover case management services for high risk pregnant women and children (up to age two). The Contractor is required to provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor is required to cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends.
Prescription Drugs	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.
Private Duty Nursing	http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf; 42 C.F.R. § 441.50 and 1905(a) of Social Security Act	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	The Contractor is required to cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor is required to cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male members for prostate cancer.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor is required to cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	Contractor is required to cover reconstructive breast surgery.
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480	No (auxiliary grant administered by DSS.)	No	The Contractor is not required to cover this service. When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment. Reference the DMAS Assisted Living Facility Provider Manual for details.
School-health Services*	12 VAC 30-50-229.1	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the Medicaid fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Medicaid school provider manual. The Contractor is responsible for covering EPSDT screenings for the general Medicaid student population. Reference Section 1 "Definitions" for more details. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school.
Skilled Nursing Facility Care	12 VAC 30-50-130 -	Yes	No	The Contractor is not required to cover skilled nursing facility care. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from Medallion 3.0 upon entry into the DMAS nursing facility authorization database. The Contractor may provide step down nursing care as an enhanced benefit to Medicaid members.

Medical Services - Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor is required to provide medical transportation to all Medicaid covered services, including those Medicaid services covered by a third party payer, and transportation to carved out services such as abortions and to services provided by subcontractors such as dental. The Contractor shall not be responsible for medical transportation for managed care members who subsequently become members in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support/Building Independence, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor is also required to cover eyeglasses under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based)		Yes	No	The Contractor is not required to cover home and community based waiver services or transportation to related waiver services, however, members enrolled with a MCO that subsequently meet one or more of the criteria listed in Section 5 during MCO enrollment shall be disenrolled as appropriate by DMAS, with the exception of those who subsequently become members in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support/Building Independence, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Inpatient Mental Health Services Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001; available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor is required to cover medically necessary inpatient psychiatric hospital stays for covered members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	No	**The Contractor is not required to cover this service**. For members aged 21 through 64, the Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements. If a member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the MCO and reimbursed by the health plan as an enhanced service, that member will be excluded from managed care participation. The MCO will notify DMAS of all member admissions to state mental hospitals.
Intensive Behavioral Dietary Counseling Services for Adults with Hyperlipidemia and Other Known Risk Factors for Cardiovascular and Diet-Related Chronic Disease, for Members Enrolled in the Medicaid Works Program *	Pending	Yes	No	**The Contractor is not required to cover this service.** This service will be covered through the DMAS fee-for-service system.

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Temporary Detention Orders (TDOs)	42 C.F.R. § 441.150 and *Code of Virginia* § 16.1-335 et seq.	Yes	Yes	Pursuant to 42 C.F.R. § 441.150 and the *Code of Virginia*, § 16.1-335 et seq., § 37.2-800 *et. seq.*, and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age 21 through 64 and admitted to a freestanding facility. The MCO is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the member is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. The duration of temporary detention shall be in accordance with the *Code of Virginia* , as follows: For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the 96-hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
				make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services. For Adults age 18 and over – Pursuant to § 37.2-809.H of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.
TREATMENT FOSTER CARE AND RESIDENTAL TREATMENT SERVICES FOR CHILDREN				
Treatment Foster Care (TFC) for children under age 21 years.*	12VAC 30-60-170 12VAC 30-50-480 12VAC 30-130-900 to 950	Yes	No	**. The TFC provider must contact prior-authorization agent for authorization. TFC (CM) services are carved-out.
Residential Treatment Facility Services (RTF) for children under age 21 years – Level A, B & C*	12 VAC 30-130-850 to 890	Yes	No	**DMAS authorization into a RTF program will result in disenrollment of the member from Medallion 3.0. The RTF provider must contact prior-authorization agent for authorization. Level A & B placements are group homes and Level C refers to RTF. Level A & B settings remain enrolled with the MCO, and members enrolled in Level C are exempted.

OUTPATIENT MENTAL HEALTH SERVICES The Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.				
Psychiatric Diagnostic Exam	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	See the highlighted section above.
Individual Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Group Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Family Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Electroconvulsive Therapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Psychological/ Neuropsychological Testing	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Pharmacological Management	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES				
Community Mental Health Services*	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430	Yes	No	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider and coordinate with the BHSA.
Community Intellectual Disability Services*	12 VAC 30-50-440	Yes	No	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES Coverage must comply with Federal Mental Health Parity law.				
Out-patient substance abuse treatment*		Yes	Yes	The Contractor is required to cover substance assessment and evaluation and outpatient services for substance abuse treatment for Medicaid members. The Department shall cover emergency services (crisis), intensive outpatient, day treatment and SA case management. Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the Contractor.
Out-patient substance abuse opioid treatment*		Yes	Yes	If a member has been prescribed drugs for opioid treatment and the member obtains such drugs through an independent pharmacy, the drugs are the responsibility of the Contractor. If the opioid treatment is administered by the Substance Abuse provider and the Substance Abuse provider obtains the drugs for the member, such drugs shall be considered a carved-out of this contract and shall be covered by the Department Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the Contractor.
Residential Treatment for Pregnant Women	12 VAC 30-50-510	Yes	No	The MCO must provide information and referral as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
Day Treatment for Pregnant Women	12 VAC 30-50-510	Yes	No	See comment directly above.

SUMMARY OF COVERED SERVICES - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - ARTS SERVICES ARE CURRENTLY IN DEVELOPMENT AND THE INFORMATION IN THIS SECTION IS SUBJECT TO CHANGE.				
Medically Managed Intensive Inpatient	ASAM Level 4.0	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Managed Intensive Inpatient Withdrawal Management	ASAM Level 4.0 WM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002
Medically Monitored Inpatient Withdrawal Management	ASAM Level 3.7 WM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002
Clinically Managed High Intensity Residential Services	ASAM Level 3.5	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002
Clinically Managed Residential Withdrawal Management	ASAM Level 3.2 WM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2034

SUMMARY OF COVERED SERVICES - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)					
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities	
OUTPATIENT WITHDRAWAL MANAGEMENT					
ARTS Partial Hospitalization	ASAM Level 2.5	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes S0201 Rev 0913	
ARTS Intensive Outpatient	ASAM Level 2.1	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0015	
Ambulatory Withdrawal Management With Extended On- Site Monitoring	ASAM Level 2WM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes	
Ambulatory Withdrawal Management Without Extended On- Site Monitoring	ASAM Level 1 WM	New Service	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes	
Medication Assisted Treatment (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Care Coordination Physician Visit - Induction Urine Drug Screen Labs Physician Visit – Maintenance	H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration S0109 Methadone 5 mg oral billed by provider G9012 Substance Abuse Care Coordination H0006 G0477-G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone in Opioid	ASAM Opioid Treatment Programs	Yes	Yes	Counseling	H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration

SUMMARY OF COVERED SERVICES - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities	
Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)				Medication	J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider
				Care Coordination	G9012 Substance Abuse Care Coordination
				Physician Visit - Induction	H0006
				Urine Drug Screen	G0477-G0483
				Labs	CPT codes
				Physician Visit – Maintenance	Use CPT E&M Established patient
Buprenorphine/Naloxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	ASAM Office Based Opioid Treatment	Yes	Yes	Counseling and Medication Oversight	H0020: Individual or Group Psychotherapy / Patient given Rx; billed by Pharmacy
				Care Coordination	G9012 Substance Abuse Care Coordination
				Physician Visit - Induction	H0006
				Urine Drug Screen	G0477-G0483
				Labs	CPT codes
				Physician Visit – Maintenance	Use CPT E&M Established patient

The following are required components of Opioid Treatment - H0020:

1. Components of Psychosocial Treatment for Opioid Use Disorder include at a minimum:
   - Assessment of psychosocial needs;
   - Supportive individual and/or group counseling;
   - Linkages to existing family support systems; and
   - Referrals to community-based services.
2. Provider Types for Psychosocial Treatment:
   - Physicians, Licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner;

SUMMARY OF COVERED SERVICES - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*				
*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities

or

- An individual with certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed above.
- Provider Types for Medication Administration:
  - Induction phase of MAT must be provided by Registered Nurse.
  - Maintenance phase of MAT may be provided by Licensed Practical Nurse or Registered Nurse.

3. Substance Abuse Care Coordination (G9012 Code):

Definition: Other specified case management services not elsewhere classified.

Description:

- Integrates behavioral health into primary care and specialty care medical settings through interdisciplinary care planning as well as monitoring patient progress and tracking patient outcomes.
- Supports in-person and telephonic conversations between buprenorphine-waivered physicians and behavioral health providers to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the person.
- Links patients with opioid use disorder with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs.
- Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice. Follows up with patients within a few days of an emergency room visit or hospital discharge. Communicates test results and care plans to patients and families.

4. Diagnosis Code: This code must be billed with Opioid Use Disorder as the primary diagnosis.
5. Required Documentation:
   - Providers must submit initial interdisciplinary care plan and regular updates to the care plan based on the patient's progress to the Managed Care plan or Magellan.
   - Updates should be at least monthly and more regularly if significant events occur that require intervention (such as positive urine drug for other substances or negative urine screen for buprenorphine, missed counseling appointments, lost prescriptions, etc.)
   - Documentation required of actions taken to address any evidence of a significant event to prevent future reoccurrence or relapse.
6. Provider Types:
   - At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse; or

SUMMARY OF COVERED SERVICES - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
• Licensure by the Commonwealth as a registered nurse or as a practical nurse with at least one year of clinical experience; or • At least a bachelor's degree in any field and certification as a substance abuse counselor (CSAC). **Reimbursement: Must be billed by buprenorphine-waivered physician who is prescribing Medication Assisted Treatment for opioid use disorder including buprenorphine/naloxone, buprenorphine (pregnant patients only), or naltrexone injections (Vivitrol)**				
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Abuse Case Management	12 VAC 30-60-185 12 VAC 30-50-431	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. (H0006)
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria (CPT Codes)
Peer Recovery Supports	To Be Determined; New Service	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria Peer Support Services – Group – S9445 Peer Support Services – Individual – T1012
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-50-180	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria 99408/99409)

ATTACHMENT III - NETWORK PROVIDER AGREEMENT REQUIREMENTS

A. RIGHT OF DEPARTMENT TO APPROVE, MODIFY OR DISAPPROVE NETWORK PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion, impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and members, including but not limited to the proposed provider's past performance. The Contractor shall submit any new network provider agreement at least thirty (30) days prior to the effective date for review, and upon request thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of members is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

The Department will review each type of agreement for services before contract signing. The Contractor shall initially submit each type of agreement for services with this Contract in the Attachments. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in all network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract):

> 1. (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid contract) with the Department of Medical Assistance Services. Provider compliance with the Medicaid Contract specifically includes but is not limited to the following requirements:
> 2. No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract.

At a minimum, MCO Contracts with Providers must include the following:

- Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the Medicaid contract.
- Provider agrees to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required

hospital/emergency department Memorandums of Understanding signed by the Contractor in accordance with the Medicaid Contract.

- The Provider agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet the Department specifications required by Medicaid Contract.
- 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.
- The Provider agrees to comply with all non-discrimination requirements in Medicaid Contract.
- The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in Medicaid Contract.
- The Provider agrees to provide 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 access to its premises and its Contract and/or medical records in accordance with Medicaid Contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with Medicaid Contract.
- Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 C.F.R.§ 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 C.F.R. § 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.
- The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid Contract. Provider agrees to make medical records available to members and their authorized representatives within ten (10) business days of the record request.
- The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.
- The Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
- The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally the Provider agrees to hold the member harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.
- The Provider agrees not to bill a Medicaid member for medically necessary services covered under the Medicaid contract and provided during the member's period of Contractor enrollment. This provision shall continue to be in effect even if the

Contractor becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then the Contractor, Contractor provider, or Contractor subcontractor can bill.

- The Provider must forward to the Contractor medical records, within ten (10) business days of the Contractor's request.
- The Providers shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the members are withdrawn from assignment to the provider.
- Except in the case of death or illness, the Provider agrees to notify the Contractor at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel members for up to thirty (30) day after such notification, until another PCP is chosen or assigned.
- The Provider agrees to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in Section 3of this Contract, to be stated in the network provider agreement.
- The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered member unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider.
- The Contractor shall follow prior authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and incorporate the requirements into its provider contracts. The Contractor must accept telephonic, facsimile, or electronic submissions of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests.

Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

B. NETWORK PROVIDER AGREEMENT SUPPLEMENT

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Network Provider Agreement. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Network Provider Agreement. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Network Provider Agreement.

If the Contractor uses the Provider Manual as a supplement to the Network Provider Agreement, all sections pertaining to Medicaid must be submitted to the Department for approval prior to signing original contract, upon revision (changes only or with changes highlighted), upon request, and as needed.

C. REVIEW AND APPROVAL OF NEW NETWORK PROVIDER AGREEMENTS AND IN APPROVED SUBCONTRACTS DURING THE CONTRACT PERIOD

- New agreements and changes in approved agreements shall be reviewed and approved by the Department before taking effect. Agreements will be considered approved if the

Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.

- This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.
- Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department.
- The Contractor shall submit its current provider network to the Department monthly.

Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in the Contract.

ATTACHMENT IV - CONFIDENTIALITY AGREEMENT FORM

This Agreement between the Virginia Department of Medical Assistance Services (DMAS) and _____ (Contractor) sets forth the terms and conditions for the disclosure of information concerning Medicare/Medicaid applicants, members or providers (Data). For purposes of this Agreement, the Contractor includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual agreement with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession. The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. The Contractor's Security Plan shall be eventually incorporated as an Attachment to this Agreement. No other uses of DMAS Data outside of the purposes stated in Attachment V will be allowed. The Contractor agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The Contractor agrees that there will be no commercial use of the DMAS data which it receives or creates in fulfillment of its contractual obligations.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. 431, Subpart F, and the *Code of Virginia*, § 2.2-3800, *et. seq.* (the Government and Data Collection and Dissemination Practices Act) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Access to information concerning applicants or members must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The Contractor attests that the data will be safeguarded according to the provisions of the written, DMAS approved, Security Plan meeting the general requirements outlined in Attachment V. In no event shall the Contractor provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 C.F.R. 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. Contractor certifies that all Data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The Contractor will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services, which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services."

The Contractor acknowledges that the Department reserves the right to audit for compliance with the terms of this agreement and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan.

The Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known by the Contractor or an employee, officer, or agent of the Contractor other than the person committing the breach, or as soon as possible following the first day on which the contractor or an employee, officer or agent of the Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach: (iii) any steps the Contractor believes individuals should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches.

In the event of impermissible use or disclosure by the Contractor of unsecured protected health information, the Contractor shall notify in writing all affected individuals as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Contractor shall be responsible for all costs associated with such notification.

The Contractor hereby agrees to comply with all of the requirements set forth herein.

ATTACHMENT V – BUSINESS ASSOCIATE AGREEMENT

THIS ATTACHMENT supplements and is made a part of the Business Associate Agreement (herein referred to as "Agreement") by and between the Department of Medical Assistance Services (herein referred to as "Covered Entity") and [name Business Associate] (herein referred to as "Business Associate").

General Conditions

This BAA ("Agreement" or "BAA") is made as of September 22, 2014 by the Department of Medical Assistance Services ("Covered Entity"), with offices at 600 East Broad Street, Richmond, Virginia, 23219, and _____ ("Business Associate"), with an office at _____. This is a non-exclusive agreement between the Covered Entity, which administers Medical Assistance, and the Business Associate named above.

The Covered Entity and Business Associate, as defined in 45 C.F.R. 160.103, have entered into this Business Associate Agreement to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the current and future Privacy and Security requirements for such an Agreement, the Health Information Technology for Economic and Clinical Health (HITECH) Act, (P.L. 111-5) Section 13402, requirements for business associates regarding breach notification, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements.

DMAS and Business Associate ("parties") shall fully comply with all current and future provisions of the Privacy and Security Rules and regulations implementing HIPAA and HITECH, as well as Medicaid requirements regarding Safeguarding Information on Applicants and Recipients of 42 C.F.R. 431, Subpart F, and Virginia Code § 32.1-325.3. The parties desire to facilitate the provision of or transfer of electronic PHI in agreed formats and to assure that such transactions comply with relevant laws and regulations. The parties intending to be legally bound agree as follows:

Definitions. As used in this agreement, the terms below will have the following meanings:

a. Business Associate has the meaning given such term as defined in 45 C.F.R. 160.103.
b. Covered Entity has the meaning given such term as defined in 45 C.F.R. 160.103.
c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.
d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain recipient (*member*), provider, and claims data for administration of the Medicaid program.
e. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 C.F.R. 160.103.
f. Breach has the meaning as that term is defined at 45 C.F.R. 164.402.
g. Required by law shall have the meaning as that term is defined at 45 C.F.R. 160.103.
h. Unsecured Protected Health Information has the meaning as that term is defined at 45 C.F.R. 164.402.

i. Transport Layer Security (TLS): A protocol (standard) that ensures privacy between communicating applications and their users on the Internet. When a server and client communicate, TLS ensures that no third party may eavesdrop or tamper with any message. TLS is the successor to the Secure Sockets Layer (SSL).

Terms used, but not otherwise defined, in this Agreement shall have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

II. Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate shall be sent via email or general mail to the DMAS Privacy Officer (with a copy to the DMAS contract administrator in II.2) at:

DMAS Privacy Officer, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
hipaaprivacy@dmas.virginia.gov

2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:

Contact: _____
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

III. Special Provisions to General Conditions

1. Uses and Disclosure of PHI by Business Associate. The Business Associate
   a. May use or disclose PHI received from the Covered Entity, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business.
   b. Shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law.
   c. Shall have a signed confidentiality agreement with all individuals of its workforce who have access to PHI.
   d. Shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, and who have signed a confidentiality agreement.
   e. Shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agree in writing to all the same restrictions, terms, special

provisions and general conditions in this BAA that apply to Business Associate. In addition, Business Associate shall ensure that any such subcontractor or agent agrees to implement reasonable and appropriate safeguards to protect Covered Entity's PHI. In instances where one DMAS Business Associate is required to access DMAS PHI from another DMAS Business Associate, the first DMAS Business Associate shall enter into a business associate agreement with the second DMAS Business Associate.

f. Shall provide Covered Entity access to its facilities used for the maintenance and processing of PHI, for inspection of its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI, for purpose of determining Business Associate's compliance with this BAA.

g. Shall make its internal practices, books, records, and policies and procedures 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 of Department of Health and Human Services (DHHS) or its designee and provide Covered Entity with copies of any information it has made available to DHHS under this section of this BAA.

h. Shall not directly or indirectly receive remuneration in exchange for the provision of any of Covered Entity's PHI, except with the Covered Entity's consent and in accordance with 45 C.F.R. 164.502.

i. Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use, disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.

j. Shall comply with 45 C.F.R. 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164 and the HITECH Act.

b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.

c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.

d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 C.F.R. 164.312(e).

e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall
    a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
        i. the date made,
        ii. the name of the person or organization receiving the PHI,
        iii. the recipient's (member) address, if known,
        iv. a description of the PHI disclosed, and the reason for the disclosure.
    b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. 164.528.

4. Sanctions - Business Associate shall
    a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
    b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:
    a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer
        i. On the first day on which such breach is known or reasonably should be known by Business Associate or an employee, officer or agent of Business Associate other than the person committing the breach, and

        ii. Written notification to DMAS Privacy Officer shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Business Associate shall confer with DMAS prior to providing any notifications to the public or to the Secretary of HHS.

    b. Breach Notification requirements.
        i. In addition to requirements in 5.a above, in the event of a breach or other impermissible use or disclosure by Business Associate of PHI or unsecured PHI, the Business Associate shall be required to notify in writing all affected individuals to include,
            a) a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
            b) a description of the types of unsecured PHI that were involved in the breach;
            c) any steps the individuals should take to protect themselves from potential harm resulting from the breach;

d) a brief description of what Business Associate is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches, and, if necessary,
e) Establishing and staffing a toll-free telephone line to respond to questions.

ii. Business Associate shall be responsible for all costs associated with breach notifications requirements in 5b, above.

iii. Written notices to all individuals and entities shall comply with 45 C.F.R. 164.404(c)(2), 164.404(d)(1), 164.406, 164.408 and 164.412.

6. Amendment and Access to PHI - Business Associate shall
   a. Make an individual's PHI available to Covered Entity within ten (10) days of an individual's request for such information as notified by Covered Entity.
   b. Make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within ten (10) days of notification by Covered Entity per 45 C.F.R. 164.526.
   c. Provide access to PHI contained in a designated record set to the Covered Entity, in the time and manner designated by the Covered Entity, or at the request of the Covered Entity, to an individual in order to meet the requirements of 45 C.F.R. 164.524.

7. Termination
   a. Covered Entity may immediately terminate this agreement if Covered Entity determines that Business Associate has violated a material term of the Agreement.
   b. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination.
   c. Within thirty (30) days of expiration or earlier termination of this agreement, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI.
   d. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate by the Covered Entity. If such return or destruction is infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this agreement shall survive with respect to such PHI.

8. Amendment
   a. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or

regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement in such manner as Covered Entity determines necessary to comply with such law or regulation.

b. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.

9. Indemnification. Business Associate shall indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

a. The names and contact information for at least one primary contact individual from each party to this Agreement.

b. A complete list of all individuals, whether employees or direct contractors of Business Associate, who shall be authorized to access Covered Entity's PHI

c. A list of the specific data elements required by Business Associate in order to carry out the purposes of this Agreement.

d. The purposes for which such data is required.

e. A description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Business Associate agrees to update the above noted information as needed in order to keep the information current. Covered Entity may request to review the above-referenced information at any time, including for audit purposes, during the term of this Agreement.

11. Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN BUSINESS ASSOCIATE'S POSSESSION OR CONTROL, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL COVERED ENTITY BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATED TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM COVERED ENTITY OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

ATTACHMENT
(To be completed by Business Associate)

DMAS/Contractor Name
Master BAA Contract # _____

Reference Section III <u>Special Provisions to General Conditions</u>

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

a. The names and contact information for at least one primary contact individual from each party to this Agreement.

Contact:
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
Phone Number :
Email Address:

Contractor Contact:
Address:
Phone Number:
Email Address:

b. Complete list of all individuals, whether employees or direct contactors, of Business Associate who shall be authorized to access Covered Entity's PHI.

c. List of the specific data elements required by Business Associate in order to carry out the purpose of this Agreement.

d. Purposes for which such data is required.

e. Description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

ATTACHMENT VI - OPEN ENROLLMENT EFFECTIVE DATES BY REGION

Medallion 3.0 Open Enrollment Effective Dates

NOTE: THESE OPEN ENROLLMENT PERIODS DO NOT APPLY TO FAMIS

CENTRAL VIRGINIA REGION LETTERS MAIL LATE JANUARY. MEMBERS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1.					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION LETTERS MAIL LATE APRIL. MEMBERS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN AND WINCHESTER REGION LETTERS MAIL LATE JUNE. RECPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1.					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
WESTERN REGION LETTERS MAIL LATE AUGUST. MEMBERS CALL SEPTEMBER AND OCTOBER. CHANGES EFFECTIVE NOVEMBER 1.					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		
ROANOKE/ALLEGHANY REGION LETTERS MAIL LATE NOVEMBER. MEMBERS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1.					
005	ALLEGHANY	063	FLOYD	141	PATRICK

017	BATH	067	FRANKLIN CO.	155	PULASKI
515	BEDFORD CITY	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
FAR SOUTHWEST REGION **LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.**					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

ATTACHMENT VII – ANNUAL NOTICE OF HEALTH CARE RIGHTS
(English Translation)
ANNUAL NOTICE OF HEALTH CARE RIGHTS

Español ? ? हिन्दी
Tiếng Việt 1-800-643-2273 اللغة العربية
فارسی 한국말

You have the RIGHT to ask your Managed Care Organization (MCO):
What medical services your MCO offers.
How to get covered services that your MCO does not offer.
How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
How to get approval from your MCO to see doctors who are not in your MCO.
What to do if you have a medical emergency or need medical advice after office hours.
How to make an official complaint about your MCO or appeal a medical decision by your MCO directly to the Department of Medical Assistance Services (DMAS).
How to get information about your MCO's doctors, other providers, translation services or transportation.

You have the RIGHT to:
Have access to health care services
Receive information about your health care and see your medical records
Be involved in decisions about your health care
Receive information about treatment options or other types of care
Be treated with respect, consideration and dignity
Expect all information about your health to be confidential
Tell DMAS about any problems you are having with your MCO
Change your MCO once a year for any reason during open enrollment
Change your MCO after open enrollment for an approved reason
Make an official complaint with your MCO or appeal directly to DMAS

You also MUST:
Present your MCO Membership Card whenever you seek medical care
Provide complete and accurate information on your health and medical history
Follow your MCO's rules for getting services and follow your doctor's instructions
Schedule appointments, be on time, and notify your doctor if you are late or must cancel
Call the Department of Social Services (DSS) to report any changes such as address, phone number and other personal information (birth, marriage, death, other health insurance, or income changes)
A monthly premium is paid by the Virginia Medicaid program to your MCO for your coverage. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your worker, you may have to repay these monthly premiums, even if you received no medical services during those months.
If you have any questions on managed care or your health care rights, call your MANAGED CARE HELPLINE at 1-800-643-2273

ATTACHMENT VIII – ANNUAL NOTICE OF HEALTH CARE RIGHTS
(Back - Spanish Translation)

Español ? ? हिन्दी
Tiếng Việt 1-800-643-2273 اللغة العربية
فارسی 한국말

ANUAL DE DERECHOS DE ATENCIÓN MÉDICA

Usted tiene el DERECHO de preguntar a su Organización de Cuidados Administrados (MCO – Managed Care Organization):
What medial services your MCO offers.Qué servicios médicos ofrece su MCO.
How to get covered services that you MCO does not offer.Cómo obtener servicios cubiertos que su MCO no ofrezca.How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
Cómo obtener un referimiento para atención especializada y otros servicios no provistos por su proveedor de cuidados primarios (PCP).
Cómo obtener la aprobación de su MCO para que lo(a) atiendan médicos que no pertenezcan a su MCO.
Qué hacer cuando tenga una emergencia médica o necesite consejo médico fuera de horario de atención.
Cómo presentar una queja oficial de su MCO o apelar a una decisión médica realizada por su MCO directamente al Departamento de Servicios de Asistencia Médica (DMAS – Department of Medical Assistance Services).
Cómo obtener información sobre los médicos, otros proveedores, servicios de traducción o transporte de su MCO.
Usted tiene el DERECHO de:
Have access to health care servicesObtener acceso a servicios de cuidado de la salud
Recibir información sobre su atención médica y ver sus registros médicos
Participar en las decisiones sobre su atención médica
Recibir información sobre opciones de tratamiento u otros tipos de cuidado
Ser tratado(a) con respeto, consideración y dignidadExpect all information about your health to be confidential
Esperar que toda la información relacionada con su salud sea confidencial
Informar al DMAS sobre cualquier problema que pudiera tener con su MCOChange your MCO once a year for any reason during open enrollment
Cambiar de MCO una vez al año, por cualquier motivo, durante la inscripción abierta
Cambiar de MCO después de la inscripción abierta por un motivo aprobado
Presentar una queja oficial a su MCO o apelar directamente al DMAS

Usted también DEBE:
Present your MCO Membership Card whenever you seek medical carePresentar su Tarjeta de Miembro del MCO siempre que reciba atención médica
Proveer informaciones completas y precisas sobre su historia de salud y médicaFollow your MCO's rules for getting services and follow your doctor's instructions
Respetar las reglas del MCO para la obtención de servicios y seguir las instrucciones de su médico
Marcar citas, llegar en horario y notificar a su médico si se atrasará o necesita cancelar la cita

Llamar al Departamento de Servicios Sociales (DSS – Department of Social Services) para informar sobre cualquier cambio, tal como de dirección, número de teléfono y otras informaciones personales (nacimiento, casamiento, fallecimiento, otro seguro de salud o cambios en sus ingresos)
Virginia Department of Medical Assistance Services paga una cuota mensual (prima) por su cobertura médica a su MCO. Si usted no reunió los requisitos por los meses anteriores de su cobertura, debido a que usted no envió la información correcta o cambios en su situación a su empleador (partrón), usted puede tener que reembolsar (pagar) las cuotas mensuales, si usted recibió servicios médicos durante esos meses.

Si tiene dudas sobre cuidados administrados o sobre sus derechos de atención médica, llame a nuestra LÍNEA DE AYUDA DE CUIDADOS ADMINISTRADOS al 1-800-643-2273

ATTACHMENT IX – HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?
Some of these questions are personal, and your answers will be confidential and private— only the MCO will get this information.
Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head	Case Head SSN		Case Head Language:
Last Name	First Name		Medicaid ID#
Address	City	State/Zip	Ph#

1	Gender	Male Female
2	Date of Birth	
3	What MCO are you choosing?	Name:
4	Do you have a doctor you want to be your Primary Care Provider?	Name:
5	If you have a regular doctor now, what is the doctor's name?	Names:
6	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? (If yes) What are the names?	Yes No List:
7	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]	Yes No List:
8	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?	Yes No What: Yes No
9	Are you pregnant? [If yes], When is the baby due? Does the doctor have any special concerns about this pregnancy?	Yes No Date:
	Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.	
10	Do you have surgery planned for the future? If yes, what is the date of surgery?	Yes No Date:
11	Are you getting home care or home hospice care? If yes, please explain.	Yes No Explanation:
12	Are you on an organ transplant list? If yes, please explain.	Yes No Explanation:
15	Are you getting physical therapy, or occupational therapy, or speech therapy?	Yes No
16	Do you have a heart condition--such as congestive heart failure?	Yes No
17	Do you have a lung disorder--such as asthma or	Yes No

	COPD?	
18	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐ No
19	Do you have diabetes?	☐ Yes ☐ No
20	High blood pressure?	☐ Yes ☐ No
21	Do you have kidney disease or are you on dialysis?	☐ Yes ☐ No
22	Do you have cancer?	☐ Yes ☐ No
23	Do you smoke?	☐ Yes ☐ No
24	Are you living with HIV or AIDS?	☐ Yes ☐ No
25	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐ No
26	Do you have tuberculosis (TB)?	☐ Yes ☐ No
27	Are any children in the house in Part C services, care coordination for children Any health department program, or Do any children receive Case Manager or Care Coordination services?	☐ Yes ☐ No List program and/or care coordinator:
28	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐ No List:
29	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐ No Reason:
30	What is your height?	Feet_____inches_____
31	And your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.
If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

ATTACHMENT X - MANAGED CARE ENTRY OR EXPANSION REQUIREMENTS

The following are Departmental requirements outside the managed care contracts that must be satisfied by the managed care organization (MCO) prior to any expansion or entry into the market being approved.

The MCO must submit a letter of intent at least 6 months in advance of the requested entry/expansion date, from the MCO to the Department requesting to expand/enter the market. The letter must include the localities where the entry/expansion is proposed, a proposed effective date, copies of BOI and VDH approval (if already obtained), a network development plan and a marketing plan. The Department shall direct its focus on MCO network development to assure access is better than what is currently available in the area the MCO seeks to expand into. The letter of intent should specify how the MCO will benefit the members of the Commonwealth and provide additional access. The letter of intent must also make clear the MCO understands that should the Department approve the expansion request, the member lives in the area will not be re-distributed. Requests to expand failing to demonstrate these requirements will not be considered.

Upon approval by the Department of the expansion /entry request, the MCO must provide the following within 30 days of the Department's approval of request to introduce one or more manage care plans into a new area:

- A plan of action to secure advocate and community support in the planned entry/expansion area.
- A project plan for the entry/expansion including completion of network development, information technology requirements, and communication deadlines.
- A list of the entry/expansion team at the MCO with their title and role on the team.
- A designee who will manage the entry/expansion project and will work with the Department as the primary contact.
- An assessment of political ramifications, if any, for the entry/expansion area. The Department will review and respond to this.
- Profit and enrollment projections for the two year period following the planned entry/expansion.
- An outreach and education plan (both long and short term) including the names of the team when available.
- A plan detailing how the entry/expansion will be incorporated in to the MCOs current processes.
- A list of subcontractors impacted and a communication plan for notifying the subcontractor of changes.
- A detailed care transition plan.
- Assurances that all ancillary programs (i.e. prenatal, disease state management) will be operational and in place prior to implementation.
- A detailed request from the Department for information which will assist the MCO in its entry/expansion process.

- A draft of the member, marketing and provider materials at least 120 days before the planned entry/expansion date. The Department will review and respond within 30 days of receipt of the materials.
- A primary care network that includes contracting with all area health departments, major hospitals, community services boards (CSBs), Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.
- A specialty care network plan detailing development for therapy, laboratory, vision, pharmacy, psychiatric, and transportation service providers.

A network development plan must include the specialties listed in this Contract.

The Department will determine network adequacy based on specific utilization for the entry/expansion area not later than 90 days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO must demonstrate adaptability to the special requirements of certain populations like pregnant women in rural areas. The final MCO network must be submitted before assignment deadlines established by the Department.

A written plan indicating the date when BOI and VDH approval will be secured, if at the time of the initial letter of intent BOI and VDH approval are not secured. The MCO must provide the Department with copies of BOI and VDH letters in addition to a written plan outlining a plan for achieving an acceptable accreditation ranking (NCQA), outlining plans for achievement of major milestones as appropriate.

In order to pursue the entry/expansion, if approved by the Department, the MCO will submit a letter accepting the terms of the contract and of these guidelines. The MCO must provide written assurances that it will accept both FAMIS and Medallion 3.0 members, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

ATTACHMENT XI – MMIS GENERATED PAYMENT XXX MCO

See MCO Specific Terms and Signature Payments for MCO Specific Rates

ATTACHMENT XII- COMMON DEFINITIONS FOR MANAGED CARE TERMS

PER 42 CFR 438.10(c)(4)

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Co-payment: A payment paid by you in order to receive medical care.

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded services: Services that are not covered under the Medicaid benefit.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.
Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Virginia Medicaid coverage rules.

Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Non-participating provider: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan.

Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, behavioral health.

Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Preauthorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

Participating provider: Providers, hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports that are contracted with your health plan. Participating providers are also "in-network providers" or "plan providers."

Premium: A monthly payment a health plan receives to provide you with health care coverage.

Prescription drug coverage: Prescription drugs or medications covered (paid) by your health plan. Some over-the -counter medications are covered.

Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary care physician: Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them.

Primary Care Provider (PCP): Your primary care provider is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Provider: A person who is authorized to give health care or services. Examples of providers include doctors, nurses, behavioral health providers, nursing homes and specialists.

Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, or major operation.

Skilled nursing care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Urgent care: Care when you need to see a doctor and your doctor is not able to see you or the office is closed. Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away.

ATTACHMENT XIII – CERTIFICATION OF DATA (NON-ENCOUNTER)

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 C.F.R. §§ 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 C.F.R. §§ 438.600 (et. al.).

> **The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.**
>
> **NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.**

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

_____
_____.

This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance and Title XXI.

_____
(INDICATE NAME AND TITLE
(CFO, CEO, OR DELEGATE)
on behalf of

_____
(INDICA)

ATTACHMENT XIV - DOCUMENTS CONSTITUTING THE CONTRACT

The documents that constitute this Contract are the following:

a. This document;

b. Subsequent modifications approved in writing by the Contractor and the Department.

The Contract hereby incorporates the attachments below:

- Authorized Workforce Confidentiality Agreement
- Summary of Medicaid and Medallion 3.0 Covered Services
- Network Provider Agreement
- Confidentiality Agreement
- Format for Business Associate Agreements
- Open Enrollment Effective Dates by Region
- Annual Notice of Health Care Rights
- Health Status Survey Questionnaire
- Managed Care Entry or Expansion Requirements
- MCO Specific Contract Terms/Signature Pages and Disclosure of Ownership and Control Interest Statement (CMS 1513)
- The Managed Care Technical Manual
- The Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications
- Any MCO specific terms & conditions negotiated and approved by the Department.

ATTACHMENT XV – MEDALLION CARE SYSTEM PARTNERSHIP QUALITY MEASURES

Menu of "Health Home Model Effectiveness" Measures for <u>all MCOs - MENU #1</u>

For the MCSP Model Chosen, PLEASE CHOOSE AT LEAST ONE MEASURE FROM THIS MENU.

Measures in this Menu indicate success of the medical home/health home model. The measures chosen reflect structural and population health improvement on a measureable, comparable basis both between and within MCOs. The "Health Home Model Effectiveness" Measures listed below will allow the Department and the MCOs to track progress and effectiveness of the MSCPs over time. For this purpose, the source-definition of an MCSP can be found in the Contract (Section 7.8.A) , and must be applied through the MCSP. While NCQA or URAC accreditation of medical homes is outlined as a measure of performance, it is not intended to be a requirement. The choice of measures below allows for variation of model types.

Measure	Rationale
Percent of primary care physicians in Medicaid network whose main practice site is an NCQA accredited medical home or a URAC recognized Patient Centered HealthCare Home Practice.	Accreditation requirements are in alignment with the Exchanges whereby eligible providers must be accredited as an NCQA medical home or URAC recognized patient centered healthcare home.
Percent of eligible primary care physicians in Medicaid network who attain at least Stage 2 Meaningful Use.	The use of electronic health records is intended to increase efficiencies, improve quality care, and reduce the administrative burden of paper-based medical records.
Percent eligible PCPs who record more than **75%** of unique patients" vital signs and chart changes (height, weight, blood pressure, calculate and display body-mass index, plot and display growth charts for children). "	This measure is applicable to all patients **ages 3** and over. Core measure #8 for Meaningful Use (MU). The measure per MU is that More than **50%** of all unique patients seen by the Eligible Provider (EP) during the reporting period. The elements within this measure (ht, wt, BP) are key indicators of health for all ages and are known risk factors for some of the preventable chronic conditions, such as CAD, diabetes, etc. The Nationally Recognized Million Hearts Campaign is widely accepted across health care settings, delivery systems, and providers.
MCO member Emergency Department (ED) utilization rate (use existing HEDIS measure for this indicator).	There should be an overall decrease in the utilization of the Emergency Department if medical home model is effective.
Relative Resource Use (RRU) for:	Select 2 Conditions from the box to the left. These are all

• Asthma • Diabetes • Hypertension • COPD • Cardiovascular conditions	measures currently calculated and scored in quality compass, so the numbers are available. When evaluated with the corresponding quality of care measures, they provide more information about the efficiency or value of organizations services.

Menu of "Outcome Measures Tied to Identifiable MCSP Models" - MENU #2

For Each MCSP Model Chosen, PLEASE CHOOSE AT LEAST ONE MEASURE FROM THIS MENU.

The quality measures identified in Menu #2 are targeted to highlight outcomes of each distinct type of MCSP innovation model. While these outcome measures are considered more resource intensive for measurement than those measures listed in Menu #1, each individual measure in Menu #2 relates directly to the desired outcome of each MCSP model & payment type. The "Outcome Measures Tied to Identifiable MCSP Models" will allow the Department to take an in depth look at the quantitative improvements over time and ultimately, to compare which MCSP innovation models are the most/least effective.

Reference Number	Model and payment options	Measures criteria
1.1.A	MCO contracts with Primary Care Providers; Performance rewards: performance pool or pay for performance	One diabetes and one asthma HEDIS measures of condition management. Alternatively or in tandem, two behavioral health measures of conditional management may be utilized if the model integrates those services.
1.2.B	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees; Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Evidence of payment structure for primary care providers who are included in this model. MCO would provide details on payment disparity between those providers within the model and those who are not, and, show improvements in condition management visits to the PCPs for those who are included in the model.
2.C	MCO contracts with provider Care System or a collaborative (primary care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/ performance payment models across services, Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute, behavioral health, and long term care	Important to monitor transitions of care; Improvements, efficiency & effectiveness, and transitions of care.
3.A	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or	Measures should be geared toward early identification and treatment of physical health issues, common chronic conditions, and use of preventive services, while simultaneously treating

Reference Number	Model and payment options	Measures criteria
	Mental/Behavioral Health services with acute/ primary care services. May include designated HCH or Health Homes Performance rewards: performance pool or pay for performance	for MHSA. Also, consider measures of care transition; readmission rates for mental health; hospital admissions for diabetes, asthma, and /or cardiovascular conditions.
3.B	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Same as above.
3.C	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes. Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Same as above.
4.D	Alternative defined by proposal Alternative Proposals	Mutually agreed upon.

ATTACHMENT XVI – QUALIFIED SIGNATORY REQUIREMENTS

The following list states the Department's minimum thresholds & reporting requirements a potential Contractor must meet to the Department's satisfaction in order to qualify as a signatory to this Contract:

- Readiness Review, as described in Section 2.4. This review may occur after signing at the Department's discretion.
- Provider Agreements, submitted 30 days prior to effective date, as described in Section 3.1.
- Credentialing/Recredentialing Policies and Procedures that meet NCQA guidelines and are in accordance with 12 VAC 4-408-170, as described in Sections 3.4.A and 7.6.A.IV.
- Primary Care Physician Assignment Policies and Procedures, as described in Section 3.6.A and 7.6.A.IV.
- Complete Provider File to Enrollment Broker, 30 days prior to the effective date of the Contract, as described in Section 3.2.D.
- Subcontractor list, at least 30 days prior to their effective date, as described in Section 3.16.B.
- Newborn Identification/Enrollment Process & Procedures, as described in Section 5.7.
- Member outreach and marketing materials must be approved in advance according to Contractually stated timeframes, including the Annual Marketing Plan as described in Section 6.1.B, incentive amounts described in Section 6.2, and member materials as described in Sections 6.4 (member requirements), 6.5 (Member ID cards) 6.6/6.7 (New Member Packets & Mailing Requirements), 6.8 (Member Handbook), 6.9 (Member Rights Requirements), and 6.12 (Member Education Program).
- Moral or Religion Objections, as described in Section 7.1.I.
- Assessment of Children and Youth with Special Health Care Needs, as described in Section 7.1.O.III.B
- Expedited Authorization Decisions/Utilization Management, as described in 7.1.P.II.
- Sterilization and Hysterectomy Policies and Processes for Compliance, as described in Sections 7.2.N.III and 7.2.N.IV.
- Coordination of Substance Abuse Services for Pregnant Women Policies and Procedures, as described in Section 7.2.N.V.j.
- Prescription Drug Formularies and Rebate Submissions, as described in Section 7.2.S.
- List of Enhanced Services, as described in Section 7.4.A.
- Maternal/Prenatal Policies and Procedures, as described in Sections 8.7, specifically 8.7.E.II.
- Fraud/Waste/Abuse Reporting Policies and Procedures and Provider Appeals Processes, as described in Section 9.2.A.III and 9.2.A.VIII.
- Member Grievance and Appeals processes, as described in Section 10.1.D.
- Enrollment Verification Provider Policies and Procedures, and Encounter Completeness requirements as described in Section 11.3 and 11.5.
- FQHC/RHC Arrangement Types List, as described in Section 12.15

- Ownership information, as required by Sections 13.5.A.II.b.iv and 13.5.B.III
- Data Security Plan, as described in Attachment V and Data Confidentiality, as described in Section 13.5.C.
- Insurance Verification, as described in 14.16.
- Medical Records and Practice Guidelines, as described in Sections 14.19.A.I and 14.24.B.
- Provider Manuals and New Agreements and Changes, as described in Attachment III (B/C).

The Department reserves the right to modify these requirements, and/or add additional requirements to this list at any time in the interest of member or provider protection, or due to necessary programmatic changes.