COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Cardinal Care Managed Care Contract

January 1, 2025 – June 30, 2025

CARDINAL CARE MANAGED CARE CONTRACT

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1. SCOPE OF CONTRACT

This Cardinal Care Managed Care Contract ("Managed Care Contract"), by and between the Department of Medical Assistance Services ("Department") and the Contractor, is for the provision of managed care services to individuals enrolled in the Cardinal Care Managed Care program. The Cardinal Care program rebrands the Department's fee-for-service (FFS) and managed care programs under a single name, and effectively combines the previous Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 programs as Cardinal Care Managed Care ("Managed Care" or "Managed Care program"), as mandated by the General Assembly in 2021. The Managed Care Contract period follows the maximum renewal timeframes set forth in the CCC Plus MLTSS RFP-2016-01, as further described in Section 21.2.40, *Termination of Contract*. The initial term was August 1, 2017 – June 30, 2022, with the potential for up to five (5) twelve (12)-month renewals on July 1 of each year. The term of the contract in effect is July 1, 2024, through June 30, 2025. If all renewal options are exercised, the contract will expire June 30, 2027. (See *Attachment A – Managed Care Signature Page*.) This Contract includes the program requirements and specifications as outlined in the Contractor's responses to the CCC Plus MLTSS RFP-2016-01 and the Medallion 4.0 RFP 2017-03, this Contract, the Cardinal Care Technical Manual, and the documents incorporated by reference and listed below. This Contract and rates will be renewed annually and/or through the Department's Contract amendment process as needed, subject to approval from CMS and the Virginia legislature, as described in Section 21.2.40, *Termination of Contract*.

The Contractor must operate in all six (6) regions of the Commonwealth of Virginia ("Commonwealth") and in all localities in each region. The Department reserves the right to deny participation in certain cities/counties where it is found that the Contractor has either network or staffing inadequacy. At that time, the Department may utilize one or all of the following: (1) issue a corrective action plan outlining the problematic areas and the timeframe required for compliance; (2) freeze enrollment statewide for any new Members until statewide participation is reached; and/or (3) terminate this Contract (refer to Section 21.2.40 Termination of Contract). The Contractor must provide the full scope of services and deliverables to its membership, through an integrated and coordinated system of care, and in compliance with service and delivery timelines as required by this Contract, and all applicable laws and regulations. Beginning with the State Fiscal Year 2025 contract term, the Contractor must comply with all provisions of the federal Medicaid and CHIP Managed Care Access, Finance and Quality Final Rule (CMS-2439-F), and the Ensuring Access to Medicaid Services Final Rule (CMS -2442-F) that take effect July 9, 2024. This includes but is not limited to those regarding to Medical Loss Ratio, In Lieu of Services and State Directed Payments.

The Department is solely responsible for the administration of this Contract. Administration of the Contract will be conducted in good faith within the resources of the State, and in the best interest of Managed Care Members. The Department retains full authority for the administration of the Medicaid and FAMIS programs in accordance with the requirements of Federal and State laws and regulations. See Section 14, Subcontractor Delegation, regarding conflicts between the Department's administration of the Medicaid program and the Contractor's policies and its subcontractor's contracts.

1.1 Applicable Laws, Regulations, and Interpretations

The documents listed below are hereby incorporated into this contract by reference. No other expression, whether oral or written, will constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the interpretation of Contract documents will be resolved using the legal order of precedence, as follows:

1. Federal statutes and regulations, as amended;
2. State statutes and regulations, as amended;
3. Virginia's State Plans for Medical Assistance Services and State Children's Health Insurance Program (CHIP);
4. The Department's 1915(b) Managed Care Waiver, 1915(c) HCBS Waivers, ARTS 1115 Waiver, and FAMIS MOMS 1115 Waiver;
5. This Contract, including any MCO specific terms and conditions negotiated and approved by the Department, all amendments and attachments, relevant provider manuals, the Cardinal Care Technical Manual, and the Department's Managed Care Model Member Handbook, including common managed care terms and definitions, per 42 CFR §438.10(c)(4);
6. Cardinal Care Technical Manual (including Cardinal Care Managed Care Core Performance Measures List), Cardinal Care Encounter Technical Manual, ARTS Technical Manual, and other technical manuals, as updated;
7. Medicaid memos, bulletins, and guidance as well as Department-issued memos, bulletins, manuals, and other guidance documents; and
8. CCC Plus MLTSS RFP 2016-02 Proposal Response, Medallion 4.0 RFP 2017-03 Proposal Response.

1.2 Operational Memoranda, Guidance Documents, and Department Forms

The Department may issue operational memoranda and guidance documents clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and/or coverage. The Contractor must comply with all documents, memoranda, and other related Department-issued forms.

The Department's program policy manuals, Medicaid memoranda/bulletins, and forms referenced in this Contract are available on the Department's web portal.

1.3 Department and Managed Care Plan Collaboration

The Contractor must work collaboratively with the Department on all Department goals and initiatives, including, but not limited to, population health and quality improvement initiatives, health equity and transparency initiatives, and Medicaid delivery system and payment reforms.

The Contractor must participate in meetings with the Department. These meetings include the Department Managed Care Advisory Committee; MCO Workgroup meeting; the Quality Collaborative; CFO Quarterly Meetings; the Compliance Collaborative; Program Integrity meetings; meetings with the Department's CMO and Pharmacy Director; the ARTS Workgroup; Child Welfare Stakeholder Collaboration workgroups; and any other meetings or workgroups as necessary or when requested to do so by the Department. In-person attendance is expected unless otherwise noted by the Department. If the Department, in its sole discretion, determines that the Department's presence is required at a

meeting with the Contractor, the Contractor must schedule such meeting at a time convenient for the Department and all involved parties.

1.3.1 Child Welfare Stakeholder Collaboration

The Contractor must participate in child welfare stakeholder collaboration workgroups as requested by the Department. These groups may include, but are not limited to, Department facilitated managed care work groups and those with other external stakeholders serving youth affected by the child welfare system.

The Contractor must establish internal program leads for foster care and adoption assistance Members. The Contractor must also ensure that the contact information for these team leads is kept up-to-date and provided to the Department for distribution to applicable child welfare stakeholders including, but not limited to, Local Departments of Social Services, Licensed Child-Placing Agencies, the Office of Children's Services and the Virginia Department of Social Services.

1.3.2 Department's 360 Degree Review

The Department is developing an internal process for assessing the Contractor's overall performance. The results of the Departments review will be shared with the Contractor either in writing or in a meeting. The Contractor must participate in this process as directed by the Department. At this time this process is not intended to be tied to oversight activities described in Section 17, *Oversight*.

1.3.3 Juvenile Justice Reentry Program

In accordance with the 2023 Consolidated Appropriations Act, the Department is in the process of creating a process to allow for Medicaid enrollment and Medicaid services, possibly including case management, health screenings, and behavioral health screenings, for youth who are incarcerated during the thirty (30) days prior to their release from incarceration. The Contractor must collaborate with the Department to support the creation and operation of the Juvenile Justice Reentry Program.

1.3.4 Emergency Room Utilization Program

In accordance with Chapter 1, Item 304 (HHH) of the 2023 Special Session Appropriations act, the Department is in the process of creating an emergency room utilization program. The Contractor must collaborate with the Department to support the creation and operation of this program.

1.3.5 Partnership for Petersburg

The Contractor will support the Partnership for Petersburg initiative and participate in at least one activity or event per month in alignment with the Department's goals to 1) provide mobile health care clinics and community events to improve access to critical health screenings and preventive care as well as enhance utilization of pediatric, primary care and dental services; 2) improve Petersburg maternal and infant health outcomes; and 3) promote health literacy for members residing within the City of Petersburg. Activities will be shared with the Department no later than the 26th day of the calendar month prior to the scheduled date.

1.4 Required Reporting and Documentation

To ensure compliance with the terms of this Contract and all applicable Federal and State statutes, regulations and guidance, the Department requires the Contractor to submit reports and other documentation related to the Contractor's performance and operations. Reports and documentation required to be maintained and/or submitted by the Contractor to the Department or its designee are included in the Cardinal Care Technical Manual, which provides the specific requirements for the content and submission of all required reports. Failure to timely and accurately provide any required reports or documentation will result in compliance enforcement actions, as provided in Section 17, *Oversight*. Notwithstanding the foregoing, the Department has the right to require additional documentation, reports, and information be maintained; and request additional documentation, reports, and information not listed in the Cardinal Care Technical Manual. The Contractor must submit such documentation and reports in the timeframes and manner as requested by the Department.

1.5 Contractor Requirements to Respond

The Contractor must acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including, but not limited to, care management evaluation requests and requests to change MCO (via good cause as outlined in Section 3.13, *Health Plan Enrollment Changes*), within the following time frames:

1. Within one (1) business day in instances where a potential/actual risk to the Member's health, safety or welfare exists;
2. In all other instances within no later than two (2) business days of receipt of the request from the Department; and
3. 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.

The Department's requests for care management and/or requests for the Contractor to contact the Member/provider must occur within the time frame set forth by the Department.

The Contractor must receive and respond to all inquiries and requests made by the Department in time frames and formats specified by the Department. The Department's urgent requests for assistance, such as issues involving legislators, other governmental bodies, or as determined necessary by the Department, must be given priority by the Contractor and completed in accordance with Departmental instructions. The Department will provide guidance with respect to any necessary deadlines and requirements, including specifications to be submitted by the Contractor.

For requests involving litigation or legal representation of any type, the Contractor must ensure that all responses are timely, thoroughly detailed, professionally written, and legally sound. All responses must be reviewed and approved by the Contractor's leadership and legal teams prior to responding to the Department.

The Contractor may request an extended timeframe for response and resolution of non-urgent requests, after initial acknowledgement of request and prior to the expiration of the original specified

timeframe. Request for extension to include reason for extended timeframe for response and requested date for new response date.

The Contractor must ensure staff attendance at all meetings and/or trainings required by the Department. The Department may further require trainings in neutral settings with the Department and other contracted health plans in attendance.

1.5.1 Requirements to Respond to Requests Regarding Liens

Within five (5) business days of receiving the Department's Fiscal Division's request for information or documentation, the Contractor must furnish the requested information or documentation to the Department's Fiscal Division. If the Contractor fails to submit the requested information or documentation within five (5) business days and such failure causes, either directly or indirectly, a negative financial consequence for the agency, as determined the Department, the Contractor shall be responsible for satisfying, paying and resolving the negative financial consequence in its entirety.

Within five (5) calendar days of receiving the Department's Third-Party Liability (TPL) Division's request for information or documentation, the Contractor must furnish the requested information or documentation to the Department's TPL Division. If the Contractor fails to submit the requested information or documentation within five (5) calendar days and such failure causes, either directly or indirectly, a negative financial consequence for the agency, as determined by the Department, the Contractor shall be responsible for satisfying, paying and resolving the negative financial consequence in its entirety.

1.6 Department Oversight

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 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. Records must be maintained in a searchable electronic format.

2. MCO REQUIREMENTS FOR OPERATION

2.1 Licensure and Solvency

The Contractor must 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 and § 38.2-5800 through 38.2-5811, 14 VAC 5-211-10 *et seq*., and any and all other applicable federal and state laws and regulations, as amended. A copy of this license must be submitted with the Contractor's signature page at each annual contract renewal (refer to Attachment A, *Cardinal Care Managed Care Contractor Signature Page*).

In accordance with 42 CFR § 438.116, the Contractor must provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate and must also ensure that Medicaid enrollees will not be liable for the Contractor's debt if the Contractor becomes insolvent. The Contractor must meet the solvency standards established by the State Corporation Commission for private health maintenance organizations and/or be licensed or certified by the State as a risk-bearing entity.

2.2 Certification of Quality

Pursuant to Code of Virginia §§ 32.1-137.1 through § 32-137.6 , and 12 VAC 5-408-10 *et seq*., the Contractor must obtain service area approval certification and remain certified by the VDH Office of Licensure and Certification (formerly State Health Commissioner Center for Quality Health Care Services and Consumer Protection) to confirm the quality of the health care services they deliver. Failure to maintain certification will result in termination of this Contract. A copy of this certification must be submitted with the Contractor's signature page at each annual contract renewal.

2.3 National Committee for Quality Assurance (NCQA) Accreditation

The Contractor must obtain and retain Health Plan Accreditation by the National Committee for Quality Assurance (NCQA). The Contractor must also obtain and retain NCQA LTSS Distinction. If the Contractor is not accredited, for example, due to merger or acquisition, the Contractor must adhere to NCQA standards while working toward accreditation based on the most current version of NCQA Health Plan Accreditation Standards.

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) calendar days of receiving the report.

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, but are not limited to: 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.

Pursuant to 42 CFR § 438.332(b)(1)-(3), the Contractor must give NCQA permission annually so NCQA can provide the Department with a copy of the Contractor's most recent accreditation review, including:

1. Accreditation status, survey type, and level (as applicable);
2. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
3. The expiration date of the accreditation.

The Contractor must advise the Department within ten (10) calendar days if the Contractor has received notification from NCQA of a change in its accreditation status, including any deficiencies. Denial or revocation of NCQA accreditation status or a status of "Provisional" may be cause for the Department to

impose remedies or sanctions as outlined in Section 17, *Oversight*, to include suspension of this Contract, depending upon the reasons for denial by NCQA.

Any new Contractor without NCQA accreditation 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:

1. EQRO Comprehensive onsite review at least annually, at dates to be determined by the Department.
2. 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).
3. Obtain NCQA accreditation with LTSS distinction status of at least "Accredited" within thirty-six (36) months of the onset of delivering care to Members.

2.4 Authorization to Conduct Business in the Commonwealth

The Contractor, as a stock or non-stock corporation, limited liability company, business trust, limited partnership, or registered as a limited liability partnership, must be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the Code of Virginia or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the Virginia Public Procurement Act must not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time during the term of the contract. A public body may void any contract with a business entity if the business entity fails to remain in compliance with the provisions of this Section.

2.5 Policy of Nondiscrimination

The Contractor and all subcontractors must comply with all applicable Federal and State laws and regulations relating to nondiscrimination and equal employment opportunity, and assure physical and program accessibility of all services to individuals with disabilities pursuant to § 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 CFR 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. Any of the Contractor's contracts with subcontractors must comply with Virginia Code § 2.2-4311.

Furthermore, the Contractor must ensure that its network providers provide contract services to Members under this Contract in the same manner as they provide those services to all non-Medicaid and non-FAMIS Members, including those with limited English proficiency or physical or mental disabilities. Additionally, in accordance with 42 CFR § 438.206(c)(1)(ii), the Contractor must ensure that

its network providers offer hours of operation that are no less than the hours of operation offered to commercial members if the provider serves only Medicaid and/or FAMIS Members.

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices setting forth the provisions of the non-discrimination clause.

2.6 Continuity of Operations Plan

The Contractor is required to provide written assurances that it has a Continuity of Operations Plan (COOP) that relates to the services or functions provided by them under this contract. The following template documents from the Virginia Department of Emergency Management (VDEM) provide key information to be included in the Contractor's COOP:

1. VDEM Continuity Plan Template;
2. VDEM Guide to Identifying Mission Essential Functions; and
3. Mission Essential Function Identification Worksheets.

The COOP document must be available to the Department, as provided for in the Cardinal Care Technical Manual.

2.6.1 Business Continuity (BC)/Disaster Recovery (DR)

The Contractor must provide a copy of its BC/DR plan for the technology and infrastructure components, as well as for the business area operations continuity and contingency plan. The Contractor must affirm the BC/DR plan and submit it to the Department, including the essential roles, responsibilities, and coordination efforts necessary to support recovery and business continuity.

The Contractor must address a wide range of infrastructure and services recovery responsibility associated with, and/or arising from, partial loss of a function or of data for a brief amount of time to a worst-case scenario in which a man-made or natural disaster results in data center equipment or infrastructure failure or total system failure. It is the policy of the State that a BC/DR plan is in place and maintained at all times. The plan must contain procedures for data backup, disaster recovery including restoration of data, and emergency mode operations. The plan must include a procedure to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency. Access control will include procedures for emergency access to electronic information.

The Contractor must be protected against hardware and software failures, human error, natural disasters, and other emergencies which could interrupt services. The plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure.

The BC/DR Plan must be submitted in the manner and format as outlined in the Cardinal Care Technical Manual.

2.7 Contractor Readiness Reviews

The Department reserves the right to conduct a readiness review of the Contractor when deemed necessary, including any major system or service change, occurring during or after a procurement or re-procurement (see also Section 2.9.1, *Proposed Acquisition and Purchase/Sale of Health Plan* and Section 21.2.31, *Qualified Signatory*). The Department will issue specific readiness review requirements under separate guidance to the extent they are applicable.

2.8 Member Experience and Provider Surveys

Annually, the Contractor must conduct Member experience and Provider survey activities, as follows:

1. Conduct an annual CAHPS survey as outlined in Section 10.6.1, *HEDIS® Quality Measures and Reporting*.
2. Conduct, as directed by the Department, the HCBS Experience survey for Members utilizing long-term services and supports (LTSS).
3. Conduct, as directed by the Department, a merged Member satisfaction survey on care management and quality of life.
4. Design and administer network providers and Member satisfaction surveys regarding their satisfaction with the Contractor. The Contractor can use the merged Member satisfaction and quality of life survey as the Member satisfaction survey or administer a separate Member satisfaction survey.
5. Conduct any other surveys as deemed necessary by the Department.
6. The Contractor must demonstrate best efforts to utilize Member experience survey results in designing QI initiatives and implement system and process changes.

2.9 Ownership and Control Interest

In accordance with Federal regulations contained in 42 CFR §§ 455.100 through 455.104, 42 CFR § 438.604(a), 42 CFR § 438.608(c), and 42 CFR § 438.610, and Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act, the Contractor must disclose all of the following for the Contractor's owner(s) and managing employee(s) or persons or corporations with an ownership or control interest (as defined in 42 CFR § 455.101) in the Contractor's plan:

1. Information on ownership and control (42 CFR § 438.608(c)(2));
2. Name and address of any person (individual or corporation) with an ownership or control interest in the Contractor, fiscal agent, or managed care entity; date of birth and Social Security Number of any person (individual); and tax identification number (corporation) with an ownership or control interest in the Contractor and any subcontractor in which the Contractor has a five percent (5%) or more interest (42 CFR § 455.104(b)(1));
3. Information on whether a person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; and information on whether a person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with

ownership or control interest in the Contractor as a spouse, parent, child, or sibling (42 CFR § 438.604(a)(6); 42 CFR § 455.104(b)(2); 42 CFR § 438.608(c)(2));

4. Information, including name, address, date of birth, and Social Security Number of any other Contractor and managing employee of the Contractor in which an owner of the Contractor has an ownership or control interest (42 CFR § 455.104(b)(3)-(4)); and
5. Information on persons convicted of crimes related to involvement in federally related health care programs (42 CFR § 455.106).

The Contractor must provide the required information using the Disclosure of Ownership and Control Interest Statement (DMAS 1513, available on the Department's website), included as part of the Contractor Specific Contract Terms and Signature Pages, at the following times, in accordance with 42 CFR §§ 438.608(c), 42 CFR § 455.100-104 and Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act:

1. When the Contractor executes the Contract with the Department
2. Annually as of the date of execution of this Contract;
3. When the Department renews or extends the Contract, as applicable;
4. Within five (5) days prior to any change in ownership, concerning each person with ownership or control interest;
5. When a provider or disclosing entity submits a provider application;
6. When a provider or disclosing entity executes a provider agreement with the Department;
7. Upon request of the Department during the revalidation of the provider enrollment; and
8. Within five (5) days prior to any change in ownership of a disclosing entity.

In accordance with Section 1903(m)(4)(B) of the Social Security Act, the Contractor must make any reports of transactions pursuant to 1903(m)(4)(A) between the Contractor and parties in interest (as defined in Section 1318(b) of the Social Security Act) available to its Members upon reasonable 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 CFR §§ 438.602(c) and 438.608(c). 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 17, *Oversight*, and/or termination of this Contract by the Department.

The Contractor must maintain such disclosed information in a manner which can be periodically reviewed by the Department. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A), 42 CFR § 438.610 and 42 CFR § 455.436.

The Contractor must conduct monthly checks for all of the Contractor's owners and managing employees against the Federal listing of excluded individuals and entities (LEIE) database. Federal database checks must be consistent with the requirements at 42 CFR § 455.436. The Contractor must confirm the identity and determine the exclusion status of its subcontractors, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor or subcontractor through routine checks of Federal databases.

2.9.1 Proposed Acquisition and Purchase/Sale of Health Plan

The Contractor must submit for review and prior approval by the Department any proposed acquisition or purchase of the Contractor and/or its Medicaid lines of business. 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 Contractor must submit notice to the Department, not less than sixty (60) days in advance or upon availability, for review and approval of the following:

1. A letter of intent which describes the purpose and manner of the sale, including the acquisition plan, method and terms (e.g. stock or asset transfer);
2. A proposed effective date, copies of BOI and VDH approval, and NCQA certification;
3. 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);
4. A project plan including completion of any network development, information technology changes and requirements, and communications;
5. An organizational chart indicating the retention of current and key personnel, as well as any staff changes;
6. A list of the acquisition/implementation team at the MCO with their title and role on the team including a project lead;
7. Profit and enrollment projections; and
8. Any additional information requested by the Department, including Acquisition/Purchase Requirements as outlined in the Cardinal Care Technical Manual.
9. A statement disclosing whether the transaction is under review by other authorities, such as the Office of the Attorney General, the Federal Trade Commission, or the Department of Justice.

The Department will review the notification and submission made by the Contractor. An acquisition, purchase or sale may require a Contract amendment. The Department may consider waiving specific requested requirements upon written request from the Contractor.

The Department will send a notice to Members at the Contractor's expense notifying them of the acquisition and purchase or sale of the Contractor and/or its Medicaid lines of business. The Department will review all Member and provider correspondence relating to the acquisition, purchase or sale prior to its disbursement by the Contractor.

Pursuant to 42 CFR § 438.66(d) the Department reserves the right to conduct a readiness review upon receipt of change of ownership notification when deemed necessary.

The Contractor 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.) within five (5) business days of an NCQA action.

2.10 Organizational Structure and Personnel Requirements

The Contractor must have a Virginia-based operation that is dedicated to this Contract. The Department does not require claims, utilization management, customer service, pharmacy management, or Member services to be physically located in Virginia; however, pursuant to 42 CFR § 438.602(i) these service areas must be located within the United States.

The Contractor must have a dedicated Virginia Managed Care Project Director and dedicated Project Manager located in an operations/business office within the Commonwealth of Virginia. If the Virginia Managed Care Project Director and Project Manager work from a remote location, rather than in the operations or business office located within the Commonwealth of Virginia, their remote location must be within the Commonwealth of Virginia. The Contractor's Project Director and Project Manager must attend all meetings required by the Department.

The Contractor must provide the Department with an organizational chart that illustrates staffing and lines of authority for key personnel. The organizational chart must include:

1. The relationship of service personnel to management and support personnel;
2. The names of the personnel and the working titles of each;
3. All divisions that perform program operations, including, but not limited to, claims processing, member services, outreach and/or marketing, health services and program integrity;
4. Any proposed subcontractors including management, supervisory, and other key personnel; and
5. An overview of current internal reporting structures.

2.10.1 Managed Care Key Personnel

The Contractor's Chief Executive Officer (CEO), President (corporate or Commonwealth business), Contract Administrator, Project Director, Project Manager, Chief Medical Director/Officer (CMO), Pharmacy Director, Behavioral Health Director, Director of Long-term Services and Supports, Consumer-Directed (CD) Services Project Manager, Maternal and Child Services Manager/Director, Medical Management Director, Care Coordination Manager, Chief Financial Officer (CFO), Chief Operating Officer or Director of Operations, Program Integrity Lead, Member Services/Operations Manager, Quality Director, Quality Improvement Manager, Senior Manager of Clinical Services, Claims Director, Information Technology Director, Encounter Data Manager, Compliance Officer, ADA Compliance Director (can be the same as the Compliance Officer), and/or equivalent position(s) are "key personnel."

Upon request by the Department, the Contractor must submit to the Department the name, resume, and job description for each of the key personnel to the Department within five (5) business days of the request. At any time during the effective dates of this Contract, if a key staff position is vacated, the Contractor must notify the Department within five (5) calendar days from receipt of formal written notice of departure. For new hires or temporary substitute(s), the Contractor must provide notification, a resume, and an updated organizational chart to the Department within five (5) calendar days of the start date.

Reporting requirements are specified in the Cardinal Care Technical Manual. 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.

2.10.2 Department Concerns Related to Staffing Performance

The Department will inform the Contractor of any concerns it may have regarding key personnel who do not perform their responsibilities (e.g., those provided in the individual's position description). The Contractor must investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify the Department of such actions. A Corrective Action Plan may be required if the Contractor's actions fail to, as determined by the Department, ensure full compliance with the terms of this Contract.

The Department reserves the right to direct the Contractor to remove any staff from this Contract when it is determined that the removal is in the best interest of the Contract and the Commonwealth.

2.10.3 Contractor Staff Email Domain

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 Department 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.

2.10.4 Managed Care Project Director

The Managed Care Project Director must be directly employed by the Contractor and one hundred percent (100%) dedicated to Virginia's Managed Care program and operations. The Project Director must be employed by or contracted with the Contractor (not a third party administrator) and must comply with all requirements of this Contract in that capacity. Additionally, the Project Director must be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia business, claims payment, and provider relations/contracting.

2.10.5 Managed Care Project Manager

The Managed Care Project Manager must have the ability to make timely decisions about Managed Care program issues and must represent the Contractor at Department meetings. The Managed Care Project Manager must be able to respond to issues involving information systems and reporting, appeals, quality improvement, Member services, service utilization management, pharmacy management, medical management, care coordination, claims payment, provider relations/contracting, and issues related to the health, safety, and welfare of Members.

2.10.6 Managed Care Clinical Leadership Staff

The Contractor's Virginia-based location must also include a dedicated full time Virginia-licensed Medical Director/Chief Medical Officer, a dedicated full time, or contracted, Medical Behavioral Health Director who is a Virginia-licensed psychiatrist and is qualified in the diagnosis of mental illness, a

Virginia-licensed Behavioral Health/Addiction Recovery Treatment Clinical Director, Long-term Services and Supports (LTSS) Director, and Care Coordination Manager able to perform comprehensive oversight and comply with all requirements covered under this Contract.

2.10.7 Managed Care Provider Relations Staff

The Contractor must have a Provider Network Manager responsible for network development, recruitment, credentialing, and management. The Contractor's provider relations staff must be located within the geographic region where the Contractor operates. The Contractor's regional provider relations staff must work with providers, including face-to-face when necessary, to ensure that appropriate and accurate information is collected during the credentialing process.

The Contractor must have dedicated staff available at all times during business hours for providers, including but not limited to community-based providers and nursing facilities, to call for assistance regarding the Managed Care program. The dedicated provider assistance staff must be able to assist providers in all areas of the program, including all long-term services and supports offered by the program.

2.10.8 Encounter Data Manager

The Contractor must have a dedicated Encounter Data Manager whose sole responsibility must be to ensure the timeliness, accuracy, and completeness of all encounter data submissions, including subcontractor data. The Encounter Data Manager must serve as the Department's primary point of contact to address and resolve any and all issues regarding encounter data.

2.10.9 Managed Care Consumer-Directed Services Manager

The Contractor must have a dedicated Consumer-Directed (CD) Services Project Manager. The CD Project Manager must work with and be the chief liaison with the Fiscal/Employer Agent (F/EA) and serve as the Contractor's subject matter expert for consumer-directed services. The CD Project Manager is responsible for ensuring oversight of the F/EA. The CD Project Manager must focus on all areas of consumer-directed services, including patient pay payment issues, fraud allegations, and reporting suspected fraud, waste and abuse (FWA) to the agency. This individual must not have major responsibility for any other portion of the Managed Care Contract. Refer to the various sections of this Contract referencing Consumer-Directed services and Patient Pay.

2.10.10 Managed Care Compliance Officer and Compliance Committee

The Contractor must 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 Contractor must designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Chief Executive Officer and the board of directors. The Compliance Officer must maintain documentation and a system to track all compliance actions taken and outcomes such actions to evaluate the success of remediation efforts. The Compliance Officer must provide updates on the monitoring and auditing results and any corrective action to the Compliance

Committee on at least a quarterly basis. Such information must be provided, if requested or otherwise required by state or federal law or this Contract, to the Department, CMS or law enforcement.

Pursuant to 42 CFR § 438.608, the Compliance Officer and Regulatory Compliance Committee must coordinate with the Department on any fraud, waste or abuse case. The Contractor may identify different contacts for Member fraud, waste and abuse; network provider fraud, waste and abuse; subcontractor fraud, waste and abuse; and Contractor fraud, waste and abuse.

2.10.11 Managed Care Program Integrity Lead

The Contractor must designate a Program Integrity (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, service authorization review, and any other fraud activities and outcomes. This individual must also be involved in the Department Program Integrity Collaborative. The Contractor must be aware and actively be involved with State, Federal, and CMS initiatives of PI.

2.10.12 Cardinal Care Quality Improvement Staffing

The Contractor must employ and maintain sufficient and qualified staff to manage the QI activities required under the Contract and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who are responsible for QM. QI staff must include:

1. Key Contractor and subcontractor staff who can represent all major areas of the Contractor's Managed Care line of business;
2. At least one (1) designated physician who must be a Medical Director or Associate Medical Director; at least one (1) designated behavioral health clinician who is knowledgeable of both mental health and substance use disorder services; and, a professional with expertise in the assessment and delivery of long-term services and supports with substantial involvement in the QI program;
3. A qualified individual dedicated to serve as the QI Director who will be directly accountable to the Contractor's Project Manager or Medical Director/Chief Medical Officer and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Contractor's executive leadership team. This individual must ensure:
    a. Overseeing all QI activities related to Members, ensuring compliance with all quality activities, and maintaining accountability for the execution of, and performance in, all such activities;
    b. Maintaining an active role in the Contractor's and subcontractor's overall QI structure; and,
    c. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities;
    d. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by the Department, or its designee, and that may be attended by representatives of the Department, a Department contractor, or other entities, as appropriate; and

e. Serving as liaison to, and maintaining regular communication with, Virginia QI representatives. Responsibilities must include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.11 Changes to Contractor Organizational Structure and Operations

Any changes to Contractor organizational structure and/or operations that have significant impact on Virginia Medicaid require advance notification to the Department. A change in organizational structure or operations may require a Contract amendment. Changes in organizational structure or operations include but are not limited to the changes described below. The Contractor must ensure, at a minimum, the following at all times:

1. Uninterrupted services and ongoing adequate access to care and choice for Members;
2. The ability to maintain and support the Contract requirements;
3. Major functions of the Contractor's organization, as well as Department programs and Members, are not adversely affected; and
4. The integrity of a fair, competitive Department procurement process for Managed Care contracts.

The Contractor must submit notice to the Department for review and approval, no less than sixty (60) days in advance of implementing a change to any of the following:

1. Changes to the organizational structure and operations of the Contractor, its parent company, or affiliated entities that have significant impact on Virginia Medicaid, as determined by the Department;
2. Significant decisions by the Contractor, its parent company, or affiliated entities affecting Medicaid business in Virginia or other states;
3. A statement disclosing whether the change/transaction is under review by other authorities, such as the Office of the Attorney General, the Federal Trade Commission, or the Department of Justice; and
4. Contractor and subcontractor material service changes directly related to the delivery of health care services to Medicaid Members, including, but not limited to:
    a. Pharmacy Benefits Manager (PBM) and specialty pharmacy;
    b. Transportation;
    c. Information management;
    d. Third Party Administrator (TPA) arrangements;
    e. Claims payment vendor;
    f. Medical management;
    g. Utilization management;
    h. Care management;
    i. Program Integrity;
    j. Fraud Waste and Abuse;
    k. Specialty services;
    l. Marketing and outreach;
    m. Provider contracting services;

n. Value-Based Purchasing;
o. Actuarial Services;
p. Quality Improvement;
q. Data Management;
r. Financial Management;
s. Provider Relations and Network Management;
t. Member Materials; and
u. Compliance.

In the event of changes to the Contractor's organizational structure or operations, the Department reserves the right to suspend a Contractor's new Member enrollment including, but not limited to, auto-assignment pending the Department's review and final determination regarding the change(s). In addition, the Department may offer open enrollment to the Members assigned to the Contractor should a significant change in organizational structure or operations occur that impacts Virginia Medicaid, as determined by the Department.

2.12 Member and Provider Call Centers

2.12.1 General Requirements

2.12.1.1 Components and Hours of Operation

The Contractor must comply with the following requirements related to call center components and hours of operations:

1. Member call center general customer service must be made available from 8:00 am to 8:00 pm, seven (7) days per week;
2. The Member Call Center clinical triage line (see Section 2.12.2.2, *Clinical Triage Line Requirements*) must be made available twenty-four (24) hours per day, seven (7) days per week, and include the nurse triage/nurse advice line, the behavioral health/ARTS crisis line, and care coordination support;
3. Provider services and coverage determinations must be made available from 8:00 am to 6:00 pm, five (5) days per week on Monday through Friday; and
4. A pharmacy technical support line must be made available during all hours for which any network pharmacy is open, seven (7) days per week.

The Contractor may have an automated or interactive voice response (IVR) system available during non-business hours, including weekends and holidays. This automated system must include, at a minimum, a secured voice mailbox for callers to leave messages. The Contractor must ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor must return all messages on the next business day. The IVR system must be certified to handle PHI and PII.

The Contractor must provide the capability for the Department to monitor calls remotely from the Department offices at no cost to the Department.

2.12.1.2 Call Center Staffing and Training Requirements

The Contractor must ensure that both the Member and Provider call centers are staffed adequately to respond to questions and concerns that are specific to the Managed Care program during the required hours of operation. It is the Contractors' responsibility to maintain up-to-date and accurate program specific information for call center staff to reference at all times.

2.12.2 Member Call Center Requirements

The Contractor must maintain a toll-free Member call center to respond to various Member concerns, health crises, complaints, and questions that can do the following:

1. Explain covered services;
2. Identify providers in the network;
3. Explain what to do in an emergency or urgent medical situation;
4. Assist Members in the selection of a PCP and understanding the role of the PCP;
5. Assist Members in making appointments and obtaining services;
6. Arrange medically necessary transportation for Members; and
7. Handle Member inquiries and grievances.

The calls may be generated from a Member, the Member's family or designated representative, or the Member's provider.

The Contractor must develop Member call center policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, monitoring of calls via recording or other means, and compliance with standards. The Contractor must ensure that Member call center staff work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues. It is the Contractor's responsibility to maintain up-to-date and accurate program specific information for call center staff to reference at all times.

2.12.2.1 Member Call Center Staffing and Training Requirements

The Contractor's Member call center staff must be trained to respond to the unique needs of the program population, including calls from Members with cognitive, physical, or mental disabilities, or from Members with limited English proficiency (including access to interpreter and translation services as necessary). The Contractor's customer service staff must be trained to apply a low threshold in identifying crisis calls; that is, they only need to suspect a crisis to initiate crisis call procedures including assessing imminent risk and immediately engaging a licensed care manager or escalating to a supervisor to ensure the Member's needs are properly addressed.

Member Call Center clinical triage line staff must be trained to identify and triage crisis, urgent, and emergency calls from Members, and to facilitate the transfer of calls to clinical triage personnel, Care Coordinators, or a supervisor from or on behalf of a Member that requires immediate attention.

2.12.2.2 Clinical Triage Line Requirements

The Contractor must have a clinical triage line dedicated to providing the management of all crisis calls (e.g., medical, behavioral health, ARTS), nurse advice, and care coordination supports that meets all of

the operating requirements detailed herein. The Contractor may accomplish this either through its general primary call center or a separate line as long as all clinical triage line requirements, including Warm Transfers, are met.

The clinical triage line(s) must be toll-free telephone line(s) staffed twenty-four (24) hours a day, seven (7) days per week with qualified clinicians to triage behavioral health, ARTS, urgent care and emergency calls from Members (see Section 2.12.1.1, *Components and Hours of Operation* and Section 2.12.2.1, *Member Call Center Staffing and Training Requirements*).

The clinical triage line must facilitate the transfer of calls to a Care Coordinator (when applicable) or appropriate Contractor staff from or on behalf of a Member that requires immediate attention. Through the clinical triage line, clinical staff must work with Members to determine their needs, discuss service options, and assist them in identifying an appropriate provider. If at any time, a caller is in distress or appears to have complex needs or a complicating condition, a clinical care manager or supervisor must provide the appropriate triage and referral. When the staff hear verbal cues or other indications that suggest an emergency, they must immediately pass the call "live" to a clinical triage crisis care manager or supervisor. If the Contractor determines that the call is not an emergency, the caller may be informed the line is reserved for emergencies only, and the caller may be transferred back through the standard phone line for assistance from the next available representative.

The Contractor must implement policies and procedures, subject to approval by the Department, that describe how calls to the clinical triage line from Members will be handled and how and when the Member's Care Manager (when applicable) is made aware of all calls in order to ensure appropriate follow-up and continuity of care. The Contractor must have policies and procedures, subject to approval by the Department, to identify and assist callers in crisis. Procedures must include established network resources for immediate referrals as clinically assessed to be warranted to protect the safety of the Member and community.

The Contractor must have mechanisms in place to promote the clinical triage line to its Members. The mechanisms must include ways to distribute periodic reminders to Members about the availability of assistance through the clinical triage line. Reminders must not be exclusive to only providing information via the Member Handbook.

The Contractor must implement protocols, subject to the Department's approval, to ensure that calls to the Member call center that should be transferred/referred to other Contractor staff, including but not limited to a Member services supervisor, a Care Coordinator, or to an external entity (including but not limited to the F/EA) are transferred/referred appropriately.

The Contractor must ensure that all calls from Members that require immediate attention are transferred via a Warm Transfer when necessary to a medical, behavioral, or ARTS professional with appropriate clinical expertise to assist the Member, and to connect the Member with their assigned Care Manager (when the Member is assigned a care manager. These Warm Transfer calls must be delineated separately in reports and metrics from other call center contacts.

At a minimum, behavioral health crisis call reporting must include:

1. Date of call, Member name and ID, Member FIPS, and contact information;

2. Call reason;
3. Assessment and referral;
4. Member status;
5. Identified treating provider(s);
6. Outcomes; and
7. Follow-up treatment and monitoring activities.

2.12.2.3 **Member Call Center Performance Standards**

The Contractor's Member call center must:

1. Have a process to measure the time from which the call is answered to the point at which a Member reaches an Enrollee Service Representative (ESR) capable of responding to the Member's question in a manner that is sensitive to the Member's language and cultural needs.
2. Answer eighty-five percent (85%) of all calls within sixty (60) seconds or less;
3. Answer Member and provider inquiries, including requests for referrals and service authorizations, with a monthly average speed of answer (ASA) of less than two (2) minutes.
4. Limit the average hold time to less than two (2) minutes (defined as any time a caller is placed on hold by the CSR, which could include time for a CSR review documentation, or placing a member on hold to transfer to another CSR/Manager/Department);
5. Limit the abandonment rate of all incoming calls to five percent (5%). Calls abandoned are the number of calls in which the caller disconnects while on hold waiting for an agent after sixty (60) seconds. If the caller hangs up before sixty (60) seconds, the call is not considered abandoned;
6. Record one hundred percent (100%) of incoming calls using up-to-date call recording technology. Call recordings must be searchable by provider NPI, Member ID number (if available), phone number (when identified), and date and time of the call. Recordings must be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call;
7. Measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff;
8. Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance;
9. Report on Managed Care program calls separately from other Virginia lines of business, if any; and,
10. Report by service area (primary, acute, behavioral health, LTSS, etc.). The Contractor's systems must also track and report on behavioral health crisis calls as described in the Cardinal Care Technical Manual.

The Contractor must report its call center statistics, as well as those of its subcontractors, to the Department on a monthly basis as described in the Cardinal Care Technical Manual.

2.12.3 Provider Call Center Requirements

The Contractor must operate a toll-free provider call center to respond to questions, concerns, inquiries, and complaints, regarding the Managed Care program, covered services, member enrollment, utilization management, referral requirements, care coordination, provider network contracting and credentialing,

claims payments and authorization requests. The Contractor's provider call center must work efficiently and provide accurate information and resolve concerns and issues.

The Contractor must have written provider call center policies and procedures that address all areas of call center operations including staffing, training, hours and days of operation, access and response standards, escalation processes for complex issues, monitoring of calls via recording or other means, and compliance with standards.

Pursuant to 42 CFR §438.66(c)(3), the Contractor must maintain a log of provider complaints and must report these to the Department as directed in the Cardinal Care Technical Manual.

2.12.3.1 Dedicated Assistance for LTSS Providers

For all areas where the Contractor is operational, the Contractor must maintain a dedicated queue to assist and support LTSS providers. The Contractor must ensure that LTSS providers are appropriately notified regarding how to access the dedicated queue for assistance. Required LTSS support may include assistance with service authorization requirements and resolution of LTSS provider claims issues.

2.12.3.2 Provider Call Center Staffing and Training Requirements

The provider call center staff must be trained to accurately respond to questions on all topics that the Provider call center must be able to address. In addition, the provider call center must be adequately staffed to provide appropriate and timely responses regarding authorization requests. The Contractor may meet this requirement by having a separate utilization management line.

2.12.3.3 Provider Call Center Performance Standards

The Contractor’s Provider call center must:

1. Answer eighty-five percent (85%) of all calls within sixty (60) seconds or less;
2. Answer Member and provider inquiries, including requests for referrals and service authorizations, with a monthly average speed of answer (ASA) of less than two (2) minutes;
3. Limit the average hold time to less than two (2) minutes (defined as the time spent on hold by the caller after the IVR system/touch tone response system/recorded greeting and before reaching a live person during regular business hours);
4. Limit the abandonment rate of all incoming calls to five percent (5%). Calls abandoned are the number of calls in which the caller disconnects while on hold waiting for an agent after sixty (60) seconds. If the caller hangs up before sixty (60) seconds, the call is not considered abandoned;
5. Record one hundred percent (100%) of incoming calls using up-to-date call recording technology. Call recordings must be searchable by provider NPI, Member ID number (if available), phone number (when identified), and date and time of the call. Recordings must be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call;
6. Measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff;
7. Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor’s call center performance;

8. Report on Managed Care program calls separately from other Virginia lines of business, if any; and,
9. Report by service area (primary, acute, behavioral health, LTSS, etc.). The Contractor's systems must also track and report on behavioral health crisis calls as described in the Cardinal Care Technical Manual.

The Contractor must report its call center statistics, as well as those of its subcontractors, to the Department on a monthly basis as described in the Cardinal Care Technical Manual.

2.13 Dual-Eligible Special Needs Plans (D-SNPs)

The Contractor must have an approved Dual-Eligible Special Needs Plan (D-SNP) contract in all localities in each region where the health plan provides services under the Cardinal Care Contract or begin operating a D-SNP in all localities in each region where the health plan provides services under this Contract. In any instance when the CMS approved D-SNP service areas do not match the State's approved Cardinal Care service areas, the State may restrict the Cardinal Care service area to align with the CMS approved D-SNP service areas. When appropriate, the State may work with the Contractor to achieve fully aligned service areas prior to terminating the Contract.

At the Department's discretion, failure to comply with this requirement may deem the Contractor noncompliant and subject to termination of this Contract. Refer to Section 21.2.40, *Termination of Contract*.

The Contractor's approved D-SNP is required to integrate their Medicare and Medicaid service and benefit coverage in a manner that is consistent with, or similar to, CMS requirements for Fully Integrated Dual-Eligible Special Needs Plans (FIDE SNP). The Department will consider exceptions to this requirement on a case-by-case basis. Specific integration requirements are fully described in the State's D-SNP contract with the Contractor. Refer to Section 3.16, *D-SNP Default Enrollment*.

2.14 Language, Translation, and Interpretation Requirements

Consistent with 42 CFR § 438.10(c)(1), the Department will identify the prevalent non-English languages spoken by Members and potential Members and share this information with the Contractor. As set forth in 42 CFR § 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, service authorization approval and denial and termination notices, available for free, in the prevalent non-English languages in its particular service area and when doing so is a reasonable step to providing meaningful access to health care coverage for a limited English proficient (LEP) individual. A prevalent non-English language is a language group that exceeds the five percent (5%) or one thousand (1,000) mark in its particular service area. Refer to Section 4.3.2, *Requirements for All Written Materials*, for more information.

The Contractor must institute a mechanism for all Members who do not speak English to communicate effectively with their PCPs and with Contractor staff and subcontractors. Free oral interpretation services must be available to ensure effective verbal communication regarding plan benefits, treatment, consent to treatment, medical history, or health education consistent with 42 CFR §§ 438.10(c)(1) and 42 CFR § 438.10(d)(2). In accordance with 42 CFR § 438.10(d)(4), this includes the use of auxiliary aids

such as TTY/TDY and American Sign Language. Trained professionals must be used when needed where technical, medical, or treatment information is to be discussed with the Member, a family member or a friend. Per 42 CFR § 438.100, the Contractor must comply with applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act.

For additional information about the measures the Department will take to ensure meaningful access to language and disability assistance services throughout the Medicaid process, please reference the Department's Language and Disability Access Plan here.

2.15 Suspected or Known Abuse

2.15.1 Child Abuse or Neglect

The Contractor must report immediately upon learning of any suspected or known abuse of a child. The Contractor must report the suspected or known abuse or neglect to either (1) 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 (2) 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

2.15.2 Abuse of Aged or Incapacitated Adults

In accordance with § 63.2-1606 of the Code of Virginia, immediately upon learning of any suspected or known abuse, neglect or exploitation of aged or incapacitated adults, the Contractor must report the suspected abuse, neglect or exploitation to (1) the local adult protective services office or (2) the Virginia Department of Social Services' toll-free Adult Protective Services hotline at: (888) 832-3858.

2.15.3 Abuse-Related Reporting and Training

The Contractor must make available to the Department upon request information pertaining to reports related to suspected or known abuse or neglect. All staff training must include policies and procedures regarding mandated reporting.

2.16 Cultural Competency

In accordance with 42 CFR § 438.206(c)(2), the Contractor must 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, diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. The Contractor must demonstrate cultural competency in all forms of communication, written and verbal, with Members and providers. Furthermore, the Contractor must ensure that cultural differences between providers and Members do not impede access and quality health care.

2.17 Addressing Health Disparities

The Contractor must consider the importance of health disparities among populations in developing its various programs to provide services to Members. The Contractor must develop and maintain an annual report outlining its efforts to address health disparities for the Managed Care population. Requirements for submission of such annual report are outlined in the Cardinal Care Technical Manual. The Contractor may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

3. COVERED POPULATIONS AND ENROLLMENT

3.1 Managed Care Covered Populations

The Medicaid and FAMIS populations listed below will be enrolled in Managed Care unless they meet an exclusion to Managed Care participation, as described in Section 3.2, *Populations Excluded from Managed Care*, and the Department's 1915(b) Managed Care Waiver.

1. Former Medallion 4.0 populations, including Low-Income Families and Children Covered Populations (as defined in Section 22, *Definitions*), including:
    a. Pregnant individuals, and postpartum individuals through the end of the postpartum period, including Medicaid, FAMIS MOMS, and FAMIS PC.
    b. Infants born to a Medicaid-eligible individual or an individual-eligible for FAMIS MOMS.
    c. Medicaid and FAMIS Children under age nineteen (19).
    d. Children under age twenty-one (21) who are in foster care or subsidized adoptions.
    e. Adults, including individuals:
        i. Under age twenty-six (26) who were formerly in foster care until their discharge from foster care at age eighteen (18) or older.
        ii. Ages nineteen (19) to sixty-four (64) who are parents or caretaker adult relatives with a child under age nineteen (19) (MAGI adults)
        iii. Ages nineteen (19) to sixty-four (64) who are childless (MAGI adults);
2. Former Commonwealth Coordinated Care Plus Populations, including Aged, Blind and Disabled (ABD), Medically Complex MAGI Adults, and LTSS Covered Populations including:
    a. Aged, blind or disabled (ABD) individuals, including disabled children and adults.
    b. Medicaid Works individuals as described in Section 4.2.3, *Medicaid Works*.
    c. Individuals who are in long-term care institutions or long-stay hospitals, other than those listed as excluded in Section 3.2, *Populations Excluded from Managed Care*;
    d. Individuals who receive services under the 1915(c) Commonwealth Coordinated Care. (CCC) Plus home- and community-based care (HCBS) Waiver.
    e. Individuals who receive services under one (1) of the three (3) 1915(c) Developmental Disability (DD) HCBS Waivers, including the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) Waivers. Individuals enrolled in any of the Developmental Disability (DD) Waivers will be enrolled in Managed Care for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services).
    f. Managed Care enrolled individuals who elect to receive hospice care.

g. Managed Care eligible populations who have Medicare (dual-eligible).
h. Individuals in a MAGI Adult Aid Category (100,101, 102, 103) with a medically complex indicator of XA, XG, XP, or X, as described below.
    i. A MAGI adult who has a LTSS indicator, as shown in the table below, will have an auto-generated medically complex benefit indicator of "XA."

LTSS Service	LTSS Indicator
Nursing Facility	1 (custodial) or 2 (skilled)
Long-Stay Hospital	L
CCC Plus Waiver without private duty nursing	9
CCC Plus Waiver with private duty nursing	A
Developmental Disability Waivers	R (FIS), S (BI), Y (CL)
Hospice	D or D1

    ii. A MAGI adult who participated in the former Governor's Access Plan for seriously mentally ill (SMI) individuals, will have a "FG" benefit indicator and an auto-generated medically complex indicator of "XG."
    iii. A MAGI adult who attests that they are medically complex by responding "yes" to the "yes/no" question shown below on their Medicaid application, will have an auto-generated medically complex benefit indicator of "XP."

> Do you need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in your home? Or has a doctor or nurse told you that you have a physical disability or long-term disease, mental or emotional illness, or addiction problem?

    For individuals with an "XP" benefit indicator, A MCO Member Health Screening (MMHS) is required to verify the member's attested medically complex status, must be completed within three (3) months, and must be submitted prior to the end of the Member's initial four (4) months of enrollment with the Contractor. See Section 8.3, *MCO Member Health Screening*.
    iv. A MAGI adult who receives a MMHS that demonstrates that the member has, 1) a complex medical or behavioral health condition and a functional impairment, or 2) an intellectual or developmental disability, will have a medically complex benefit indicator of "X."

3. Managed Care eligible populations listed above who have other third party liability insurance (TPL), except coverage purchased through HIPP and FAMIS Select;
4. Managed Care eligible populations listed above who are in the hospital at the time of initial MCO enrollment. See Section 3.8, *Enrollment Process for Individuals Hospitalized at Enrollment*.

The Contractor must refer to the Department's Provider Manuals, Chapter III, Member Eligibility, for additional information about Medicaid-covered populations.

3.2 Populations Excluded from Managed Care

In accordance with the Department's 1915(b) Managed Care Waiver, the Department will exclude the following populations from Managed Care program participation. The Department will, upon new State or Federal regulations or Department policy, modify the list of excluded individuals as appropriate. If the

Department modifies the exclusion criteria, the Contractor must comply with the amended list of exclusion criteria.

1. Individuals enrolled in a Program of All-inclusive Care for the Elderly (PACE) program;
2. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program or the FAMIS Select program;
3. Individuals with temporary eligibility coverage (less than 3 months), retroactive eligibility coverage (other than newborns per Section 3.7, *Enrollment Process for Newborns*), enrolled in presumptive eligibility groups, or who are Medicaid-eligible in limited coverage groups, including:
    a. Individuals enrolled in Plan First (the Department's family planning program for coverage of limited benefits surrounding pregnancy prevention)
    b. Individuals in Medicare-Related Covered Groups (Medicare Savings Plans or MSPs) for whom Medicaid pays the Medicare costs on behalf of these beneficiaries. These individuals do not have full Medicaid benefits, and include, Qualified Medicare Beneficiaries (QMBs), Special Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), or, Qualifying Individuals (QIs);
4. Medically Needy (spenddown) individuals who have a limited period of full coverage; (Medically Needy LTSS participants who meet their spenddown and maintain ongoing eligibility will be Managed Care enrolled);
5. Other individuals with temporary or limited Medicaid eligibility coverage;
6. Individuals who elect hospice benefits while enrolled in fee-for-service will not be enrolled into Managed Care. However, a Managed Care enrolled individual who subsequently enters a hospice program will remain Managed Care enrolled;
7. Individuals who live in areas where less than two MCOs participate, such as Tangier Island;
8. Individuals under age twenty-one (21) years of age who are approved for admission to a VA Medicaid Psychiatric Residential Treatment Facility (PRTF) programs);
9. Individuals in fee-for-service with end stage renal disease (ESRD) will be enrolled into Managed Care unless the individual requests to be excluded from Managed Care participation within the individual's first ninety (90) days of Managed Care enrollment. Individuals who do not request exclusion within the first ninety (90) days of Managed Care enrollment or who develop ESRD while enrolled in Managed Care, will remain Managed Care enrolled;
10. Individuals of any age who are institutionalized in State or private ICF/ID and State ICF/MH facilities (a State acute care facility is not excluded);
11. Individuals receiving care in a Christian Science Sanatoria Facility. Individuals will be excluded from Managed Care when admitted to a Christian Science Sanatoria and services will be covered under the fee-for-service program within Department- established criteria and guidelines, per 12 VAC 30-50-300 (Christian Science Nursing Services are not covered);
12. Individuals aged twenty-one (21) to sixty-four (64) who are hospitalized in a State or private institution for mental disease (IMD), other than individuals admitted to an IMD as part of a Contractor approved admission, in lieu of an acute care hospital (psychiatric unit), consistent with 42 CFR § 438.6(e) and Section 5.5.1.2*, IMD Enhanced and State Plan Substituted (In Lieu of) Services for Certain Medicaid Members*;

13. Individuals who reside at Piedmont State Hospital, Hiram Davis Medical Center, and Hancock Geriatric Treatment Center state facilities operated by DBHDS;
14. Individuals who reside in nursing facilities operated by the U.S. Department of Veterans Affairs, the Virginia Home Nursing Facility, local government-owned nursing homes, and individuals authorized by the Department to receive care/treatment in facilities located outside of Virginia, including but not limited to Braintree Manor Nursing and Rehabilitation Center located in Braintree, Massachusetts. These include the following nursing facilities:
    a. Bedford County Nursing Home
    b. Birmingham Green
    c. Dogwood Village of Orange County Health
    d. Lake Taylor Transitional Care Hospital (Different from Lake Taylor Long-Stay Hospital)
    e. Lucy Corr Nursing Home
    f. The Virginia Home Nursing Facility
    g. Virginia Veterans Care Center
    h. Sitter and Barfoot Veterans Care Center
    i. Braintree Manor Nursing Facility and Rehabilitation Center
15. Individuals who are incarcerated (individuals on house arrest are not considered incarcerated); and
16. Individuals enrolled in the Birth Injury Fund.

3.3 Managed Care Enrollment and Assignment Process

The Department has sole responsibility for determining the eligibility of an individual for Medicaid funded services. The Department also maintains sole responsibility for determining Member participation in Managed Care and determining Member enrollment with the Contractor. Such determinations are final and not subject to review or appeal by the Contractor. The Contractor must enroll and provide coverage for its membership in accordance with the terms of this Contract. In accordance with 42 CFR § 438.3(d)(1), the Contractor must accept new enrollments from individuals in the order in which they apply without restriction, up to the limits set forth in Section 3.5, *Intelligent Assignment*.

The Contractor agrees to provide services to its membership as defined and outlined in Federal and State laws and regulations as well as this Contract. The Department reserves the right to transition additional populations and services into the Managed Care program in the future. The Contractor must provide services, including to any additional populations specified, that the Department, Governor or General Assembly may deem appropriate. As appropriate, the Department will create a distinct contract amendment when adding new population groups, including appropriate rates and specific program requirements. The Contractor will work with the Department to ensure services are provided to the populations outlined in this Contract, as well as ensuring that Departmental goals and focuses are met.

3.4 Health Plan Assignment Process

The Managed Care program enrollment and auto-assignment process runs monthly on the eighteenth (18^{th}) of the month. Individuals determined to be eligible as of the eighteenth (18^{th}) of the month have an effective date of the first of the following month (for example, an individual is identified as being

eligible on May 7th. The effective date is June 1st). Individuals found to be eligible after the eighteenth (18th) are enrolled with an effective date of the first (1st) of the second (2nd) month (for example, an individual is identified as being eligible on May 19th. The effective date is July 1st).

For Medicaid, FAMIS, and FAMIS MOMS, if no health plan is selected by the eighteenth (18th) of the month preceding the effective date (May 18th for a June 1st effective date), the Member is auto-assigned to a health plan through the Department's intelligent assignment process, as described in Section 3.5, *Intelligent Assignment*. The Member's health plan default assignment is based upon the plans that have been approved by the Department for participation in the Member's locality of residence and the Department's intelligent assignment rules.

Members whose eligibility changes from CHIP to Medicaid will 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.

All assignments are prospective. There are no retroactive enrollments in Managed Care, except as necessary to establish coverage for the contractually required birth month plus two (2) period on newborns who are born to a mother that is enrolled in a participating MCO on the date of birth. Refer to Section 3.7, *Enrollment Process for Newborns*.

The MCO must create and maintain an interface and system that will accept and store all Member eligibility and enrollment information provided by the Department. The data elements transferred must include, but are not limited to Member name, ID number, address, date of birth, age, gender, and race.

3.5 Intelligent Assignment

Enrollment in an MCO may be the result of an enrollee's selection of a particular MCO or assignment by the Department. Pursuant to 42 CFR § 438.54, the Department has established a Member-friendly assignment process which varies by population. For Members newly enrolled in Managed Care and receiving LTSS services, the assignment process seeks to preserve the Member-to-LTSS provider relationships. For children, caretaker adults, pregnant individuals, and MAGI adults, the process attempts to assign newly enrolled Members based on case relationship, as defined in Section 22, *Definitions*. The process also seeks to reenroll returning Members based on their prior MCO history. FAMIS members are assigned to an MCO in accordance with this process and 12 VAC 30-141-660. Additional details are provided in the table below.

A limit of forty percent (40%) of enrolled lives within an operational region may be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an operational region exceed forty percent (40%), the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at forty percent (40%) or below. However, the enrollment cap may be exceeded due to Member-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary. The Department reserves the right to revise the assignment methodology, as needed based upon the Department's sole discretion, including to address concerns for underperforming MCOs or other performance or operational concerns.

Population	Assignment Hierarchy
Families, children, pregnant individuals, and MAGI adults, except newborns (Includes FAMIS Children, MOMS, and PC)	1. Member choice; 2. Previous MCO; 3. Case Relationship; 4. Assignment to an MCO where the Member's PCP participates (based on claims history); 5. Members who do not meet one (1) of the above criteria will be equitably distributed between the currently contracted MCOs.
Aged, blind or disabled (ABD) individuals, including disabled children and adults	1. Member choice; 2. Previous MCO; 3. Members who do not meet one (1) of the above criteria will be equitably distributed between the currently contracted MCOs
Members who have Medicare	1. Member choice; 2. Previous MCO within the past two (2) months (reenrollment); 3. Member's Medicare Plan - If known, most recent previous Medicare plan, within the past two (2) months (excluding Part D only plans); 4. Members who do not meet one (1) of the above criteria will be equitably distributed between the currently contracted MCOs
Individuals who are in long-term care institutions or long-stay hospitals	1. Member choice; 2. Previous MCO within the past two (2) months (reenrollment); 3. MCO Contractor with the Member's nursing facility in the MCO's network - Member will be assigned to a Contractor that includes the individual's Nursing Facility in its network, based upon the Contractor's successful submission of its provider network file to the Department's Provider Services Solution (PRSS). If the Nursing Facility is in more than one (1) Contractor's network, the assignment will be random between the Contractors who have the Member's Nursing Facility in the network; 4. Members who do not meet one (1) of the above criteria will be equitably distributed between the currently contracted MCOs
Individuals who receive services under the 1915(c) Commonwealth Coordinated Care (CCC) Plus home- and community-based care (HCBS) Waiver	1. Member choice; 2. Previous MCO; 3. MCO Contractor with the Member's LTSS provider in the MCO's network, as follows: a. Individuals in the CCC Plus Waiver who receive adult day health care (ADHC) services will be assigned to a Contractor that includes the Member's ADHC provider in its network, based upon the Contractor's successful submission of its provider network file to the Department's PRSS. If more than one (1) Contractor's network includes the individual's ADHC provider in its

	network, the assignment will be random between the Contractors; b. Individuals receiving private duty nursing services under the CCC Plus HCBS waiver will be assigned to a MCO Contractor that includes the Member's private duty nursing provider, based upon the Contractor's successful submission of the provider network file to the Department's PRSS. If more than one (1) Contractor's network includes the individual's private duty nursing provider in its network, the assignment will be random between the Contractors. 4. Members who do not meet one (1) of the above criteria will be equitably distributed between the currently contracted MCOs.
Newborns; infants born to a Medicaid-eligible individual or an individual-eligible for FAMIS MOMS or FAMIS Children	See Section 3.7, *Enrollment Process for Newborns*

3.6 Foster Care and Adoption Assistance Enrollment and Health Plan Selection

All of the following applies to health plan selection, including changes, for children in foster care and adoption assistance (designation codes 070, 076 and 072, respectively):

1. The social worker is responsible for health plan selection, including changes, for children in foster care (AC 076);
2. The adoptive parent is responsible for health plan selection, including changes, for children in adoption assistance (AC 072);
3. The former foster care or Fostering Futures Members (AC 070) are responsible for their health plan selection and any subsequent health plan changes; and
4. Members in foster care and adoptions assistance may change their health plan at any time and are not restricted to their health plan selection following the initial ninety (90) day MCO enrollment period.

3.7 Enrollment Process for Newborns

The Contractor must have written policies and procedures to govern the identification of MCO newborns by their network providers that facilitate the enrollment of newborn children into Medicaid and FAMIS as appropriate. The Contractor must submit these policies and procedures to the Department in accordance with the Cardinal Care Technical Manual.

The Contractor is responsible for advising the parent or guardian of the newborn that Medicaid or FAMIS eligibility rules ensure continuous eligibility for the child up to twelve (12) months following birth; however, to receive ongoing coverage, the parent or guardian should contact the Cover Virginia Call center at 1-855-242-8282 or their local DSS office to quickly enroll their newborn. Additional

information is available here. The Contractor must adhere to a process that makes every effort to assure newborns are enrolled in Medicaid or FAMIS within sixty (60) days of the infant's date of birth, including all of the following activities:

1. Conduct outreach to pregnant individuals to track births including contacting mom at hospital once notified of the birth;
2. Report all live births to the Department monthly using the specified format and parameters as documented in the Cardinal Care Technical Manual;
3. Review the first 834 sent postpartum and identify newborns without Medicaid or FAMIS IDs;
4. Conduct outreach to the parents/guardians of newborns without Medicaid or FAMIS IDs;
5. Review the second 834 sent postpartum and the E213 Live Births Report;
6. If newborns are not included on second 834 or are listed on the E213 Live Births Report, complete the CoverVirginia electronic DMAS E-213 form; and
7. Encourage contracted hospitals to submit enrollment information for newborns via the streamlined online enrollment process through the Medicaid provider web portal.

3.7.1 Infants of Contractor Enrolled Members

Where possible, newborns of Members enrolled with the Contractor will be assigned to the birth Member's MCO, effective with the newborn's date of birth. Until the Department implements an automated process, the Department will work with the Contractor to manually enroll infants born to individuals enrolled with the Contractor in the CCC Plus benefit plan, so that coverage is effective with the Contractor on the newborn's date of birth. The timeliness of the newborn's Managed Care enrollment with the Contractor is dependent on how quickly the parent reports the child's birth to the Cover Virginia Call center at 1-855-242-8282 or their local DSS office to have the child enrolled in the Medicaid system. The Contractor must work with the Member to facilitate timely Medicaid/FAMIS enrollment of the newborn, per Section 3.7, *Enrollment Process for Newborns*. The Contractor must provide coverage for these infants during the entire birth month, plus two (2) additional consecutive months, as follows:

1. Whether or not the newborn receives a Medicaid or FAMIS ID number;
2. Whether or not the birth Member remains enrolled with the Contractor;
3. In circumstances where this Contract is terminated in whole or in part by the Contractor; the Contractor must continue coverage for the newborn until the child is enrolled with another Contractor in the Department's MMIS, or until the end of the birth month plus two (2) coverage period, whichever is earlier;
4. Any medically necessary claims for the newborn may not be denied by the Contractor 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 Contractor's service area, or medically necessary services received from out-of-network providers. The Contractor is also required to reimburse providers if treating the 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 Contractor's network. In the absence of a provider agreement otherwise, a Contractor

must reimburse the non-network provider at the Medicaid rate in place at the time the services were rendered; and

5. The Department will reimburse the Contractor at the appropriate capitation payment for newborns for the entire birth month plus two (2) period. Any payment for Newborns that is not reflected on the Contractor's 820 Payment Report will be handled via the reconciliation process as outlined in Section 12, *Provider Payment*, and the Cardinal Care Technical Manual.

3.7.2 Infants of Members not Enrolled with the Contractor at Time of Birth

The Contractor must provide coverage for any newborns who are enrolled with the Contractor, including when the member's mother is not enrolled with the Contractor. These newborns are enrolled into the Managed Care program prospectively with the Contractor and are not subject to the birth month plus two (2) coverage requirement.

3.8 Enrollment Process for Individuals Hospitalized at Enrollment

Individuals admitted to the hospital under FFS who remain hospitalized at the time of Managed Care enrollment will be enrolled in Managed Care through the Department's intelligent assignment process, as described in Section 3.5, *Intelligent Assignment*, unless they meet an exclusion to Managed Care participation, as described in Section 3.2, *Populations Excluded from Managed Care*. Individuals may also be enrolled with the Contractor through a health plan enrollment change, as described in Section 3.13, *Health Plan Enrollment Changes*.

The Contractor is responsible for the Member's care from the effective date of enrollment with the Contractor and must make every effort to reach out to these Members immediately upon learning of their enrollment and hospitalization. Where the member is enrolled with the Contractor through a health plan enrollment change, the transitioning MCO Contractor and the receiving MCO Contractor must work to ensure a seamless transition and continuity of care on behalf of the Member. The Contractor is responsible for working with the Member and the Member's care team to ensure a person-centered, safe and effective discharge plan, and timely and appropriate follow-up treatment. Refer to Section 12.2.1, *Hospital Payments*, for payment of services for individuals hospitalized at time of enrollment.

3.9 Contractor Responsibilities Related to Enrollment

The Contractor must accept enrollment assignments for any eligible Member as determined by the Department. Such determinations are final and are not subject to review or appeal by the Contractor. This does not preclude the Contractor from providing the Department with information to ensure that enrollment with the Contractor is correct.

As specified in 42 CFR § 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.

The Contractor must refer Members and Potential Members who inquire about Managed Care eligibility or enrollment to the Department's Enrollment Broker. The Contractor may provide factual information

about the Contractor's plan and its benefits prior to referring a request regarding Managed Care eligibility or plan enrollment to the Enrollment Broker. The Contractor is prohibited from being on an enrollment broker call, app or website with Members. The Contractor is permitted to facilitate a Warm Transfer of the Member to the Enrollment Broker. However, the Contractor must exit the call as soon as the transfer is complete or when requested by the Enrollment Broker. The Contractor is not permitted to remain on the call while the Member discusses their eligibility or enrollment options with the Enrollment Broker.

In conducting any enrollment-related activities permitted by this Contract, or otherwise approved by the Department, the Contractor must assure that Member enrollment meets the non-discrimination provisions of 42 CFR § 438.3(d)(3)-(4) and (q)(4).

The Contractor must notify the Member of his or her enrollment in the Contractor's plan in accordance with requirements described in Section 3.11, *Initial Enrollment Notice*. Upon disenrollment, the Contractor must 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 specified in Section 3.7, *Enrollment Process for Newborns*, the Contractor should inform mother/parent/guardian that in order to continue the newborn's eligibility, the mother/parent/guardian must notify DSS to obtain a Medicaid identification number for the newborn.

The Contractor is responsible for keeping its network providers informed of the enrollment status of each Member. The Contractor must report and ensure enrollment to network providers through electronic means.

At least monthly, the Department or its enrollment broker will share with the Contractor data regarding reasons for enrollment and disenrollment with the Contractor (via the MCO Change Report).

The Contractor must notify the Department within two (2) business days upon learning that a Member meets one (1) or more of the Managed Care exclusion criteria. The Contractor must report to the Department any Members it identifies as incarcerated within two (2) business days of knowledge of the incarceration. See the Cardinal Care Technical Manual for reporting requirements.

3.10 Enrollment and Disenrollment Effective Periods

All enrollments are effective 12:00 a.m. on the first (1st) day of the first (1st) month in which they appear on the enrollment report, except for newborns, whose coverage begins at birth.

The Contractor will not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but is liable for the costs of covered services obtained on or after 12:00 a.m. on the Member's effective date of enrollment with the Contractor.

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.

Upon disenrollment from the Contractor's plan, the Contractor must 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.

3.10.1 Automatic Reenrollment

In accordance with 42 CFR § 438.56(g), individuals who have been previously enrolled with the Contractor and who regain eligibility for the Managed Care program within sixty (60) calendar days of the effective date of exclusion or disenrollment will be reassigned to the Contractor without going through the selection or assignment process. The Department will send Members a notice informing them of their reenrollment with the Contractor.

3.11 Initial Enrollment Notice

At the time an individual is determined to be eligible, the Department will send a letter to the individual stating that the individual is being enrolled into the Managed Care program and that the individual may select a health plan.

This initial notification letter includes:

1. Eligibility for Managed Care program notification;
2. Information on how to contact the Enrollment Broker;
3. A "call by" date (on or before the eighteenth (18^{th}) of the month) prior to the MCO effective date for the Member to make his/her health plan selection; and
4. An explanation that if the Member does not call the Enrollment Broker by the "call by" date, the Member will be enrolled with a default MCO, and provides the default MCO enrollment effective date.

3.12 Enrollment Assignment Notice

At the time a Member is assigned, an assignment letter will be generated by the Department, either confirming the selected MCO or assigning the Member to an MCO for enrollment. The letter will also include the enrollment broker phone number, information about the smartphone application, a link to the Managed Care website, and instructions to contact the toll-free Managed Care helpline number for assistance with questions.

The assignment letter is mailed with the Managed Care MCO comparison chart. It explains the Member's right to change from one (1) MCO to another during the initial ninety (90) calendar days of Managed Care program enrollment and during annual open enrollment periods.

3.13 Health Plan Enrollment Changes

Pursuant to 42 CFR § 438.56, as amended, the Department will permit a Member to disenroll from one (1) health plan to another at any time for cause unless otherwise limited by an approved CMS waiver of applicable requirements. The Contractor is not permitted to file a request for disenrollment.

The Member (or the Member's representative) must request disenrollment by submitting an oral or written request to the Department in accordance with 42 CFR § 438.56(d)(1). The Department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR § 438.56(d)(2). The Department will respond to "cause" requests, in writing, within fifteen (15) business days of the Department's receipt of the request. Consistent with 42 CFR §§ 438.56 and 438.6, approved disenrollment requests must be effective no later than the first (1st) day of the second (2nd) month following the month in which the Member files the request. In accordance with 42 CFR §§ 438.56 and 438.3(q), if the Department fails to make a determination by the first (1st) day of the second (2nd) month following the month in which the Member files the request, the disenrollment request must be considered approved and effective no later than the first (1st) day of the second (2nd) month following the month in which the member requests the plan change. If the Member is dissatisfied with the Department's decision, the Member may appeal through the State Fair Hearing Process as described in Section 9.7, *State Fair Hearing Process*.

3.13.1 For Cause Enrollment Changes

1. The Contractor does not, because of moral or religious objections, cover the service the Member seeks;
2. The Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk;
3. The Member who receives LTSS would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment;
4. Pregnant individuals, in Medicaid or FAMIS MOMS, who are in their third trimester of the pregnancy, may request good cause exemption to temporarily return to fee-for-service if their OB provider is enrolled in Medicaid FFS but does not participate under any health plan. In order to be considered for good cause exemption, pregnant Members within the third trimester of the pregnancy must obtain an attestation from a physician or nurse practitioner (including Certified Professional Midwives and other Nurse Practitioners), within the third trimester, that no diagnoses are present which could increase the risk of adverse outcomes for mother or baby. Following the end of the pregnancy, the Member will be required to enroll in a MCO to the extent the Member remains eligible for Medicaid/FAMIS MOMS. FAMIS enrollees cannot be exempted for this reason; and
5. Other reasons as determined by the Department, including but not limited to poor quality of care, lack of access to services covered under this Contract, lack of access to an available FQHC provider or to providers experienced in dealing with the Member's care needs, aligning Managed Care plan enrollment with D-SNP plan enrollment, or lack of access to providers experienced in dealing with the Member's care needs.

3.13.2 Without Cause Enrollment Changes

1. Within the initial ninety (90) calendar days (three [3] calendar months) following the effective date of Managed Care program enrollment with a health plan, the individual will be permitted to change from one (1) Contractor to another. This ninety (90) day timeframe applies only to the individual's initial program start date of enrollment. It does not reset or apply to any subsequent enrollment periods with a different Contractor. After the initial ninety (90) day period following the initial enrollment date, individuals (other than Foster Care and Adoption Assistance children) may not disenroll without cause until the next open enrollment period unless disenrolled under one (1) of the conditions described and pursuant to 42 CFR § 438.56(c);
2. In accordance with 42 CFR § 438.56(c)(2)(iv), when the Department imposes the intermediate sanction specified in 42 CFR § 438.702(a)(4); and
3. Upon automatic reenrollment, if the temporary loss of Medicaid eligibility, as verified by the Department, has caused the individual to miss the opportunity to change from one (1) Contractor to another during their annual open enrollment, described below.

3.14 Open Enrollment

Consistent with federal rules at 42 CFR § 438.56, members must be provided the opportunity to change their health plan for any reason at least once every twelve (12) months. These open enrollment periods vary by population, as shown in the table below.

The Department will notify Members of their ability to change plans during an annual open enrollment period of least sixty (60) calendar days before the end of their enrollment period. Enrollment selections will be effective no later than the first (1st) day of the second (2nd) month following the month in which the Member makes the request for the change in plans. MCOs that have contractual enrollment limits must be able to retain existing Members who select them and must be able to participate in open enrollment until contractual limits are met.

Open enrollment for all Managed Care populations will follow the regional open enrollment schedule below.

Managed Care Open Enrollment	
Population	**Annual Open Enrollment**
Managed Care participants An individual enrolled in Managed Care will know their annual Managed Care open enrollment time frame based on the	1. Tidewater Region: February 19 – April 30 2. Central Region: April 19 – June 30 3. Northern Virginia Region: June 19 – August 31 4. Charlottesville/Western Halifax Regions: August 19 – October 31

region in which they reside.	5. Roanoke/Allegheny and Southwest Regions: December 19 – February 28

3.15 Loss of Managed Care MCO Enrollment

A Member's enrollment in the Managed Care program will end upon occurrence of any of the following events:

1. Death of the Member;
2. Cessation of Medicaid/FAMIS eligibility;
3. Members that meet at least one (1) of the exclusion criteria listed in Section 3.2, *Populations Excluded from Managed Care*.
4. Transfer to a Medicaid eligibility category not included in this Contract; or
5. Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

In certain instances, a Member may be excluded from participation effective with retroactive dates of coverage. Refer to Section 12.1.4, *Payment for Disenrolled Members*.

3.16 D-SNP Default Enrollment

State-Contracted D-SNPs not previously approved by CMS for default enrollment activities must submit to CMS an initial application to perform such activities subject to the requirements of 42 CFR § 422.66, as outlined below, and applicable CMS regulatory sub-guidance, including the Medicare Managed Care Manual, Chapter 2, Section 40.1.4.

CMS approval of an initial application to perform default enrollment activities must be obtained by no later than five (5) calendar days before initiating Default Enrollment activities. Once authorized by CMS to perform default enrollment activities, state-contracted D-SNPs must renew such authorizations in accordance with the requirements and timeframes of 42 CFR §422.66 and applicable CMS regulatory sub-guidance. State-contracted D-SNPs must coordinate default enrollment of newly Medicare eligible individuals who are currently enrolled only in its companion Medicaid plan, who are aging-in to Medicare, and those qualifying for Medicare upon completion of the twenty-four (24) month waiting period due to a disability.

The Contractor must ensure that the following conditions are met before initiating default enrollment activities, including enrolling individuals into a Medicare Advantage dual-eligible special needs plan.

1. During an individual's initial coverage election period, an individual may be deemed to have elected a MA special needs plan for individuals entitled to medical assistance under a State plan under Title XIX (including a fully integrated dual-eligible special needs plan as defined in 42 CFR § 422.2) offered by the organization provided all the following conditions are met:
    a. At the time of the deemed election, the individual remains enrolled in an affiliated Medicaid Managed Care plan. For purposes of this Section, an affiliated Medicaid Managed Care plan is one that is offered by the MA organization that offers the dual-

eligible MA special needs plan or is offered by an entity that shares a parent organization with such MA organization;

b. The state has approved the use of the default enrollment process in the contract described in § 422.107 and provides the information that is necessary for the MA organization to identify individuals who are in their initial coverage election period;
c. The MA organization offering the MA special needs plan has issued the notice described in § 422.66 (c)(2)(iv) to the individual;
d. Prior to the effective date described in paragraph § 422.66 (c)(2)(iii), the individual does not decline the default enrollment and does not elect to receive coverage other than through the MA organization;
e. CMS has approved the MA organization to use default enrollment under § 422.66 (c)(2)(ii);
f. The MA organization has a minimum overall quality rating from the most recently issued ratings, under the rating system described in §§ 422.160 through 422.166, of at least 3 stars or is a low enrollment contract or new MA plan as defined in § 422.252; and
g. The MA organization does not have any prohibition on new enrollment imposed by CMS.

The state-contracted D-SNPs must report on default enrollment statistics monthly to the Department on an informational basis only, as specified in its state-contracted MIPPA Agreement.

The Department will continue to establish requirements to improve alignment for dual-eligible Members, including, but not limited to initiatives that enhance care coordination. State-contracted D-SNPs must collaborate with the Department, and CMS as applicable, in developing and implementing additional strategies that enhance alignment of dual-eligible Members enrolled in D-SNPs and companion Medicaid Plans.

The Contractor's approved D-SNP is required to integrate its Medicare and Medicaid service and benefit coverage in a manner that is consistent with, or similar to, CMS requirements for Fully Integrated Dual-Eligible Special Needs Plans (FIDE SNP). The Department will consider exceptions to this requirement on a case-by-case basis. Specific integration requirements are fully described in the State's D-SNP contract with the Contractor.

3.16.1 Alignment with D-SNP

Dual-eligible Members will have the option of having their Medicaid and Medicare services coordinated by the same Contractor. Therefore, the Contractor must educate the Member on benefits of alignment and encourage dual-eligible Members that are enrolled with them for Managed Care to enroll in their companion D-SNP for the Medicare portion of their benefits. However, these Members will continue to have the option of receiving their Medicare benefits from Medicare fee-for-service or through another Medicare Advantage/D-SNP Plan. The Contractor must ensure that Members understand this is a choice and not a requirement.

3.17 Continuous 12-Month Enrollment for Children

Per Section 5112 of the Consolidated Appropriations Act of 2023, effective January 1, 2024, the Contractor must provide 12 months of continuous eligibility for children under age 19, including FAMIS-enrolled children. Refer to CMS State Health Official Letter #23-004 for detail.

4. MEMBER SERVICES AND COMMUNICATIONS

4.1 Member Rights and Protections

In accordance with 42 CFR § 438.100, the Contractor must have written policies and procedures regarding Member rights and ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to Member rights. Pursuant to 42 CFR §§ 438.100 and 438.6, policies and procedures must include compliance with: Title VI of the Civil Rights Act of 1964 as implemented at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; Section 1557 of the Patient Protection and Affordable Care Act, and all federal and State laws regarding privacy and confidentiality.

The Contractor must comply with requirements for Member rights. At a minimum such Member rights include the right to:

1. Receive information in accordance with 42 CFR §§ 438.10, 438.100(b), and 45 CFR 147.200(a);
2. Be treated with respect and with due consideration for his or her dignity and privacy;
3. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand;
4. Participate in decisions regarding his or her health care, including the right to refuse treatment.
5. 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. Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526;
7. 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; and
8. Receive health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in this Contract.

4.1.1 Provider Protections for Member Advising

Under Section 1932(b)(3)(A), Section 4704 (b)(3) of Public Law 105-33, and 42 CFR § 438.102(a)(1)(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:

1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
2. Any information the Member needs to decide among all relevant treatment options;
3. The risks, benefits, and consequences of treatment or non-treatment; and
4. 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 CFR § 438.102(d), the Contractor is subject to intermediate sanctions if there is any violation of 42 CFR § 438.102(a)(1).

4.1.2 Communication and Interpreter Assistance

The Contractor must make interpretation services available to each Member and potential Member free of charge. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages as required in 42 CFR § 438.10(d)(4). For additional information, see the Department's Language and Disability Access Plan at https://www.dmas.virginia.gov/about-us/2021-language-and-disability-access-plan/.

The Contractor must institute policies and procedures, including a timely and effective process, for all Members and potential Members who are unable to speak or who do not speak English to communicate effectively with their PCPs, providers, Contractor staff, and subcontractors. The Contractor's process must be consistent with 42 CFR §§ 438.10(c)(4), 42 CFR § 438.10(d)(2), and 42 CFR §438.100(b)(2), where oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. Trained professionals must 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 consistent with 42 CFR § 438.10(d)(4). The Contractor's policies and procedures for oral interpretation, including a description of the Contractor's process must be provided to the Department when revised and upon request.

4.1.3 Response to Member Inquiries

The Contractor must 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 non-claims related inquiry, in writing or by phone, the Contractor must respond to the inquiry within three (3) business days.

4.1.4 Content of Medical Records

The Contractor must ensure that each Member's medical record(s) include(s) the required elements pursuant to 42 CFR §§ 456.111 and 456.211, including but not limited to: Member ID, primary care provider name and contact information, 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 CFR §§ 456.80 and 456.180, initial and subsequent continued stay review dates as required by 42 CFR §§

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.

4.1.5 Advanced Directives

In accordance with 42 CFR § 438.3(j)(1), the Contractor must comply with the requirements of 42 CFR § 422.128 for maintaining written policies and procedures for advance directives.

Members must be provided information about advance directives (at a minimum, those required in 42 CFR §§ 489.102, 422.128, 438.6(i), 438.10, and 438.3(j)(3)), including:

1. Member rights under the law of the Commonwealth of Virginia in accordance with the Virginia Health Care Decisions Act, Code of Virginia § 54.1-2981 et seq.;
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 must 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 CFR § 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, in accordance with 42 CFR § 489.102(a), the Contractor must educate staff concerning their policies and procedures on advance directives upon hire and at least annually. The Contractor must maintain records of all staff education and provide to the Department within seventy-two (72) hours upon request.

The Contractor's advance directive written policies, procedures, must be submitted to the Department as outlined in the Cardinal Care Technical Manual.

4.2 Member Engagement

4.2.1 Member Advisory Committee

In accordance with 42 CFR § 438.110, the Contractor must establish a Member Advisory Committee that will provide regular feedback to the Contractor on issues related to Managed Care program

management and Member care. The Contractor must ensure that the Member Advisory Committee: (1) meets at least once quarterly; and (2) is comprised of a reasonably representative sample of the Contractor's Members, or other individuals representing Members including family Members, independent advocates and caregivers. The Member Advisory Committee must reflect the diversity of the Managed Care population, including: pregnant Members, parents and children, adults without children, LTSS Members, individuals with disabilities and individuals residing in NFs; Members with limited English proficiency and diverse cultural, racial, and ethnic backgrounds; and Members with differing abilities, genders, sexual orientations, and gender identities–or other individuals representing such Members. The Contractor may establish more than one (1) Member Advisory Committee, or hold focused sessions, for example a maternal child member advisory group.

The Contractor must advise all Members of this Committee and provide a procedure for interested Members, family Members, independent advocates, and other caregivers to participate on the Committee. The Department reserves the right to review and approve Committee Membership. The Contractor must include Ombudsman reports in quarterly updates to the Member Advisory Committee and must participate in all statewide stakeholder and oversight meetings as requested by the Department. The Member Advisory Committee must be a standing committee with identified committee members. The Contractor must develop a "feedback loop" where feedback from the committee is addressed and a response to the feedback is provided at the next meeting.

4.2.2 Member Healthy Incentives

The Contractor may offer non-cash incentives or discounts to their enrolled Members for the purpose of rewarding healthy behaviors, e.g., vaccines (flu, shingles, pneumonia, etc.), EPSDT well-child visits and immunizations, prenatal visits, provider visits, or participating in disease management, HEDIS or HEDIS related measures/activities.

The Contractor must also ensure that incentives are made available in equal amount, duration, and scope to the Contractor's Membership in all localities served except with prior approval from the Department. Incentives shall be limited to a value of no more than $50.00 for each medical goal, unless otherwise approved by the Department. Incentives over $50 per medical goal must be approved by the Department prior to implementation. The Contractor must submit all incentive award packages to the Department in accordance with the requirements of the Cardinal Care Technical Manual. The Department reserves the right to deny healthy incentive initiatives that do not align with the Department or CMS policy. Non-cash incentives may include gift cards or discounts for services. The Contractor must have assurances that gift cards cannot be redeemed by the business (Walmart, Target, etc.) for cash; cash incentives are not permitted.

4.2.2.1 **Member Healthy Incentives Report**

The Contractor must track incentives by individual and must provide information to the Department upon request. The Contractor must, in the manner detailed in the Cardinal Care Technical Manual, provide the Department with a report that summarizes the Contractor's wellness and Member incentive programs that encourage active participation in health and wellness activities to both improve Member health and control costs.

The Contractor must describe activities supporting health and wellness initiatives to include healthy behavior incentives to encourage Members to take an active role in their health. Examples of healthy behavior activities include engagement in disease management programs, performance of best practice preventive measures such as flu shots, participation in smoking cessation programs, etc.

4.2.3 Medicaid Works

Medicaid Works is a work incentive opportunity offered by the Virginia Medicaid program through an alternative benefit plan (ABP) for individuals with disabilities who are employed or who want to work. Medicaid Works individuals are at least sixteen (16) years of age and less than sixty-five (65) years of age. Additional background information about Medicaid Works is available here.

Medicaid Works individuals must receive the same amount, duration and scope of services as Medicaid expansion MAGI adults (see Section 5.11, *Covered Services for MAGI Adult Medicaid Expansion Population*), with the additional benefit of personal care services, including agency-directed or consumer-directed, or both. Individuals who receive personal care services through Medicaid Works do not have a patient pay responsibility for the personal care services. The coverage criteria for personal care services for Medicaid Works enrolled Members must be the same as the personal care coverage criteria described under the CCC Plus HCBS waiver. Criteria information regarding personal care can be found in the Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapter IV, and the Cardinal Care Summary of Covered Benefits Chart.

Medicaid Works individuals may not be simultaneously enrolled in a HCBS waiver. Medicaid Works individuals are not required to have a Medicaid LTSS Screening. The Department is solely responsible for determining eligibility for and enrolling Members in Medicaid Works.

4.3 Member Materials

4.3.1 Approval Process for Written Materials

All enrollment, disenrollment, informational materials, marketing materials and content for media, social media or websites made available to Members or potential Members by the Contractor must be submitted to the Department for its review prior to use, upon revision, and upon request, unless specified elsewhere in this Contract. The Contractor must submit its Member and marketing materials to the Department for review and approval thirty (30) calendar days prior to initial posting and thirty (30) calendar days prior to any substantive changes being made. Materials may not be sent to Members without Department approval. The Department has the ability to designate materials as critical to obtaining services, per 42 CFR §438.10(d)(3). The Department will not require prior review and approval of electronic communications regarding unforeseen circumstances that may require urgent action on behalf of the Contractor or Members (i.e. office closings due to inclement weather, power outages, etc.).

The Contractor must ensure that all promotional items and materials are approved by the Department prior to printing and distribution. The Contractor may include the name of the MCO and a general phone number for the MCO in the designated space on the Department's designed and approved materials. The Department will approve, deny, or ask for modifications to the materials within thirty (30) calendar

days of the date of receipt by the Department. Contractors can order brochures, applications and other materials via the Cover Virginia website.

4.3.2 Requirements for All Written Materials

Written materials include enrollment, disenrollment, informational materials, marketing materials and content for media, social media, smartphone applications, or websites. The Contractor must have mechanisms in place to help Members and potential Members understand the requirements and benefits of their plan as specified in 42 CFR §438.10(c)(7). In accordance with 42 CFR §438.10(c)(4)(ii), the Contractor must utilize Member notice templates as developed and directed by the Department. The Contractor must update materials to reflect any changes in Federal or State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

Per 42 CFR § 438.10(c)(4)(i) and 42 CFR §438.10(d)(3), the Contractor is required to provide all written materials for Members and potential Members:

1. In easily understood language and format;
2. In a size no smaller than twelve (12) point font;
3. In 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, as required under 42 CFR § 438.10(d)(1). Examples of alternate formats must include, but not be limited to, Braille, large font (size 18 point font or larger), audio tape, oral interpretation services, American Sign Language video tape, and information read aloud to a Member;
4. With the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDD) telephone number of the Contractor's Member/customer service unit; and
5. In a way that uses Managed Care terminology definitions, as defined in the Department's Managed Care Model Member Handbook available on the Managed Care website.

The Contractor must ensure that documents for its Membership are comprehensive, yet written in nontechnical, readily understandable plain language as required in Va. Code § 32.1-330.2. For further guidance, refer to the "Toolkit for Making Written Material Clear and Effective" by CMS here.

When considering the issuance of materials to FAMIS members, the Contractor must utilize Department designed and approved brochures, application, and enrollment forms to provide to potential members and the parents or guardians of potential members that list all the possible MCO choices available in the members' locality/region.

The Contractor must market the FAMIS program as a program of the Commonwealth of Virginia. The Contractor is prohibited from marketing the FAMIS program as a program specific to the Contractor's company or organization. Materials must indicate that FAMIS is a program of the Commonwealth, administered by the Department in partnership with (name of MCO).

As set forth in 42 CFR § 438.10, 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, service authorization approval and denial and termination notices, available in the prevalent non-English languages in its particular service area and when doing so is a reasonable step to providing meaningful access to health care coverage for an LEP individual. A prevalent non-English

language is a language group that exceeds the five percent (5%) or one thousand (1,000) population mark in its particular service area (see HHS Guidance). In accordance with 42 CFR § 438.10(d)(5)(i)-(iii), the Contractor's written materials critical to obtaining services must include taglines in the prevalent non-English languages in the state, explaining the availability of written translation in prevalent non-English languages, and oral interpretation in any language free of charge, to understand the information provided and how to access services. Further, the written materials must include in large print (no smaller than eighteen (18) point font) information about the availability of and how to access auxiliary aid services free of charge and the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDD) telephone number of the Contractor's Member/customer service unit.

Written materials critical to obtaining services are required to have a non-discrimination statement that includes the following: 1) The Contractor must not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities and 2) How to file a discrimination complaint with the Contractor's Office of Civil Rights and the U.S. Department of Health and Human Services, Office for Civil Rights.

4.3.3 Requirements for New Member Materials

The Contractor must provide its Members, as expediently as possible upon receiving the end of the month 834 file in which their enrollment starts, an identification card that includes the Medicaid ID number (if not already mailed) and a welcome/introduction letter that includes informational documentation indicating the Member's first effective date of enrollment. Each Member must receive an individual identification (ID) card. The Contractor must mail all Member ID cards as expeditiously as possible and no later than five (5) business days from the Member's effective date. Further, the Contractor must utilize at least first class or priority mail delivery services as the medium for providing the Member identification cards in envelopes marked with the phrase "Return Services Requested."

The Contractor is required to send one (1) Member handbook notification per Member. The Contractor must provide the handbook as described in Section 4.3.7, *Member Handbook*, and a Provider Directory, or a separate notice on how to access this information online and how to request a hard copy.

In addition, at a minimum, all new Members must receive the following information: formulary Information, or a separate notice on how to access this information online and how to request a hard copy; PCP assignment (for non-duals); and Care Manager name and contact information (as applicable).

The Contractor must submit a copy of all new Member materials for review ninety (90) days prior to commencement of the initial Contract term, upon revision and upon request by the Department.

In accordance with 42 CFR § 438.10, the Contractor must notify the Member in writing of the following, at minimum:

1. That information is available on the MCO's Member website, the Department website, the enrollment broker website, and the enrollment smartphone app, and includes applicable internet addresses; and
2. How to access and utilize smartphone application(s).

4.3.4 Written Materials in an Electronic Format

Except as specifically required by this contract, the Contractor must provide the required Member materials, described below, as outlined in 42 CFR § 438.10(g)(3). Further, if information is made available to the Member electronically, then the information provided must further meet the requirements as outlined in 42 CFR § 438.10(c)(6) (i)-(v)). Required membership materials must not be provided electronically by the Contractor unless all of the following are met:

1. The format is readily accessible; as per 42 CFR § 438.10, readily accessible means electronic information must comply with modern accessibility standards (ADA) such as:
    a. Section 508 guidelines; and
    b. Web Content Accessibility Guidelines (WCAG).
2. The information is placed in a location on the Contractor's website that is prominent and readily accessible;
3. The information is provided in an electronic form which can be electronically retained and printed;
4. The information is consistent with the content and language requirements described in 42 CFR § 438.10; and
5. The Member is informed that the information is available in paper form without charge upon request and provides it upon request within five (5) business days.

4.3.5 Adequate Written Descriptions to Inform Health Plan Selection Decisions

The Contractor must provide to Members and potentially interested members 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 their health plan selection.

4.3.6 Member Identification Card

The Contractor must provide each Member an identification (ID) card that is recognizable and acceptable to the Contractor's network providers. The Contractor's ID card must also serve as sufficient evidence of coverage for non-participating providers.

The Contractor's identification card must include, at a minimum:

1. Cardinal Care Managed Care logo;
2. Name of the Member;
3. Member's Medicaid identification number;
4. Member's Contractor identification number;
5. Name and address of the Contractor;
6. Member's copayment obligations (if applicable);
7. Telephone number to be used to access after-hours non-emergency care;
8. Behavioral health and ARTS crisis line number (if different);
9. Instructions on what to do in an emergency;
10. Any other information needed to process claims;
11. Telephone contact information for the dental program;
12. Telephone number for transportation services; and

13. Telephone number for the Contractor's Member Services Department.

The Contractor must submit and receive approval of the identification card from the Department prior to production of the cards. The Department will work with the Contractor to determine a feasible timeframe for sending new Cardinal Care ID Cards to members; however, in the interim, the Contractor must ensure that the former ID Cards (for Medallion 4.0 and CCC Plus) enable full Member access to all contractually required and contractor enhanced benefits.

4.3.7 Member Handbook

In accordance with 42 CFR § 438.10, the Contractor must develop a Member handbook that includes all required elements as defined in the Department's Managed Care Model Member handbook available on the Managed Care website.

The Contractor's handbook must include information about the transitions of care policy, in accordance with 42 CFR §438.62(b), and the amount, duration, and scope of benefits available under this contract in sufficient detail to ensure that Members understand the benefits to which they are entitled. The Contractor must revise its Member handbook to coincide with changes that the Department makes to the handbook template and as directed by the Department. The Contractor must revise its Member handbook when significant program changes are made that are initiated by the Contractor. Changes to the printed version of the handbook must be revised to incorporate needed changes at least on an annual basis on September 30 or as directed by the Department. A revised redlined version of the Member Handbook must be provided to the Department for review and approval at least sixty (60) days prior to planned printing or within ten (10) days of the Department's request. If a significant mid-year change is required, the plan may revise through the use of an insert. Changes to the online version of the handbook must be revised to incorporate needed changes within thirty (30) calendar days receipt notice of the required change. Any changes to the Member handbook or inclusion of new inserts must be approved by the Department prior to use by the Contractor.

If a Member is reenrolled 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.

The Contractor must provide the Member Handbook to each Member. In accordance with 42 CFR § 438.10(g)(3)(i)-(iv), the handbook information is considered to be provided to the Member if the Contractor:

1. Mails a printed copy of the information to the Member's mailing address;
2. Provides the information by email after obtaining the Member's agreement to receive the information by email;
3. 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, and provided that the information

is available in the prevalent non-English languages in its particular service area as prescribed under 42 CFR §438.10(d)(3); and

4. Provides the information by any other method that can reasonably be expected to result in the Member receiving that information. This method must be documented in the Member's record. An example could include a paper copy hand-delivered by the Care Manager.

According to 42 CFR § 438.10(g)(4), 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 must 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.

Services listed in the Contractor's evidence of coverage or any Member handbook do not take precedence over the services, including amount, duration, and scope, required under this Contract or the State Plan for Medical Assistance.

4.3.8 Provider Network Directory

The Contractor must 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, behavioral health providers, and LTSS providers in accordance with all requirements described in 42 CFR § 438.10. The Department will periodically monitor the Contractor's provider directories to ensure compliance with these content requirements and may impose any remedies available under the Contract for Contractor noncompliance.

In accordance with 42 CFR § 438.10(h), the provider directory must include, at a minimum, the following information for all providers in the Contractor's provider network:

1. The names, addresses, and telephone numbers of all current network providers;
2. 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;
3. As applicable, whether the health care professional or non-facility-based network provider has completed cultural competence training;
4. 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;
5. 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;
6. Whether the provider is accepting new patients as of the date of publication of the directory;
7. Provider website/URL, if available;
8. Whether the network provider is on a public transportation route;

9. 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;
10. For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use;
11. Whether there are any restrictions on the Member's freedom of choice among network providers (e.g., providers that require a referral prior to receiving care); and
12. 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.

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

1. Update information in its paper directory at least monthly;
2. Update information in its online and printed directories no later than thirty (30) calendar days after receipt of provider updates;
3. Provide either a copy, or a separate notice about how to access this information online or request a hard copy within five (5) business days at no charge, to all new Members and annually thereafter;
4. Provider directories must be made available on the Contractor's Web site in a machine readable file and format per 42 CFR § 438.10(h);
5. When there is a significant change to the network, the Contractor must send a special mailing to Members;
6. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 CFR § 438.10;
7. Consistent with 42 CFR § 438.10(f)(1) the Contractor must make a good faith effort to give written notice of termination of a network provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider; and
8. Include written and oral offers of such provider and pharmacy directories in its outreach and orientation sessions for new Members.

4.3.9 Prescription Drug Formulary

In accordance with 42 CFR § 438.10(i), the Contractor must make available in electronic or paper form, the following information about its formulary:

1. Which medications are covered (both generic and name brand);
2. What tier each medication is on; and
3. The Contractor's formulary drug lists must be made available on the Contractor's Web site in a machine readable file and format.

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.

4.4 Marketing Requirements

For the purposes of this Contract, marketing materials and services as defined in this Contract apply to Members who may or may not be currently enrolled with the Contractor.

The Contractor must submit to the Department a complete marketing plan and any revisions thereto in accordance with the requirements contained in the Cardinal Care Technical Manual. Any material changes to the marketing plan must be submitted to the Department for approval prior to use. The Contractor must submit to The Department all electronic addresses of all social media and video platforms as well as smartphone applications.

The Contractor may utilize subcontractors for marketing purposes; however, Contractor is responsible for the marketing activities and actions of subcontractors who market on their behalf.

4.4.1 Approval and Distribution of Marketing Materials

In accordance with 42 CFR § 438.104(b), the Contractor must submit all new and/or revised marketing and informational materials, to include print, radio, TV, apps, video and web-based media, and social media platforms, etc. to the Department before their planned launch and/or distribution. The Contractor must also provide the Department with a description of any efforts to reach Members through various social media platforms. The Department will approve, deny, or ask for modifications to the materials within thirty (30) calendar days of the date of receipt by the Department.

All marketing materials must be distributed in accordance with 42 CFR § 438.104(b). The Contractor must distribute marketing materials to the Contractor's entire eligible population and to the Contractor's entire service area, and also through the Contractor's website. The Department may consider and approve a Contractor's 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 to Section 1851(h) of the Social Security Act and 42 CFR §422.111.

4.4.2 Approval of Marketing Events

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

4.4.3 Permitted Marketing and Outreach Activities

The Contractor may engage in the following promotional activities:

1. **General Public:** Notify the general public of the Managed Care program in an appropriate manner through appropriate media, including social media, throughout its enrollment area;
2. **Potential Member Request:** Fulfillment of potential Member requests to the Contractor 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 or electronically;

3. **Community Sites:** The Contractor must convene all preapproved educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Members or eligible Members, including persons with disabilities and persons using public transportation;
4. **Health Awareness/Community Events:** Hosting or participating in health awareness events, community events, and health fairs preapproved by the Department. The Department reserves the right to attend any Contractor events, and may include representatives from the enrollment broker and/or local Health Departments and/or Departments of Behavioral Health and Developmental Services. 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 may supply copies of comparison charts upon proper notification;
5. **Health Screenings:** Health screenings may be offered by the Contractor at community events, health awareness events, and in wellness vans. The Contractor must 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. **Promotional Items or "Giveaways":** Offers of free, non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of $50.00 to any prospective Member or family for marketing purposes are permissible. 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 behaviors, e.g., toothbrushes or immunization schedules;
7. **Health Education Program and Materials:** The Contractor must maintain a written plan for health education and prevention that is based on the needs of its Members. The Contractor must submit its 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 must 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. 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. The Contractor may develop, administer, and implement health education program materials for its new and continuing Members. The Contractor's materials must be written using clear, concise, and accurate information in plain language. ; and
8. **Outreach to Pregnant Members Who Qualify for Medicaid in a Non-Pregnant Covered Group:** The Contractor must assist Members who are twelve (12) months postpartum and in an aid category related to the pregnancy with assistance in transitioning to another aid category, if eligible.

4.4.4 Prohibited Marketing and Outreach Activities

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

1. **Certain Informational Marketing Activities:** Engaging in any informational or marketing activities which could mislead, confuse, or defraud Members or misrepresent the Department (42 CFR § 438.104);
2. **"Cold Call" Marketing Activities:** Directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites (42 CFR § 438.104);
3. **Direct Mailing:** All mailings must be processed through the Department or its agent except mailings to Managed Care Members of the Contractor;
4. **Home Visits/Direct Marketing or Enrollment:** The Contractor is not permitted to conduct unsolicited personal/individual appointments. Making home visits for direct marketing or enrollment activities is allowed only when requested by the Member or his/her authorized representative. The Contractor is prohibited from making unsolicited offers of individual appointments. However, to the extent a Contractor provides individual appointments, a Contractor can make an individual appointment to an Member, Potential Member, or his/her authorized representative if the Member/representative has contacted the Contractor to request assistance or information. The Contractor must make reasonable efforts to conduct an appointment in the Member or Eligible Beneficiary's preferred location. The Contractor cannot require that an individual appointment occur in a Member or Potential Member's home. The appointment must be staffed by a trained Member service representative;
5. **Incentives:** Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll in the Contractor's plan;
6. **Prospective Member Marketing:** Continuous, periodic marketing activities to the same prospective Member, e.g., monthly or quarterly giveaways, as an inducement to enroll;
7. **Improper Use of the Department Eligibility Database:** Using the Department 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 eligible individuals with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract;
8. **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. The Contractor may, however, direct marketing to its Members about its programs for specific health status;
9. **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, as directed by the Department, for care coordination purposes, or as part of a Department approved survey to determine reasons for disenrollment;
10. **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 CFR § 438.104). No enrollment related activities may be conducted at

any marketing, community, or other event unless such activity is conducted under the direct onsite supervision of the Department or its enrollment broker;

11. **DSS Offices:** No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department. The Contractor may collaborate with local DSS agencies on mutually identified initiatives, subject to The Department's approval;
12. **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 CFR § 438.104);
13. **Enroll to Keep Benefits:** No assertion or statement that the Member must enroll with the Contractor in order to keep from losing benefits (42 CFR § 438.104);
14. **Renewal of Medicaid Benefits/Reason for Disenrollment:** The Contractor may not solicit reason for disenrollment from Members leaving the Contractor's plan, except as permitted in paragraph nine (9) above;
15. **Influence Enrollment:** The Contractor may not seek to influence enrollment in conjunction with the sale or offering of any private insurance (42 CFR § 438.104(b)); and
16. **Direct Marketing to Any Child Under Nineteen (19) Years of Age:** The Contractor may not direct market to those under nineteen (19) years of age that is not expressly approved in advance by the Department.

4.4.5 Federal and State Marketing Laws

Pursuant to 42 CFR § 438.104, marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to Members.

The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor or its subcontractor(s) 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.

4.4.6 Marketing Sanctions

In accordance with 42 CFR §§ 438.700(c), 438.704(b), and Sections 1932(e)(1)(A) and 1932(e)(2)(A)(i) of the Social Security Act, and this Contract, the Contractor is subject to suspension of all or part of Contractor's marketing activities, or sanctions, if it conducts marketing activities that are not approved in writing by the Department. The Contractor is also subject to sanctions for any marketing materials or methods that are found to be inaccurate, misleading, confusing, or defrauds the intended recipients or the Department. Refer to Section 17.3, *Contractor Compliance Infrastructure Requirements*.

Sanctions may also be levied as part of the audits performed by the Department or its designee of Contractor marketing, outreach, and communications activities, including, but not limited to:

1. Review of onsite marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits;

2. Random reviews of actual marketing, outreach, and communications materials as they are used in the Marketplace;
3. "For cause" review of materials and activities when complaints are made by any source, and the Department determines cause to investigate; and
4. "Secret shopper" activities where the Department requests Contractor materials, such as Enrollment packets.

4.5 Member Access to and Exchange of Data

The Contractor is required to implement an Application Programming Interface that meets the criteria specified at 42 CFR § 431.60 and permits third-party applications to retrieve, with the approval and at the direction of a current member or the member's representative, data specified in 42 CFR § 431.60 through the use of common technologies and without special effort from the beneficiary. Data made available through the interface must include:

1. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and beneficiary cost-sharing pertaining to such claims, no later than one (1) day after a claim is processed;
2. Encounter data, including encounter data from any network providers the Contractor is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors no later than one (1) day after receiving the data from providers;
3. Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) day after the data is received by the Contractor; and
4. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) day after the effective date of any such information or updates to such information.

5. BENEFITS AND SERVICES

5.1 Cardinal Care Covered Services

Throughout the term of this Contract, the Contractor must promptly provide, arrange, purchase or otherwise make available to all of its Members the full continuum of services required under this Contract, as described in Attachment E *Cardinal Care Summary of Covered Benefits Chart* and in accordance with medical necessity criteria described in Section 6.1.6, *Service Authorization and Medical Necessity Criteria*, and 42 CFR § 438.210(a)(1). The Contractor (the Member's current MCO) must assume responsibility for all covered services authorized by the Department, its designee, or a previous MCO, which are rendered on or after the Member's enrollment effective date with the Contractor. In the absence of an agreement, out-of-network payments will be made in accordance with the Department's Medicaid fee schedule. The Contractor must cover all pre-existing conditions. The Contractor's coverage rules for covered services must also ensure compliance with Federal EPSDT coverage requirements for Members under the age of twenty-one (21). Details pertaining to covered benefits for FAMIS Children are detailed in Attachment E, *Cardinal Care Summary of Covered Benefits Chart*.

The Department may modify covered services required by this Contract through a contract amendment and/or regulatory change and, if applicable, will adjust the capitation payment in an amount deemed acceptable by the Department and the Contractor. The Department will notify the Contractor in advance of any modification to the services, contract and/or capitation payment that occur during the term of this Contract.

5.1.1 General Requirements for Covered Services

5.1.1.1 Court-Ordered Services

The Contractor is contractually liable for covering all covered, court-ordered services, including involuntary commitment orders, deemed medically necessary, in accordance with the terms set forth in this Contract and § 37.2-815 of the Code of Virginia. In the absence of an agreement, out-of-network payments will be made in accordance with the Medicaid fee schedule.

5.1.1.2 Moral or Religious Objections

In accordance with 42 CFR § 438.102, the Contractor is not 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 the following guidelines:

In accordance with Section 1932(b)(3)(B)(i) of the Social Security Act, the Contractor must furnish information about the services it does not cover, subject to Department approval:

1. With the initiation of the Contract, whenever changes are made, and upon request;
2. Upon adoption of such policy in the event that the Contractor adopts the policy during the term of this Contract;
3. To potential Members, before and during enrollment; and
4. To Members, within thirty (30) days before the effective date of this policy.

Pursuant to 42 CFR § 438.10(e), if the Contractor does not cover counseling or referral services because of moral and religious objections and chooses not to furnish information on how and where to obtain such services, the Department must provide that information to potential Members.

5.1.1.3 Laboratory and X-Ray Services

The Contractor must 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. In accordance with 42 CFR §§ 493.1 and 493.3, 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.

5.1.1.4 Second Opinions

The Contractor must 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. In accordance with 42

CFR § 438.206(b), 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 (1) outside the network, at no cost to the Member. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, the Contractor cannot deny a second opinion request as a non-covered service.

5.2 Carved-Out Services

The services listed in this Section are covered under the Medicaid or CHIP State Plan but are carved out of this Contract and handled by the Department or its designee directly, on a fee-for-service basis.

The Contractor must ensure that all Care Managers and care management extender staff are familiar with all carved-out services, which are identified in the attached Cardinal Care Summary of Covered Benefits Chart. The Contractor is not permitted to provide authorizations or pay claims for excluded or carved-out services, but is required to assist the member in accessing these services through referrals, etc., and to coordinate coverage for related services covered under this contract, such as transportation, pharmacy, and other necessary related services. The Contractor must communicate and work collaboratively with the Department, the Department's SA Contractor, DBA, DBHDS, DSS, LTSS and other provider staff, and other formal and informal community and family supports to ensure coordination of care, including for carved-out services. The Contractor must also ensure that carved-out services are included as appropriate in the Member's person-centered Individualized Care Plan (ICP). Refer to Section 8.6.1, *ICP Required Elements*.

5.2.1 Dental and Related Services

Dental Services for adults and children are carved-out of this Contract and covered through the Department's Dental Benefits Administrator (DBA). The Department's dental benefit includes a comprehensive array of diagnostic, preventive, and restorative dental services for children and adults, including: x-rays, exams, cleanings, fillings, root canals, gum related treatment, dentures, extractions, and other oral surgeries. Dental benefits are slightly different for adults, pregnant individuals and children under age twenty-one (21), as described on the Department's website. The Contractor is not permitted to provide coverage for carved-out dental services but is required to assist the member in accessing these services through referrals, etc., and to coordinate coverage for related services covered under this contract, as further described below. The Contractor must refer all Members needing dental care to the Department's DBA. The Contractor is required to provide coverage for dental related services as described in Section 5.2.1.1, *Coordination with the Dental Benefits Administrator (DBA)*.

5.2.1.1 **Coordination with the Dental Benefits Administrator (DBA)**

The Contractor must coordinate with the DBA to improve member utilization and to share information on dental services that must be included in both the Contractor's handbook and website. The Contractor is responsible for transportation and any medications related to covered dental services.

In addition, the Contractor must work closely with the DBA, and must cover medically necessary dental related procedures for adults and children, including but not limited to, the following:

(1) Medical 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.
(2) 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.
(3) Hospitalization and anesthesia related services, in accordance with the 2022 Virginia Appropriations Act, Item 304 PPPP and Code of Virginia, § 38.2-3418.12, as further described below:
    a. Effective July 1, 2022 in accordance with 2022 Virginia Appropriations Act, Item 304 PPPP, the Contractor must provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Medicaid enrollee who is determined by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care to an enrollee age ten or younger.
    b. The Dental Benefit Administrator (DBA) will serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, the Contractor, the Department, and any other required provider. The DBA dental director will review the case for medical necessity for members eleven years and older, and render an approval or denial of the services. Once the DBA has approved the case, the DBA will coordinate authorization for nondental services (example: facility and anesthesia) with the MCO as appropriate. The DBA will not review cases for medical necessity for members age ten or younger where a determination has been made by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care. The DBA will coordinate authorization for non-dental services (example: facility and anesthesia) with the MCO as appropriate.
    c. 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. The Contractor shall provide a comprehensive list of routine and escalation contacts. This list should be updated as changes occur. The Contractor shall adhere to all turnaround times.
    d. 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 Consultant. 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.

5.2.2 DD Waiver Services, DD Case Management Services, and Related Transportation Services

Developmental Disability (DD) Waiver services (including when covered under EPSDT), targeted DD case management and transportation to the waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. DD Waivers include the Community Living (CL), Family and Individual Supports (FIS), and Building Independence (BI) Waivers as described in Attachment E, Cardinal Care Summary of Covered Benefits Chart, Part 4C. Individuals enrolled in one (1) of the DD waivers are enrolled in the Managed Care program for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services).

The Contractor must ensure that it develops and maintains an adequate network of qualified providers to meet the non-waiver integrated care needs of the DD subpopulation through a person-centered delivery model.

All individuals enrolled in one (1) of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in a person-centered ISP. Individuals receiving home- and community-based services (HCBS) through one (1) of these waivers have a variety of choices of both types of services and providers.

Individuals with any DD seeking waiver services must have diagnostic and functional eligibility assessments completed by their local Community Services Board (CSB) and, as appropriate be placed on a waiting list. Individuals who are on the DD waiting list may be eligible for the CCC Plus Waiver if they meet the level of care requirements, until a DD Waivers slot becomes available. Local waiver waiting lists are maintained by the CSBs for all individuals under their jurisdiction.

The Contractor must have policies and procedures in place to provide care management with Members who are enrolled in the DD Waivers, in addition to all individuals with a diagnosis of a DD. Such policies and procedures must be submitted to the Department in accordance with the requirements contained in the Cardinal Care Technical Manual. The Contractor must work with the Member's DD Waiver support coordinator and service providers to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services, as applicable, to support the individual's health and wellbeing. The Contractor must be able to identify and access the appropriate community-based resources for these Members.

The Contractor must not enter DD Waiver level of care information; DD waiver enrollment and services are managed by DBHDS.

5.2.3 Local Education Agency-Based Services

Local education agency –based services are covered services rendered by service providers who are employed or contracted by a local education agency, and the local education agency is the billing provider of those services. Local education agency-based services are carved out of this Contract and are reimbursed directly by the Department.

Covered services provided in a school setting and rendered by an in-network health care provider who is not a paid employee or contractor of the Local Education Agency may be covered by the Contractor. In such cases, the in-network provider is the billing provider, not the local education agency.

The Contractor must not deny medically necessary services based on the fact that the services are provided in a school setting.

The Contractor must not deny medically necessary services based on the fact that the child is receiving local education agency-based services. The fact that the child is receiving local education-based services must not impact the child's access to services rendered by in-network providers.

5.2.4 Tribal Clinic Provider Types

Services provided through tribal clinic provider types are carved out of this Contract and reimbursed through fee-for-service, per the provider's agreement with the Department.

5.3 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. Such services must be approved by the Department and must comply with Federal requirements described in 42 CFR §§438.3(e)(2), 438.6(e) and State Medicaid Directors letter #23-001.

The Contractor may cover services or settings for enrollees that are in lieu of those covered under the state plan if:

1. The Department determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the state plan.
2. The Department determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the state plan.
3. The enrollee is not required by the Contractor to use the alternative service or setting.
4. The approved in lieu of services are authorized and identified in this Contract.
5. The approved in lieu of services are offered to enrollees at the option of the Contractor.

The Contractor must 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.

The Department has approved MCOs to provide coverage in an IMD setting in lieu of providing services in an inpatient psychiatric unit of an acute care hospital for certain members. For additional information on State Plan Substituted (In Lieu of) Services specific to IMDs, refer to Section 5.5.1.2, *IMD Enhanced and State Plan Substituted (In Lieu of) Services for Certain Medicaid Members*. The Contractor must not approve any other "In Lieu of" services. Enhanced Benefits are not considered "In Lieu of" services.

5.4 Enhanced Benefits

Enhanced benefits are services offered by the Contractor to Members in excess of the Managed Care program's covered services. No increased reimbursement must be made for enhanced benefits provided

by the Contractor. When being developed, the Contractor must consider the population to whom they are being offered and should address the Members' needs.

By October 1 of the contract year, the Contractor must provide to the Department for approval the list of enhanced benefits it would like to offer and to whom the benefits would be available, the benefit limits, and criteria for each enhanced benefit. Revisions to enhanced services must be made only in October of each year for the next year's open enrollment, beginning in January.

Enhanced benefits do not have to be offered to individuals in every category of eligibility; however, must be available to all individuals if placed on the Managed Care program comparison chart).

If consumer-directed personal care services will be offered as an enhanced benefit, the Contractor must contract with and reimburse the F/EA for all of the administrative costs associated with the F/EA functions for this benefit.

Enhanced benefits offered by each Contractor will be listed in the Department's Managed Care program comparison charts. Comparison charts are revised annually in October, prior to the coming year's open enrollment. Any changes to enhanced services occurring after the Department's annual comparison chart publication cannot be incorporated until the next annual revision. 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 and expenditures for enhanced benefits provided to Members during the Contract, as required by the Cardinal Care Technical Manual.

Examples of potential enhanced benefits for the Managed Care program population may include, but are not limited to, social determinants of health interventions, chiropractic care, environmental modifications and assistive technology for non-CCC Plus Waiver members, vision, hearing, and personal care services for individuals who do not meet waiver or EPSDT criteria.

5.5 Behavioral Health Services

5.5.1 Inpatient and Outpatient Behavioral Health Services

5.5.1.1 **Inpatient Psychiatric Services**

Inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital must be covered for all eligible Members regardless of the age of the Member, as set forth in 12 VAC 30-50-100.

The Contractor must cover all medically necessary services rendered in free-standing psychiatric hospitals, including institutions for mental disease (IMD), for Members up to twenty-one (21) years of age and Members over sixty-four (64) years of age. The Contractor is not required to cover services rendered in free-standing psychiatric hospitals, including IMDs, for Members aged twenty-one (21) through sixty-four (64).

The Contractor must cover medically necessary inpatient psychiatric treatment services for children under age twenty-one (21) in accordance with EPSDT criteria per Social Security Act § 1905(a).

5.5.1.2 IMD Enhanced and State Plan Substituted (In Lieu of) Services for Certain Medicaid Members

The Contractor may authorize admission to a free-standing psychiatric hospital as an enhanced service to Medicaid Members aged twenty-one (21) through sixty-four (64), in lieu of providing inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital, in accordance with the Contractor's overall mental health protocols, policies, network requirements, and in accordance with federal rules described below.

In accordance with 42 CFR §438.6(e), for Medicaid Members ages twenty-one (21) through sixty-four (64), the Contractor may provide coverage for a Member receiving inpatient treatment in an IMD, as defined in 42 CFR §435.1010. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services at § 438.3(e)(2)(i) through (iii). See Section 5.3, State Plan Substituted (In Lieu of) Services, for additional information on requirements for providing in lieu of services.

In accordance with 42 CFR § 438.6(e), if the Contractor elects to provide coverage in an IMD setting "in lieu of" providing services in an inpatient psychiatric unit of an acute care hospital or other state plan covered setting, the Contractor must refund the full capitation payment paid by the Department for any treatment provided to the Member in an IMD where the length of stay in the IMD exceeds fifteen (15) days during the calendar month. If the Member's length of stay crosses two calendar months but does not exceed fifteen (15) days in each respective calendar month, the Contractor is permitted to retain the capitation payment for both calendar months. The fifteen (15) day IMD length of stay provision is not relevant to the Contractor's payment responsibility to the provider. The fifteen (15) day provision applies to the Contractor's receipt of the capitation payment. If the length of stay exceeds fifteen (15) days in a calendar month, the Contractor must return the capitation payment following the process described in Section 15.6, *Refund of Capitation Payment for IMD Stays Exceeding 15 Days in a Calendar Month*. However, the Contractor remains responsible for payment to the provider per the health plan's contractual agreement with the provider. The fifteen (15) calendar day limit does not apply to IMD treatment for substance use disorders. Refer to Section 5.5.6, *Addiction and Recovery Treatment Services (ARTS)*. Involuntary admissions, including in IMD settings, follow the Temporary Detention Order (TDO) process described in Section 5.5.1.3, *Temporary Detention Orders (TDO) and Emergency Custody Orders (ECO).*

5.5.1.3 Temporary Detention Orders (TDO) and Emergency Custody Orders (ECO)

A Temporary Detention Order (TDO) is an order issued by a magistrate for a person who (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The Contractor must provide coverage for TDOs and ECOs pursuant to 42 CFR § 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 must follow all Department program

policies and MCO guidance Memos issued by the Department on TDO processes. 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. 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 state-run psychiatric hospitals.

Coverage for services for Members admitted to a free-standing psychiatric facility under a TDO must be handled as follows:

If the Member is under age twenty-one (21) or over age sixty-four (64) and goes into a private free-standing IMD or a State free-standing IMD for a TDO, the Contractor is responsible for the TDO. If the Member remains admitted to the IMD after the TDO expires, the Contractor is responsible for the psychiatric stay. Following expiration of the TDO, the Contractor can require that the Member transfer to a network facility.

If the Member is age twenty-one (21) through sixty-four (64) and goes into a private free-standing IMD or a State free-standing IMD for a TDO, providers should submit the TDO claim to the state TDO program. The Member will remain enrolled with the Contractor beyond the TDO timeframe. The Contractor must manage the Member's treatment needs beyond the TDO timeframe and can require that the Member transfer to a network facility.

The duration of temporary detention must be in accordance with the Code of Virginia, as follows:

1. **For Individuals under age eighteen (18) (Minors):** Pursuant to § 16.1-340.1.G of the Code of Virginia, the duration of temporary detention must be sufficient to allow for completion of the examination required by § 16.1-342, preparation of the preadmission screening report required by § 16.1-340.4, and initiation of mental health treatment to stabilize the minor's psychiatric condition to avoid involuntary commitment where possible, but must not exceed ninety-six (96) hours prior to a hearing. If the ninety-six (96)-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the minor may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. The minor may be released, pursuant to § 16.1-340.3, before the ninety-six (96)-hour period herein specified has run.
2. **For Adults age eighteen (18) and over:** Pursuant to § 37.2-809.H of the Code of Virginia, the duration of temporary detention must be sufficient to allow for completion of the examination required by § 37.2-815, preparation of the preadmission screening report required by § 37.2-816, and initiation of mental health treatment to stabilize the person's psychiatric condition to avoid involuntary commitment where possible, but must not exceed seventy-two (72) hours prior to a hearing. If the seventy-two (72)-hour period herein specified terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the person may be detained, as herein provided, 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. The person may be released, pursuant to § 37.2-813, before the seventy-two (72)-hour period herein specified has run.

5.5.1.4 **Behavioral Health Homes**

At its option, the Contractor may develop and implement behavioral health homes (BHHs). If the Contractor elects to implement a BHH, the Contractor must utilize a model that integrates medical and behavioral health services. Prior to implementation of the BHH, the Contractor must:

1. Notify the Department of its intent to offer a BHH and include a description of the delivery model in accordance with the requirements of the Cardinal Care Technical Manual. Elements and goals of the Contractor's BHHs should include:
    a. Improving health and behavioral health outcomes and opportunities for community integration for BHH individuals using evidence-based practices;
    b. Empowering medical and behavioral health providers to collaborate and exchange information for aligned care planning to provide person-centered care at the right time in the least restrictive environment;
    c. Improving the experience of care, quality of life and consumer satisfaction, and promoting a seamless and timely experience for enrolled individuals;
    d. Improving access and utilization of primary and urgent care services, community-based health services, lowering the rates of hospital emergency room use, reducing hospital admissions and readmissions, and decreasing reliance on long-term care facilities and other high cost services; and
    e. Providing Member education for medical, behavioral health, pharmacy, and other community services, supports and needs, including principles of recovery and resiliency as defined by SAMHSA.
2. Work with the Department, the Department of Behavioral Health and Developmental Services (DBHDS), and community systems (such as CSBs) to ensure BHHs are appropriate for Members, including individuals with serious mental illness (SMI).

5.5.2 Mental Health Services (MHS)

The Contractor must provide coverage for the subset of behavioral health services known as Mental Health Services (MHS), within the amount, duration, and scope of coverage described in Attachment E, the Cardinal Care Summary of Covered Benefits Chart, and as described in the Department's Mental Health Services Provider Manual. The Contractor's coverage rules and authorization practices must at all times comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), as further outlined in Section 5.6, *Mental Health Parity and Addiction Equity Requirements*.

The Contractor must use the Department- defined medical necessity criteria for the MHS benefit as defined in the Department's Mental Health Services Manual and in regulations at 12 VAC 30-50-130, 12VAC30-50-226, 12VAC30-60-5, 12VAC30-60-61 and 12VAC30-60-143. The Contractor's medical necessity guidelines, program specifications and service components for mental health services must, at a minimum, be submitted to the Department for review and approval in accordance with the requirements of the Cardinal Care Technical Manual.

All MHS services will require a service authorization or registration to qualify for reimbursement. See Sections 6.1.4, *NCQA Service Authorization Standards* and 6.1.7, *Mental Health Services Registrations and Authorizations* for additional information on service authorization requirements.

The Contractor must follow all guidelines set forth in the DMAS ARTS and MHS *Doing Business with the MCOs Spreadsheet* available at this link, https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/. The Contractor must implement all MHS requirements, provider training goals and targeted programmatic improvements as directed by the Department. The Contractor will work with the Department to ensure that the Contractor's MHS system of care is able to meet its Members' needs.

5.5.3 Residential Treatment and Therapeutic Group Home Services

Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. Reference Attachment E, the Cardinal Care Summary of Covered Benefits Chart. Any member admitted to a PRTF will be temporarily excluded from Managed Care until they are discharged. Any member admitted to a TGH is not excluded from the Program; however, the TGH per diem service is carved out of this Contract and is administered through the DMAS Service Authorization Contractor. Covered services rendered to Contractor enrolled members in a TGH that are allowed to be billed outside of the TGH per diem must be administered and covered by the Contractor. See Chapter V of the DMAS Residential Treatment Services Manual.

The Contractor must work closely with the DMAS Service Authorization Contractor to ensure against unnecessary institutional placement, i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. The Contractor must also collaborate with the DMAS Service Authorization Contractor to facilitate Independent Assessment Certification and Coordination Team (IACCT) activities on behalf of the Member, including to ensure that physician engagement occurs on behalf of the Member during the independent certification of need process as required prior to any residential treatment service authorization.

The Contractor must work collaboratively with the DMAS Service Authorization Contractor to ensure coordination of Medical, ARTS, and behavioral health services for its Members and must provide coverage for transportation and pharmacy services necessary for the provision of, and as related to, TGH carved-out services. Members enrolled with the Contractor and who are admitted to a Residential Treatment Center for Substance Use Disorder are not excluded and will remain enrolled with the Contractor.

Transitioning PRTF and TGH services including the Independent Assessment Certification and Coordination Team (IACCT) functions to the Managed Care program will occur at a later date following a collaboratively developed, strategic transition plan, described in Section 5.6.5, *Alignment with State Plan*.

5.5.4 Treatment Foster Care Case Management

Treatment Foster Care Case Management (TFCCM) services are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. The Contractor must also collaborate with the Member's Treatment Foster Care case management provider to coordinate the provision of covered benefits rendered to the Member. This includes, but is not

limited to, coordinating step down services for the Member when TFCCM services are no longer deemed medically necessary by the DMAS Service Authorization Contractor.

5.5.5 Collaboration with Key Behavioral Health Service Stakeholders

5.5.5.1 Collaboration with the DMAS Service Authorization Contractor

The Contractor must refer to and collaborate with the DMAS Service Authorization Contractor for behavioral health and mental health services not included in the contract. The DMAS Service Authorization Contractor will communicate via medical records and other appropriate means to enable the Contractor to adequately track Member progress.

5.5.5.2 Collaboration with the Department, DBHDS, and Interested Stakeholders

The Contractor must work collaboratively with the Department as well as other stakeholders including DBHDS, local CSBs, OCS and local CSA, Department of Health Professions, DMAS contractors, DOE and local school districts as well as any other relevant local and state social service and health agencies to design and implement behavioral health improvements as authorized by Item 288, Chapter 2, 2024 Virginia Act of Assembly, Special Session I. Planned service redesign of legacy community mental health rehabilitative services will impact home, school, and community based services and supports for adults and youth. The Contractor must also work collaboratively with DBHDS as part of its System Transformation Excellence and Performance (STEP-VA) initiative.

The Contractor also must work collaboratively with the Department, as well as with DBHDS, DHP, VDH, OCS and local CSA Coordinators, DSS, providers, Department contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support successful transition of TFC-CM and the comprehensive residential treatment services (RTS) benefit, including PRTF, TGH, and IACCT services, to Managed Care, including to ensure that the Contractor's RTS benefit is fully operational upon notification from the Department, and through separately issued guidance on the planned transition of these services into Managed Care, the date of which is to be determined. To support this work, the Contractor must identify and maintain a dedicated lead (with dedicated email address and phone number) who will serve as the Contractor's primary point of contact for the transition of residential treatment services into the Managed Care program and to work with the DMAS Service Authorization Contractor to coordinate care, especially PRTF services, for Members with historic or current enrollment with the Contractor.

5.5.6 Addiction and Recovery Treatment Services (ARTS)

The Contractor must implement all ARTS requirements and improvements as directed by the Department, and work with the Department to ensure that the Contractor's ARTS system of care is able to meet the needs of Members with substance use disorder (SUD). The Contractor's ARTS system of care must 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, to address the immediate and long-term physical, mental and SUD care needs of the individual.

The Contractor must provide coverage for services at the most appropriate ASAM level of care based on the current version of the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, the Department's criteria defined in 12VAC30-130-5000, and the ARTS Provider Manual. This includes ASAM Level 4.0 services (Medically Managed Intensive Inpatient Services) provided in an acute care hospital settings licensed by VDH or an inpatient psychiatric unit of an acute care hospital or free-standing psychiatric facility licensed by DBHDS; ASAM Level 3 services (Residential/Inpatient Services) provided in a facility licensed by DBHDS; ASAM Level 2 services (Intensive Outpatient /Partial Hospitalization Services) and ASAM Level 1 services (SUD outpatient services) by licensed or credentialed staff through the Department of Health Professions (DHP). As directed by the Department, the Contractor must 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.

The Contractor's ARTS network must ensure Member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care. 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 Department will collect reliable and valid data from the Contractor to enable reporting of ARTS specific metrics to the Centers for Medicare and Medicaid Services (CMS). The Department has the authority to add and remove ARTS specific metrics. The Contractor must report data specific to the ARTS benefits as detailed in the Cardinal Care Technical Manual. The ARTS specific quality measures and reporting and monthly ARTS deliverables are referenced in Section 10.7.1, *Behavioral Health Services Outcome Measures,* and described in the Cardinal Care Technical Manual.

5.5.6.1 **ARTS Medical Necessity Criteria**

The Contractor must use Department-defined medical necessity criteria for coverage of ARTS. In order to receive ARTS services, the Member must meet the following medical necessity criteria:

1. Must have one (1) diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 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 age twenty-one (21));
2. Must meet the severity and intensity of treatment requirements for each level of care defined by the Department for ARTS services. Medical necessity for all 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 the multidimensional assessment; and
3. If applicable, must meet the ARTS adolescent treatment criteria. For individuals under the age of twenty-one (21) who do not meet the ARTS 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 are coordinated to correct and ameliorate health conditions that are coverable under Section 1905(a) EPSDT Medicaid authority.

The Contractor must review the requests on an individual basis. The length of treatment and service limits must be based on the individual's most current multidimensional risk profile and apply the ARTS criteria in accord with 12VAC30-130-5000 to 5150.

5.5.6.2 **ARTS Benefit Management**

The Contractor must provide coverage for ARTS benefits within the amount, duration, and scope of coverage requirements described in the Cardinal Care Summary of Covered Benefits Chart of this Contract, in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and as defined in 12 VAC 30-130-5100.

To the greatest extent possible, the Contractor must 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 must 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 must 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 Preferred OBOT organization. The following ARTS Services will require a service authorization to qualify for reimbursement:

1. Intensive Outpatient (ASAM Level 2.1);
2. Partial Hospitalization (ASAM Level 2.5);
3. ASAM Level 3 residential services (ASAM Level 3.1, 3.3, 3.5, 3.7); and
4. ASAM Level 4 inpatient hospital services (ASAM Level 4.0).

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 must 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 following NCQA requirements for urgent preservice and concurrent decisions, within seventy-two (72) hours of the request for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1, 2.5) and Group Home (ASAM Level 3.1). The Contractor must respond to the provider's service authorization submission via the ARTS Service Authorization Request Forms within seventy-two (72) hours of the request for placement in Residential Treatment Services (ASAM levels 3.3, 3.5, and 3.7) and Inpatient Hospitals (ASAM Level 4.0).

The Contractor must employ an ARTS Care Manager who is one of the following licensed practitioners of the healing arts;

1. An addiction-credentialed physician or physician with experience or training in addiction medicine;
2. Physician extenders with experience or training in addiction medicine;
3. A licensed psychiatrist;
4. A licensed clinical psychologist;
5. A licensed clinical social worker;

6. A licensed professional counselor;
7. A certified psychiatric clinical nurse specialist;
8. A licensed psychiatric nurse practitioner;
9. A licensed marriage and family therapist;
10. A licensed substance abuse treatment practitioner; physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner; or
11. A registered nurse with clinical experience in treatment of substance use disorder.

The ARTS Care Manager must perform an independent assessment of initial and concurrent service authorization requests for all ARTS intensive outpatient programs, partial hospitalization programs, residential treatment services and inpatient services (ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7 and 4.0). The ARTS Care Manager must also provide clinical care coordination as defined in Section 8.12.4, *ARTS Care Management*. This requirement also may be met by another Care Manager experience with substance use disorders.

In accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, the Contractor must cover medication-assisted treatment (MAT), including FDA-approved drugs, counseling services, and other behavioral therapies for the treatment of substance use disorder. The Contractor must require all ARTS Intensive Outpatient Programs (ASAM Level 2.1), Partial Hospitalization Programs (ASAM Level 2.5), and Residential Treatment Providers (ASAM Levels 3.3, 3.5, and 3.7) to ensure that Medicaid enrolled Members with an Opioid Use Disorder admitted to any of these programs have access to FDA- approved, evidence-based Medication for Treatment of Opioid Use Disorder (MOUD) Assisted Treatment, including buprenorphine, methadone, or naltrexone. The Contractor must ensure that ARTS IOP, PHP, and RTS providers are assessing and referring Members for MOUD in these settings.

5.5.6.3 Integration of Physical Health, Behavioral Health and ARTS

The Contractor must implement viable strategies to implement a fully integrated care model including coordination of physical and behavioral health, primary care, and pharmacy services. This includes clinically indicated infectious disease testing such as HIV, Hepatitis A/B/C, syphilis, and tuberculosis testing for Members with SUD at initiation of and as indicated during treatment. The Contractor must also ensure coverage of Hepatitis C treatment and HIV treatment and prevention including pre-exposure prophylaxis. For individuals of childbearing age, the Contractor must promote contraception management with addiction treatment including long acting reversible contraception (LARC).

The Contractor must focus on the primary care physician (PCP) relationship as the Member's provider "health home." This strategy will promote one (1) provider having knowledge of the Member's health care needs, whether disease specific or preventive care in nature. The Contractor must ensure that PCPs are educated regarding their responsibilities.

5.5.6.4 ARTS Community Integration

The Contractor must ensure compliance with CMS established person-centered planning and community-based setting requirements into all ARTS service planning and service delivery efforts. ARTS

service planning and delivery will be based upon a person-centered assessment designed to help determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. The Contractor must ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency as detailed in this contract.

Peer recovery support services must be made available to Members receiving ARTS services at all levels of care. Peer recovery support resources are an integral component of community integration.

5.6 Mental Health Parity and Addiction Equity Requirements (MHPAEA)

At all times, the Contractor's coverage rules and authorization practices must comply with MHPAEA. In accordance with 42 CFR §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 42 CFR §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 42 CFR §438.910(d), the Contractor may not impose non-quantitative 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.

5.6.1 Aggregate Lifetime and Annual Dollar Limits

In accordance with 42 CFR §438.905(b), because the Department does not apply aggregate lifetime or annual dollar limits to at least one-third (1/3) of medical/surgical benefits, the Department does not allow aggregate lifetime or annual dollar limits on any behavioral health benefit regardless of classification.

5.6.2 Financial Requirements and Quantitative Treatment Limitations

Pursuant to 42 CFR §438.910(b)(1), the Contractor must not apply any financial requirements or treatment limitations to MH/SUD benefits in any classification (inpatient, outpatient, emergency and pharmacy) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical (M/S) benefits in the same classification furnished to enrollees.

5.6.3 Application Across Classifications

In accordance with 42 CFR §438.910(b)(2), if an enrollee of the Contractor is provided MH/SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), the MH/SUD benefits must be provided to the Member in every classification in which M/S benefits are

provided. This does not preclude the Contractor from limiting coverage for M/S and MH/SUD services on the basis of medical necessity.

5.6.4 Non-Quantitative Treatment Limits (NQTL)

In accordance with 42 CFR §438.910(d), the Contractor may not impose NQTL's for behavioral health benefits in any classification (inpatient, outpatient, emergency care or prescription drugs) 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 behavioral health 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.

5.6.5 Alignment with State Plan

In accordance with 42 CFR §438.3(e)(1)(ii), the Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance abuse benefits in 42 CFR §438, subpart K and only to the extent such services are necessary for the Contractor to comply with 42 CFR §438.910.

5.6.6 Mental Health Parity Reporting and Compliance Assurance Activities

As requested, the Contractor is required to provide documentation and reporting necessary to establish and demonstrate compliance with MHPAEA (42 CFR §438, subpart K) regarding the provision of MH/SUD benefits, as required by the Cardinal Care Technical Manual.

The Contractor must utilize the following Department definitions for purposes of mental health parity reporting and compliance assurance activities:

1. MH/SUD Services: services for the conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with the exception of:
    a. The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09);
    b. The conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79); and
    c. The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89).
2. M/S Services: services for the conditions listed in ICD-10-CM Chapters 1–4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6–20.
3. Benefit Classifications:
    a. Inpatient services: All covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a facility admission which will exceed twenty-four (24) hours.
    b. Outpatient services: All covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable) order/certification for a facility admission which will exceed twenty-four (24) hours, and does not meet the definition of Emergency care. This includes observation bed services for up to twenty-three (23) hours.

c. Emergency Care: All covered services or items (including medications) provided in an emergency department setting or to stabilize an emergency/crisis, when provided in a setting other than in an inpatient setting.
d. Prescription Drugs: Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

5.7 Emergency and Post-Stabilization Services

The Contractor must cover and pay for emergency and post-stabilization care services in accordance with the federal standards at 42 U.S.C. § 1396u-2(b)(2), 42 CFR §438.114, 42 CFR §422.113(c), and Section 1852(d)(2) of the Social Security Act, and in compliance with mental health parity rules per 42 CFR §438.910. The Contractor must cover emergency services without a service authorization.

5.7.1 Payment of Emergency Services

In accordance with 42 CFR §438.114(c) and Section 1932(b)(2) of the Social Security Act, the Contractor must cover and pay for emergency medical and behavioral health services as defined in Section 22, Definitions, and ensure that these services are available twenty-four (24) hours a day and seven (7) days a week, regardless of whether the provider that furnishes emergency services is a network provider. For out-of-network providers, all claims for emergency services must be reimbursed at the applicable Medicaid FFS program rate in effect at the time the service was rendered. The Contractor may not deny payment for treatment obtained if a representative of the Contractor instructs the Member to seek emergency services or an enrollee had an emergency medical condition as defined in Section 22, *Definitions*, including cases of severe pain, psychiatric disturbances and/or symptoms of substance abuse in which the absence of immediate medical attention would not have had the following outcomes:

1. Placing the Member's health (or, for a pregnant individual, the health of that individual or their unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

As described at 42 CFR §438.114(d), the Contractor cannot limit what constitutes an emergency medical or behavioral health condition on the basis of lists of diagnoses or symptoms nor can the Contractor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP, the Contractor, or an applicable State entity of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services. The Contractor may not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. The Department further requires the Contractor to ensure that Medicaid and FAMIS MOMS Members are not held liable for any charges for emergency services furnished by the Contractor's network or out-of-network providers. Similarly, the Department requires the Contractor to ensure that FAMIS Children are not held liable for any charges for emergency services furnished by the Contractor's network or out-of-network providers. The attending emergency physician, or the provider treating the Member, is

responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment.

5.7.2 Payment of Post-Stabilization Care Services

In accordance with 42 CFR §438.114(e), the Contractor must cover and pay for post-stabilization care services as defined in Section 22, *Definitions*, regardless of whether such services are obtained within or outside the Contractor's network, if such services are:

1. Preapproved by a network provider or a representative of the Contractor;
2. Not preapproved by a network provider or representative of the Contractor, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care; and
3. Not preapproved by a network provider or representative of the Contractor, but administered to maintain, improve, or resolve the Member's stabilized condition, if:
    a. The Contractor does not respond to a request for pre-approval within one (1) hour;
    b. The Contractor cannot be contacted; or
    c. The network provider and the treating physician cannot reach an agreement concerning the Member's care and a network provider is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a network provider, and the treating physician may continue with care of the Member until the network provider is reached or one (1) of the criteria for post-stabilization care services that it has not preapproved (below) is met.

Per 42 CFR §438.114(e), the Contractor's financial responsibility for post-stabilization care services that it has not preapproved ends when:

1. The network provider with privileges at the treating hospital assumes responsibility for the Member's care;
2. A network provider assumes responsibility for the Member's care through transfer;
3. The Contractor's representative and the treating physician reach an agreement concerning the Member's care; or
4. The Member is discharged.

Per 42 CFR §438.114(e), the Contractor must limit charges to Members for post-stabilization care services to an amount no greater than what the Contractor would charge the Member if they obtained the services through a Contractor's network provider. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. The Department further requires the Contractor to ensure that Medicaid and FAMIS MOMS Members are not held liable for any charges for post-stabilization care services furnished by the Contractor's network or out-of-network providers. Similarly, the Department requires the Contractor to ensure that FAMIS Children are not held liable for any charges for post-stabilization care services furnished by the Contractor's network or out-of-network providers.

5.7.3 Behavioral Health Crisis Services

The Contractor must provide coverage for behavioral health crisis services consistent the emergency and post-stabilization services provisions described above and in Attachment E, Cardinal Care Summary of Covered Benefits Chart.

5.7.4 Medicaid Hospital Readmission Policy

In accordance with Item 313 #BBBBB, Chapter 1289, 2020 Virginia Acts of Assembly and subsequent Appropriation Acts, hospital readmissions include cases when members are readmitted to a hospital for the same or a similar diagnosis within thirty (30) days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the member was originally discharged against medical advice. If the member is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases must be paid at fifty percent (50%) of the normal rate, except that a readmission within five (5) days of discharge must be considered a continuation of the same stay and must not be treated as a new case. Similar diagnoses must be defined as ICD diagnosis codes possessing the same first three (3) digits. Claims for readmission which occur within five (5) days of an original inpatient admission must be reviewed and reimbursed based on the actual diagnosis code submitted by the hospital. The MCO must adjust the payment of the first claim to reflect a payment for the combined case, and an adjust the second claim reflecting a zero payment where the second diagnosis is same or similar as described above.

5.7.5 Virginia Emergency Department Care Coordination Program

The Contractor must participate in the Virginia Emergency Department Care Coordination Program. Participation will require the Contractor to sign the ConnectVirginia Exchange Trust Agreement. The Contractor must work with the Department and hospital and physician representatives on any workgroup established by the Department, VDH, and/or ConnectVirginia to develop shared care coordination models to leverage this technology solution to improve outcomes for high-risk and high cost Members with high utilization of EDs or other high-risk populations.

The Contractor must describe activities supporting appropriate utilization of hospital emergency room services, to include incentives the Contractor provides for primary care practices that provide night and weekend hours and same-day appointments, and advanced levels of Care Management for those exhibiting high utilization of emergency services; and use of the ED Care Coordination encounter alerts and care coordination plans by MCO Care Managers to identify frequent ED utilizers and address their needs. Refer to the Cardinal Care Technical Manual.

The Contractor must ensure that its systems allow the Care Coordination Platform and Triage Algorithm to be continuously updated with the real time Admission Discharge Transfer (ADT) feeds from the Emergency Department Care Coordination solution.

5.8 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

In accordance with 42 CFR §441.50, the Contractor is required to provide early and periodic screening, diagnostic, and treatment (EPSDT) for eligible Medicaid beneficiaries under age twenty-one (21). Refer to Attachment E, Cardinal Care Summary of Covered Benefits Chart, Part 3A. EPSDT requires a broad

range of outreach, coordination, and health services that are distinct from general state Medicaid requirements. EPSDT services include periodic screenings (well visits) and interperiodic screenings as necessary, as well as vision, dental, and hearing services. The Contractor must comply with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct or ameliorate defects and physical and mental illnesses and conditions, or to maintain health status. Any treatment service which is not otherwise covered under the State Plan for Medical Assistance can be covered for a child through EPSDT, as long as the service is allowable under the Section 1905(a) of the Social Security Act. To comply with this requirement, the Contractor must design and employ policies and procedures to ensure that children receive prescreening and treatment when due. Such policies and procedures must be submitted to the Department in accordance with the requirements of the Cardinal Care Technical Manual. If the family requests assistance with transportation and scheduling to receive services, the Contractor must provide this assistance.

The Contractor must work with the Department and the other contracted MCOs to study the scope of underutilization of EPSDT resources among children. The study must include the following components:

1. Identification of underutilization issues within the population;
2. A quality improvement strategy to address the identified issues for this population; and
3. A mechanism for reporting results to the Department for the issues identified.

5.8.1 EPSDT Outreach

The Contractor must inform members about EPSDT services consistent with 42 CFR §441.56(a)(1). The Contractor must educate and inform Members identified as not complying with the EPSDT periodicity and immunization schedules, as appropriate. The Contractor must provide to the Department copies of any EPSDT materials sent to members and provide documentation as to the frequency and timing of such materials, as well as further outreach if notices are not successful.

The Contractor must ensure, through a combination of written and oral methods, that Medicaid-eligible children and their families are informed about (1) the EPSDT benefit, (2) the availability of screening services, and (3) that a formal request for an EPSDT screening service is not required. The Contractor must include information about EPSDT and how to access such services in its member handbooks. The Contractor must use clear and non-technical language to explain:

1. The benefits of preventive health care;
2. What services are available and where and how to obtain the services;
3. That EPSDT services are free to children and youth up to age twenty-one (21); and
4. That necessary transportation and scheduling assistance are available.

5.8.2 EPSDT Medical Necessity Review

The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child, and must fully consider EPSDT criteria. The Contractor must consider the child's long-term needs, not just what is required to address the immediate presenting problem. The Contractor must consider all aspects of a child's needs, including, but not limited to, nutritional, social development, and mental health and substance use disorders. Services for Medicaid children that do not meet the plan's general coverage criteria must

receive an individualized secondary review by a physician with experience in treating the Member's condition or disease and that ensures that the EPSDT provision has been considered. Service limits that apply to Medicaid recipients over age twenty-one (21) may not be imposed under EPSDT. The Contractor must not use a definition of medical necessity that is more restrictive than the state's definition. The Contractor must not issue a denial for a child's service until an individualized secondary medical necessity review has been completed.

EPSDT may provide other medically necessary health care, diagnostic services, treatment, and measures as needed to correct or ameliorate defects and physical, mental, and substance use disorders 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. The Contractor must cover medical services (even if experimental or investigational) for children per EPSDT guidelines if it is determined that the treatment or item would be effective to correct or ameliorate the child's condition. The Contractor is required to provide coverage for medically necessary care and services under EPSDT even if services are not available under the State's Medicaid Plan for the rest of the Medicaid population.

For children under age twenty-one (21) on the CCC Plus waiver, assistive technology, and private duty nursing are covered through EPSDT. These services are described further in Attachment E, Cardinal Care Summary of Covered Benefits Chart. The CCC Plus Waiver must be used for any services not covered under EPSDT, such as respite services and environmental modifications. For more information on the CCC Plus Waiver, see Section 5.12.2, *Commonwealth Coordinated Care Plus Waiver*.

For more information on EPSDT, visit the CMS Early and Periodic Screening, Diagnostic, and Treatment website https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

5.8.3 EPSDT Screenings

EPSDT Screenings include 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 American Academy of Pediatrics (AAP) policy statements and clinical guidelines and as required and indicated in the Screenings and Assessments provisions of this Contract. The Contractor must ensure that EPSDT medical screenings include:

1. 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.
2. A comprehensive unclothed physical examination, including:
    a. Vision and hearing screening;
    b. Dental inspection;
    c. Nutritional assessment;
    d. Height/weight and Body Mass Index (BMI) assessment; and
    e. The Contractor must require 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 must be documented in the medical record using a standardized screening tool. The Contractor must not require any service authorization associated with the appropriate billing of these developmental screening services (e.g., CPT 96110) in accordance with AAP recommendations.

3. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations must be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. The Contractor must also cover Covid-19 vaccine counseling visits for children and youth under EPSDT.
4. Appropriate laboratory tests. The following recommended sequence of screening laboratory examinations must be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and must be obtained as necessary.
    a. Hemoglobin/hematocrit;
    b. Tuberculin test (for high-risk groups); and
    c. Blood lead testing including venous and/or capillary specimen (finger stick) 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 (finger stick) must be confirmed using a venous blood sample.

In accordance with the Virginia "Reportable Disease" regulations at 12 VAC 5-90-215, the Contractor must ensure and require the directors of its laboratories to report all "detectable" blood lead levels for its members to the local Health Department within three (3) days. Lead reportable levels, consistent with 12 VAC 5-90-10, means any detectable blood lead level in children fifteen (15) years of age and younger and levels greater than or equal to five (5) µg/dL in a person older than fifteen (15) years of age. The Contractor's providers must report children's blood lead levels that are greater than or equal to five (5) µg/dL using the EP-1 form located on the VDH website.

5.8.4 EPSDT Treatment and Referrals

When a developmental delay has been identified by a provider for Contractor enrolled members under age three (3), the Contractor must ensure appropriate referrals are made to the Infant and Toddler Connection of Virginia and documented in the Member's records.

The Contractor must work with the Department to refer Members for further diagnosis and treatment or follow-up of all conditions uncovered or suspected. Persons outside of the health care system can determine the need for an interperiodic screen. If the family requests assistance with transportation and scheduling to receive services for early intervention, the Contractor must provide this assistance.

5.8.5 EPSDT 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 (6) month/biannual screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child aged 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.

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 must be covered. The Contractor must report utilization to the Department on an annual basis.

5.8.6 EPSDT Immunizations and Vaccinations

The Contractor must 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. The Contractor also must, as set forth in Section 5.8.3, *EPSDT Screenings*, work with its network providers to adhere to the ACIP recommendations.

The Contractor must encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health. The Contractor also must include enrollment instructions and a "Vaccines for Children" application (or, if electronic, a hyperlink to the application) in its provider network enrollment and reenrollment packages.

The capitation rate paid to the Contractor includes the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The Contractor must 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 must 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.

5.8.7 EPSDT Hearing Services

All newborn infants will be given a hearing screening after birth and before discharge from the hospital. 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 include 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 must include diagnosis of and treatment for defects in hearing, including hearing aids. At a minimum, hearing

screenings must include observation of an infant's response to auditory stimuli. A speech and hearing assessment must be part of each preventive visit.

5.8.8 EPSDT Private Duty Nursing (PDN)

The Contractor must cover medically necessary PDN services for children under age twenty-one (21), in accordance with the Department's criteria described in the Department's EPSDT Nursing Supplement and as required in accordance with EPSDT regulations described in 42 CFR §§441.50 et seq. Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT Private Duty Nursing must be reimbursed no less than the Department's fee-for-service rate.

Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing which provide for short-term, intermittent care where the emphasis is on Member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring of unstable conditions, and skilled interventions.

PDN for children under the age of twenty-one (21) enrolled in the CCC Plus Waiver is covered through EPSDT and is not a covered CCC Plus Waiver service.

Medically necessary PDN services rendered in the school setting and billed by an in-network, non-local education agency provider must be paid for by the Contractor in accordance with the Department's established criteria and guidelines for EPSDT PDN. Such services are not local education-based services. See Section 5.2.3 for more information on Local Education Agency-based services.

5.8.9 EPSDT Tobacco Cessation Services

The Contractor must cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy for children and adolescents. 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). (Refer to the State Medicaid Director Letter dated June 24, 2011, page 4).

5.8.10 EPSDT Vision Services

Periodic vision assessments appropriate to age, health history, and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), must be provided in accordance with the Department's EPSDT periodicity schedule. At a minimum, these services must include diagnosis of and treatment for defects in vision, including eyeglasses. Glasses to replace those that are lost, broken, or stolen also must be covered. Vision screening for infants must include, at a minimum, eye examination and observation of responses to visual stimuli. For older children, screening for visual acuity must be done. Vision services are also described in Attachment E, Cardinal Care Summary of Covered Benefits Chart.

The Contractor must 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. The Contractor must submit a *Vision Services Plan,* as described in the Cardinal

Care Technical Manual, that details the Contractor's plan and related efforts to increase utilization of vision services for children.

5.8.11 EPSDT Services for Adolescents and Youth with Substance Use Disorder (SUD)

The Contractor must ensure timely access to the full scope of coverage for Members younger than the age of twenty-one (21). For Members under the age of twenty one (21) who do not meet the medical necessity criteria upon initial assessment, a second individualized review by a licensed physician must be conducted to determine if the Member needs medically necessary treatment under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit described in the Social Security Act § 1905(a) and 12VAC30-130-5040 to correct or ameliorate defects and physical and mental illnesses and conditions, including SUD, discovered by the screening. The Contractor must ensure that providers working with children under age twenty-one (21) have experience in addiction treatment with children and adolescents.

5.8.12 EPSDT Clinical Trials

Clinical trials are considered on a case-by-case basis using EPSDT criteria when no acceptable or effective standard treatment is available for the child's medical condition.

5.8.13 EPSDT Documentation Requirements

EPSDT services are subject to the following additional documentation requirements:

1. The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT related services whether provided by the PCP or another provider;
2. Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized; and
3. The medical record must indicate when a developmental delay has been identified by the provider and an appropriate referral has been made.

5.9 Early Intervention (EI) Services

In accordance with federal and state law, children may be eligible to receive EI services from birth to age three (3) pursuant to 20 U.S.C. §§1431, 1432; Virginia Code § 2.2-5300; 12 VAC 35-225-70; and 12 VAC 30-50-131. EI services are not medically indicated for children aged three (3) and above. The Contractor must cover Early Intervention (EI) services as outlined in this Contract and related state and federal laws and regulations, as well as the Department of Behavioral Health and Developmental Services' (DBHDS's) Part C Manual and the Department's EI Program Manual. EI services are provided through Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 CFR §440.130(d), and 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 who have: 1) a twenty five percent (25%) developmental delay in one (1) or more areas of development, 2) atypical development, or 3) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

5.9.1 Early Intervention Contractor Requirements

In Virginia, the EI) services program is called the "Infant and Toddler Connection of Virginia" and is managed by the DBHDS. DBHDS contracts with forty (40) local lead agencies (LLAs) to facilitate implementation of local EI services statewide and is also responsible for certification of EI providers and service coordinators/case managers. The Contractor must develop and maintain a network of early intervention providers, certified by DBHDS, with sufficient capacity to serve its Members in need of EI services. EI providers must be reflected in the Contractor's networks. The Contractor's EI network must be sufficient in all disciplines to provide assessments and ongoing services in accordance with Federal timelines and DMAS program requirements. See Section 12.2.4.4, *Early Intervention Payments*, for EI payment requirements.

EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Part C funds are to be used as "payer of last resort" for direct services to children and families when no other source of payment is available pursuant to 20 U.S.C. § 1440 and 12 VAC 35-225-210. EI services must be recommended by the child's primary care provider or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition. When a developmental delay has been identified by the provider for children under age three (3), the Contractor must ensure appropriate referrals are made to the Infant and Toddler Connection and are documented in the Member's records. The Contractor must work with the Department to refer Members for further diagnosis and treatment or follow-up of all conditions uncovered or suspected.

If the family requests assistance with transportation and scheduling to receive services for Early Intervention, the Contractor must provide this assistance. The Contractor must coordinate with EI providers for children who "age out" (age three [3] and above) of the early intervention program and need to continue receiving services. The Contractor's Care Manager must ensure that services are transitioned to non-early intervention providers (i.e., Physical Therapy, Occupational Therapy, and Speech Language Pathology) as appropriate.

Children are first evaluated by the local lead agency to determine if they meet Part C requirements. If determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, the Department of Behavioral Health and Developmental Services (DBHDS) staff enters the early intervention (EI) level of care in the DMAS Medicaid system. Once the LOC is entered, the EI services are billable, and must be paid by the Contractor, based upon the physician's order on the Individualized Family Service Plan (IFSP). All EI service providers must be contracted with the child's health plan prior to billing.

The Contractor must provide coverage for EI services as described in the Member's IFSP developed by the local lead agency. Medical necessity for Early Intervention services will be defined by the Member's IFSP, including in terms of amount, duration, and scope. EI services are provided in accordance with the child's IFSP, developed by the multidisciplinary team, including the EI service team (two (2) or more individuals from separate disciplines or professions and one (1) of these must be the EI Service Coordinator), the family/caregiver, and the health plan Care Manager as applicable. The Contractor's Care Manager may collaborate with the EI Service Coordinator if unable to attend the IFSP meeting. The EI multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. EI services must

be performed by EI certified providers in the child's natural environment, to the maximum extent appropriate. Natural environments include the child's home or a community-based setting in which children without disabilities also participate.

The IFSP must be approved by the member's physician, physician assistant, or nurse practitioner. The signature of the physician, physician assistant, or nurse practitioner on the IFSP or a letter accompanying the IFSP or an IFSP Summary letter within thirty (30) days of the first visit for the IFSP service is required for reimbursement of those IFSP services. If physician certification is delayed, services are reimbursed beginning the date of the physician signature. The Contractor must ensure that its EI policies and procedures, including credentialing, follow Federal and State EI regulations and coverage and reimbursement rules in the Department's Early Intervention Services Manual and the DBHDS Infant and Toddler Connection of Virginia Practice Manual, available on the DBHDS Website.

The Contractor must not require any additional service authorization beyond what is indicated in the IFSP for EI services, as defined by EI codes, nor deny the EI services authorized in the IFSP, unless the child does not meet EI criteria or the billing provider is not a certified EI provider. The Contractor must work collaboratively with the LLA EI Service Coordinator to: (1) ensure the member receives the necessary EI services timely and in accordance with Federal and State regulations and guidelines, (2) to coordinate other services needed by the member, and (3) to transition the member to appropriate services. The Contractor must ensure that there are designated EI leads on their care coordination teams who are knowledgeable about EI services and related federal and state laws. EI leads must have demonstrated working knowledge in the operations of EI services and act as a point of contact for stakeholders and providers serving EI members.

The LLA EI Service Coordinator will send to the Contractor the following sections of the IFSP:

Section I – Child and Family Information
Section V – Services Needed To Achieve EI Outcomes
Section VI – Other Services

These sections must be forwarded to the Contractor upon initial development of the IFSP, when a change of service is indicated, and annually. The IFSP must become part of the Member's records. The LLA EI Service Coordinator must forward to MCO Section VII – Transition Planning - once the Transition Plan Section is developed. The Contractor may request other sections of the IFSP to assist in care management and provision on non-EI services.

If the IFSP (Sections I, V, and VI) is not on file, the Contractor must make every effort to obtain the IFSP from the LLA EI Service Coordinator or provider prior to processing the claim in order to prevent a premature denial of a claim. Lack of an IFSP (Sections I, V, and VI) on file with the Contractor will constitute a non-clean claim, except for the codes noted in Section 12.2.4.4, *Early Intervention Payments*.

5.10 Foster Care Covered Services

The Contractor must cover services for Members in foster care and adoption assistance (designation codes 070, 076 and 072, respectively), and adhere to the following:

1. For decisions regarding the foster care Member's medical care, the Contractor must 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 Member's medical care, the Contractor must work directly with the adoptive parent; and
2. For decisions regarding the medical care of former foster care or Fostering Futures Members (AC 070), the Contractor must work directly with the former foster care Members.

5.11 Covered Services for MAGI Adult Medicaid Expansion Population

In accordance with the Patient Protection and Affordable Care Act, states who cover the MAGI Adult Medicaid expansion population must do so through an Alternative Benefit Plan (ABP). In accordance with 42 CFR §440.347, ABPs authorized under section 1937 of the Social Security Act are required to meet essential health benefit (EHB) standards, including where these are not covered under the State Plan. The Virginia Medicaid MAGI Adult Medicaid Expansion ABP aligns with its Medicaid State Plan.

5.12 Long-term Services and Supports (LTSS)

Long-term Services and Supports (LTSS) are designed to assist individuals with health or personal needs, activities of daily living, and instrumental activities of daily living over a period of time. LTSS can be provided at home, in the community, or in various types of facilities, including Nursing Facilities.

LTSS may be provided in the home or community through a 1915(c) Home- and Community-Based Services (HCBS) waiver. The Department operates two (2) types of waivers, the CCC Plus Waiver and the Developmental Disability (DD) Waivers. The Contractor must comply with regulations and policy governing the CCC Plus Waiver. Individuals enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) waiver receive waiver services through the Contractor as well as medically necessary non-waiver services. Individuals enrolled in the DD waivers are covered under this Contract only for their medically necessary non-waiver services. The Contractor is responsible for knowledge of the services within the CCC Plus and DD waivers in order to educate members about these benefits and to assist members in accessing these LTSS services as appropriate.

Refer to Attachment E, Cardinal Care Summary of Covered Benefits Chart for more information on LTSS services, billing codes, and links to the Department's regulatory and policy guidelines.

In accordance with 42 CFR § 438.210(b)(2)(iii), the Contractor's authorization process for LTSS must be based on a Member's current needs assessment and consistent with the Member's person-centered service plan (See the CMS Home- and Community-Based Settings Final Rule located at https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html). Coverage decisions for LTSS must be provided in a manner that supports a participant in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The Contractor must cover appropriate LTSS based on needs identified through the initial LTSS Screening Instrument, other comprehensive assessments, and subsequent level of care reviews.

The Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the ICP determines that such authorization would provide sufficient value to the Member's care. Value must be determined in light of the full range of services included in the ICP, considering how

the services contribute to the health and independent living of the Member in the least restrictive setting with reduced reliance on emergency room use, acute inpatient care and institutional LTSS.

5.12.1 LTSS Screening Requirements

The Contractor must not reimburse a NF or CCC Plus Waiver services provider for services to any of its members who are newly admitted to a NF or the CCC Plus Waiver until all of the following has been completed:

1. A LTSS screening has been completed for the Member by an appropriate screening team (described below);
2. The screening has been entered into the electronic Medicaid LTSS screening (eMLS) record system (also described below); and
3. The individual is found to meet NF level of care criteria. Payment must not be made to the LTSS provider until the Contractor receives a copy of the screening. For those members who are not newly enrolled in a NF or CCC Plus Waiver who do not have a screening, the Contractor must notify the Department.

In accordance with Va. Code §32.1-330, all individuals requesting the Program of All-Inclusive Care for the Elderly (PACE), the Commonwealth Coordinated Care Plus waiver or LTSS nursing facility services and supports must receive a LTSS screening to determine if they meet the level of care needed for NF services. The Department contracts with the Virginia Department of Health (VDH), Virginia Department of Social Services (VDSS), PACE sites, hospitals and nursing facilities to conduct screenings for individuals. Community screenings for adults (over the age of eighteen (18]) are conducted by members of the local health departments (LHD) that include physicians and nurses along with social workers and family services specialists within the local department of social services (LDSS). Community screenings for children (up to the age of eighteen [18]) are contracted to a Department designee, currently VDH, through the local health departments in the jurisdiction where the child resides. Acute care hospitals utilize persons designated by the hospital to complete the LTSS screening. A Member receiving inpatient services in a hospital discharged to a nursing facility for skilled care only is not required to be screened prior to discharge from the hospital unless the Member requests the screening. The Nursing Facility LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services. Additionally, in accordance with Code of Virginia §32.1-330(G), if a member is admitted to a skilled nursing facility for LTSS without having been screened, the NF LTSS screening team may complete the screening. For these Members, coverage of LTSS shall not begin until six (6) months after the individual's admission to the skilled nursing facility unless the nursing facility can provide sufficient evidence to indicate that the admission without a screening was of no fault of the skilled nursing facility. See Section 5.12.3.4, *Nursing Facility Admissions and Discharges*, for more information.

Details about the screening process and the criteria for meeting the level of care required for eligibility for LTSS can be found in the Department's Screening Manual for Medicaid-Funded Long-Term Services and Supports (LTSS) on the Virginia Medicaid Provider Portal.

The LTSS screening process is automated through the Department's eMLS record system. The eMLS system is a mandatory paperless, automated payment and tracking system for all entities contracted by

the Department to perform LTSS screenings. The Department requires all LTSS screenings to be entered by the appropriate screening team into the eMLS automated system. Timeframes for the validity of the screenings are outlined in the Medicaid Long-Term Services and Supports (LTSS) Screening Manual.

A Medicaid LTSS Screening team, which may be a community-based team, hospital, or nursing facility team (only for those individuals who were not eligible for Medicaid upon admission and are transitioning from skilled care to LTSS), conducts the screening using forms such as the Uniform Assessment Instrument (UAI), the DMAS-96 (Medicaid Funded Long-Term Services and Supports (LTSS) Authorization Form), and other required forms. The LTSS Screening team determines level of care needs and enters the Member's screening information into eMLS. The LTSS Screening must successfully process and reflect a Medicaid LTSS authorization in order for LTSS to begin.

As part of the screening, individuals who are technology dependent also receive an age-appropriate Department CCC Plus Waiver with Private Duty Nursing (PDN) Adult Referral form (DMAS-108) or CCC Plus Waiver with Private Duty Nursing (PDN) Pediatric Referral form (DMAS-109). The CCC Plus Waiver must be offered to individuals who meet criteria as described in 12VAC30-60-303 and request this Waiver. Appropriate community-based services must be offered and explained to the individual prior to consideration of nursing facility placement; community-based services include the CCC Plus Waiver and the Program of All-Inclusive Care for the Elderly (PACE). (PACE participants are excluded from participating in the Managed Care Program.)

The LTSS screening includes the following documentation requirements referred to as the screening packet:

1. Uniform Assessment Instrument (UAI);
2. DMAS-95 MI/ID/RC (and DMAS-95 MI-ID/RC Supplement Form, Level II, if applicable) for individuals who select nursing facility placement;
3. DMAS-96 (Medicaid Funded Long-Term Services and Supports Authorization Form);
4. DMAS-97 (Individual Choice – Home- and Community-Based Services or Institutional Care or Waiver Services Form); and
5. DMAS-108 (Adults) or DMAS-109 (Children) for individuals who are technology dependent and need private duty nursing.

For Members that have screening determinations completed after enrolling in the Managed Care program, the LTSS screening information must be submitted to the Contractor by the LTSS screening team.

The Contractor must follow-up with the Member as expeditiously as the Member's health condition requires and within no more than five (5) business days following receipt of the information from the screening team. The Contractor must use information obtained from the LTSS Screening in the Assessment/ICP process.

Individuals must not be approved to receive Medicaid funded LTSS without having a screening on file that confirms the individual meets NF level of care. Exceptions to this process are outlined in 12VAC30-60-302. Excluding the exceptions outlined in 12 VAC 30-60-302, the Contractor must ensure the appropriate level of care documentation is on file for its Members prior to the Contractor's payment of

nursing facility or community-based LTSS claims. The term LTSS in this Section refers specifically to nursing facilities and the CCC Plus Waiver.

5.12.2 Commonwealth Coordinated Care Plus Waiver

On July 1, 2017, Virginia received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver covers a comprehensive array of community support services to individuals who are aged, who have a disability, or who are technology dependent and rely on a device for medical or nutritional support (e.g. ventilators, feeding tube, or tracheostomy). The CCC Plus Waiver has two (2) benefit plans: without private duty nursing (PDN) and with private duty nursing. Individuals who are enrolled in the private duty nursing benefit plan are eligible to receive all CCC Plus Waiver services as well as private duty nursing services. Individuals receiving the private duty nursing benefit are technology dependent and have experienced loss of a vital body function and require substantial and ongoing skilled nursing care.

In accordance with 12 VAC 30-120-905, CCC Plus Waiver services must not be furnished to individuals who are inpatients of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), inpatient rehabilitation facility, assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS. Transition services may be available to individuals residing in some settings if criteria are met. Additionally, certain CCC Plus Waiver services are not available to individuals residing in an assisted living facility licensed by VDSS that serves four (4) or fewer individuals. These services include respite, PERS, ADHC, environmental modifications, assistive technology and transition services. Personal care services may be covered for individuals living in these facilities but must be limited to personal care not to exceed five (5) hours per day. Personal care services must be authorized based on the individual's documented need for care over and above that provided by the facility. CCC Plus Waiver Services are only permitted to be authorized in settings that meet the CMS Home- and Community-Based Settings Final Rule.

5.12.2.1 **Level of Care (LOC)**

In order to be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a Nursing Facility, a specialized Nursing Facility, or a long-stay hospital. Enrollment into the CCC Plus Waiver requires a screening, performed by a hospital, community team, PACE provider or nursing facility as described in Section 5.12.1, *LTSS Screening Requirements*.

The Contractor is responsible for ensuring that the CCC Plus Waiver LOC is correct for its membership. It is important that the LOC information be updated timely so that the Member has access to the appropriate services and also to enable the Department to pay the Contractor at the correct capitation rate. See Section 15.2.2, Medicaid Capitation Reconciliation and Recoupment. The Contractor must follow the process described in Section 5.12.8, Entry Into the Virginia Medicaid Web Portal, for LOC entries and notifications to the Department regarding certain LOC admissions, discharges, and changes. The Contractor must enter CCC Plus Waiver LOCs into the web portal only for members with a valid LTSS screening documenting NF LOC is met, and when CCC Plus Waiver services have been initiated. For all new CCC Plus Waiver with PDN services (Waiver LOC A) admissions, the Contractor will enter the waiver LOC A directly into the Virginia Medicaid Web Portal after validating that the Member meets LTSS Screening requirements and after PDN services have been initiated.

5.12.2.2 Level of Care (LOC) Reviews

In accordance with 42 CFR §441.302(c)(2), LOC reviews must be completed at least annually. The annual LOC review may be completed up to sixty (60) calendar days prior to the annual due date for the Member. These LOC reviews are required to ensure that Members enrolled in the CCC Plus Waiver continue to meet the functional and medical criteria for continued enrollment in the waiver. The Contractor must submit to the Department the policies and procedures for its LOC Reviews in accordance with the requirements of the Cardinal Care Technical Manual.

In addition to the annual LOC review, the Contractor must initiate a LOC review at any time that there is evidence that the Member may not meet the CCC Plus Waiver LOC criteria. This could be based on the Care Coordinator assessment or information received from other sources.

LOC Reviews must be conducted using an assessment that includes all elements of the Level of Care Review Instrument (LOCERI), also known as the DMAS-99 Series Form. The Contractor must enter all required information for the LOCERI electronically using the Care Management Solution (CRMS) Module of the Department's Medicaid Enterprise System.

All Contractor Care Managers who meet the requirements to conduct LOC reviews (consistent with the HCBS § 1915(c) waiver) are required to complete the LTSS screening online training modules 1 and 2. Care Managers must pass the training before conducting LOC reviews and will need to complete and pass the training every three (3) years from the last date the training was passed. This training is offered online through Virginia Commonwealth University. Care Managers will need to first register through this link. Once registered, the training can be accessed through this link.

Care Managers must:

1. Register as **"**GUESTS"
2. Designate which health plan they belong to
3. Document their health plan email address

If these elements are not included, the Department is unable to record completion and passing of the training. It is the Contractor's responsibility to ensure Care Managers complete and pass the training as required, maintain documentation, and have it available upon request by the Department.

All LOC reviews for Members in CCC Plus Waiver must:

1. Be conducted face-to-face;
2. Be performed by individuals who meet the requirements as outlined in the HCBS § 1915 (c) waiver;
3. Be conducted timely (within three hundred and sixty-five (365) calendar days of the last annual LOC review or waiver admission date);
4. Be conducted when a Member experiences a change in status that could impact waiver eligibility;
5. Include all the elements on the DMAS-99 Series Form (Level of Care Review Instrument);

6. For Members who are receiving PDN services, the LOC review must also include all of the elements on the DMAS-109 (Private Duty Nursing Pediatric Form) or the DMAS-108 (Private Duty Nursing Adult Form); and
7. The review is to be conducted in the environment in which the Member spends the majority of his or her time (typically the home or ADHC).

For Members who transition from CCC Plus Waiver with PDN to CCC Plus Waiver without PDN (Waiver LOC A to 9) or CCC Plus Waiver without PDN to CCC Plus Waiver with PDN (Waiver LOC 9 to A) the Contractor must complete a LOCERI and submit it into the CRMS Portal to validate the LOC change. This must occur prior to making any waiver LOC change in the Virginia Medicaid Web Portal. Based upon CRMS Portal LOC entry outcome, the Contractor will enter any necessary waiver LOC changes directly into the Virginia Medicaid Web Portal within five (5) business days.

The Contractor must provide the Department with all LOC review data and results for its CCC Plus Waiver participants via the CRMS Portal within five (5) business days of completion of the LOC face-to-face review. All submitted information in the initial submission must be accurate and complete, as determined by the Department.

For individuals that do not meet criteria, the Department will conduct a second level review. During this review, the Department may contact the Contractor and/or the Member for additional information. The Contractor must provide the Department with any additional information requested within two (2) business days. If the Department's second level review confirms that the Member does not meet criteria, the Department will notify the Member and the Contractor in writing of the termination of the waiver (with appeal rights.)

Upon receipt of a copy of the waiver termination letter from the Department, the Contractor is required to notify all active CCC Plus Waiver provider(s) and terminate all associated waiver services authorizations (as described in the MCO process document, MCO Process Following Waiver Termination which will be provided by the Department.)

When CCC Plus Waiver services are terminated, the Contractor's Care Manager must assess and ensure the member's care plan includes the necessary supportive services, such as other covered services (i.e., home health, physical therapy, occupational therapy, DME, etc.,) community-based supports (i.e., home delivered meals, companion services, etc.,) primary caregiver supports, or Contractor enhanced benefits, to meet Member's care needs when waiver services are no longer in place. The Contractor's Care Manager must revise the Member's ICP accordingly. This includes when a Member transitions between LOC benefit plans (refer to the MCO process document, MCO Process Following Waiver Termination which will be provided by the Department.)

All waiver terminations resulting in a Member appeal will be led by the Department. The Contractor must work collaboratively with the Department on all appeal-related activities, must ensure all case information is accurate and complete, must have representation present for all appeals, and must defend the LOCERI submitted. If the Member requests continuation of services during the appeal process or if the appeal decision results in the Member regaining waiver eligibility, the Department will notify the Contractor.

The Contractor must maintain the LOC evaluation and reevaluation documentation for a minimum of ten (10) years from the date the LOC evaluation is completed in a searchable, electronic format. LOC evaluation and reevaluation documentation must be provided to the Department upon request and within required time frames and formats. Aggregate data from all participating health plans will be maintained by the Department for reporting purposes.

5.12.2.3 Individual Experience Survey (IES) for ADHC Members

In conjunction with the annual LOCERI assessment, the Contractor's Care Manager must conduct the IES provided by the Department. This is to ensure that the Member's services and supports are provided in a manner that comports with the requirements of the Home and Community Based Settings provisions outlined in 42 CFR §441.301(c)(4)-(5). The Department developed this survey in collaboration with the Cardinal Care managed care plans and it must be used without modification.

Care Managers must conduct the IES on all Members that attend an ADHC for the past two (2) months. The IES will need to be conducted in conjunction with the LOCERI assessment on an ongoing basis and must be included as part of the plan of care. All IESs for Members in an ADHC setting must be conducted face-to-face. The IES can be conducted at the ADHC facility or the Member's home. The ADHC staff must not be utilized to assist the Member with completion of the IES. The Contractor must maintain the IES as part of the Member record.

5.12.2.4 Individual Experience Survey (IES) Training

All Care Managers are required to complete the IES online training prior to administering the IES. Care Managers will need to complete the training every three (3) years from the date of the last training. The Contractor is required to track and monitor completion of the training by each Care Manager and maintain documentation of completion dates.

The training, power point presentations, FAQ document and DMAS Guidance is posted on the Department's SharePoint site.

The Contractor must create Policies and Procedures which include:

a. Identification of ADHC Members that are eligible for an IES;
b. Strategies to complete the IES in conjunction with the LOCERI assessment;
c. Tracking and monitoring of completion of the IES training by Care Managers;
d. Tracking completion of IES for ADHC Members;
e. Conducting quality reviews of completed IESs (for example, frequency and sampling methodologies of quality reviews; monitoring completeness of the IES (all questions of the IES are answered); monitoring accuracy of the IES (I.e., only one (1) answer is selected);
f. Utilize the IES for analysis and as part of the re-credentialing process of ADHC providers; and
g. Provide remediation at a CM level to work with the Member and ADHC for any objective findings.

The Contractor is required to submit IES-related reports and Policies and Procedures as detailed in the Cardinal Care Technical Manual.

5.12.2.5 CCC Plus Waiver Services

For Members enrolled in the CCC Plus Waiver, the Contractor must cover all services which provide Members an alternative to institutional placement. This includes the following qualifying CCC Plus Waiver Services: adult day health care, personal care (agency-directed and/or consumer-directed), private duty nursing, respite care (agency-directed and/or consumer-directed) or skilled respite care (agency-directed) as well as the following services that can be covered for individuals who receive at least one (1) qualifying waiver service: personal emergency response systems and medication monitoring, assistive technology, and environmental modifications. Transition services must be covered for those Members meeting criteria who are transitioning back to the community from a Nursing Facility or long-stay hospital. For children under age twenty-one (21) in the waiver, assistive technology and private duty nursing will be covered through EPSDT; however, the CCC Plus Waiver would be used for all other waiver services the member needs and is qualified for, such as personal care, respite, PERS, or environmental modification services. See Section 5.8, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for details regarding EPSDT. Also see Section 8.10.3, Transitions from NF to the Community and Attachment E, Cardinal Care Summary of Covered Benefits Chart.

5.12.2.6 CCC Plus Waiver Services Scope of Coverage

The Contractor must provide CCC Plus Waiver services at least in equal amount, duration, and scope as available under Medicaid FFS as described 12VAC30-120-924 and in Attachment E, Cardinal Care Summary of Covered Benefits Chart. Waiver services may be provided through agency-directed (AD) or consumer-directed (CD) models or both. CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

Hospice enrollment does not limit the waiver services an individual may receive. The Contractor must ensure that waiver services are coordinated with hospice services for members receiving both waiver and hospice benefits.

5.12.2.7 Consumer-Directed or Agency-Directed Services

A Member may receive consumer-directed (CD) services along with agency-directed (AD) services. A Member receiving CD personal care services can also receive Adult Day Health Care (ADHC) or agency-directed personal care. However, Members cannot simultaneously receive multiple/duplicative services. Simultaneous billing of personal care and respite care services is not permitted. The choice of CD is made freely by the Member or the authorized representative or caregiver, if the Member is not able to make a choice.

For both AD and CD care, the Member must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the Member, etc.) in case the personal care aide or CD attendant or nurse is unable to work as expected or terminates employment without prior notice. The identification of a back-up plan is the responsibility of the Member and family and must be identified and documented on the ICP. The back-up plan may be the primary caregiver, when the primary caregiver is not a paid attendant for the Member. Members who do not have viable back-up plans are not eligible for services until viable back-up plans have been developed. For AD care, the provider must

make a reasonable attempt to send a substitute personal care aide. If this is not possible, the Member must have someone available to perform the services needed.

The Contractor must only reimburse CCC Plus Waiver services when the Member is present; in accordance with an approved ICP; the services are authorized; and a qualified provider is providing the services to the Member. Services rendered to or for the convenience of other individuals in the household (e.g., cleaning rooms, cooking meals, washing dishes or doing laundry etc. for the family) are not covered.

5.12.2.8 Adult Day Health Care (ADHC)

Adult Day Health Care includes long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at-risk of placement in a nursing facility. The program must be licensed by the Virginia Department of Social Services (VDSS) as an Adult Day Care Center (ADCC).

5.12.2.9 Personal Care Services

Assistance with Activities of Daily Living (ADL) includes assistance with eating, bathing, dressing, transferring, and toileting, as well as medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Board of Nursing` regulations at 18 VAC 90-19-240 through 18 VAC 90-19-280. When specified in the individual service plan, personal care services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves. Supervision, as an allowable personal care service, must be provided pursuant to 12 VAC 30-120-924(D)(2)(c) and (d) and 12 VAC 30-120-924(G)(2)(b). CD skilled services must be provided pursuant to the Va. Code § 54.1-3001(12).

The Contractor must provide coverage for personal care services for work-related or post-secondary school-related personal assistance when medically necessary. This allows the personal care provider to offer assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal care services to meet their ADLs. Workplace or school supports through the CCC Plus Waiver are not provided if they are services provided by the Department for Aging and Rehabilitative Services, required under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

For CD services, when skilled care is needed, Va. Code § 54.1-3001(12) states “any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks” is exempted from

the Nurse Practice Act and nurse delegation requirements. Reference Chapter IV of the Department's Commonwealth Coordinated Care Plus Waiver Services Provider Manual for additional details.

In accordance with 12 VAC 30-120-924(B), the Contractor must develop policies and procedures for Department that include the ability to determine the capacity of Members to self-direct services, the criteria for determining when a person receiving services is no longer able to self-direct services received, and regularly verifying that appropriate services are provided. The Contractor has the option to use the DMAS-95 Addendum form to determine the Member's capacity to self-direct services. The policies and procedures should also address intermediate steps the Contractor will use to address emerging issues prior to resorting to involuntary disenrollment from consumer-directed services. Such policies and procedures must be submitted to the Department in accordance with the requirements contained in the Cardinal Care Technical Manual.

There are no maximum limitations to the number of personal care hours that an individual may receive. Personal care hours are based on medical necessity and must be used to maintain the individual in the community in order to prevent institutionalization. Under the fee-for-service program, personal care hours are limited to fifty-six (56) hours per week, where the Department provides exceptions based on medical necessity using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided. The Contractor must manage exception requests for its membership in accordance criteria is listed in 12VAC30-120–927 and contract standards. Refer to Section 6, *Utilization Management Requirements*.

Personal care is not a replacement of Private Duty Nursing (PDN) services and the two (2) must not be provided concurrently. Personal care cannot be used for ADL/IADL tasks expected to be provided during PDN hours by the RN/LPN. Trained caregivers must always be present to perform any skilled tasks not delegated in accordance with 18VAC90-19-280.

Personal care services may be provided by a Legally Responsible Individual of the Member. A Legally Responsible Individual is a parent, stepparent, or legal guardian of a minor child or spouse. Legally Responsible Individuals may be reimbursed for up to forty (40) hours per week. Respite care is not available when there is a legally responsible individual providing personal care services.

5.12.2.10 **Respite Care Services**

Respite care services are provided to Members who are unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief to the Member's unpaid primary caregivers who normally provides care. Respite care services may be provided in the community, the Member's home or place of residence, or a children's residential facility. Respite services include skilled nursing respite and unskilled respite.

Individuals may choose to use agency-directed (AD), consumer-directed (CD), or a combination of these models of service delivery. CD respite is only available to Members requiring unskilled respite care services. Respite care services are limited to four hundred and eighty (480) hours per individual per state fiscal year (July 1st through June 30th).

Respite services are not available for Members who have a paid Legally Responsible Individual as defined in Section 5.12.2.9, *Personal Care Services*, as their paid caregiver for personal care services.

5.12.2.11 Services Facilitation (SF)

Services Facilitation is a covered benefit that assists the Member (or the Member's family or representative, as appropriate) when consumer-directed services are chosen. The SF provider serves as the agent of the individual or family and the SF benefit is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the Member/family to be the employer. The SF benefit also includes offering and providing practical skills training to enable families and Members to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving. The SF benefit also includes providing information to ensure that Members understand the responsibilities involved with directing their services. The Contractor is permitted to furnish services facilitation benefits through qualified staff, credentialed providers, or by other qualified entities that are designated by the Contractor. When SF services are provided directly through Contractor staff, all SF requirements and documentation requirements outlined in 12 VAC 30-120-935(H)(7) must be maintained in the Member record.

5.12.2.12 Environmental Modifications (EM)

Environmental Modifications (EM) are not covered under Medicaid's State Plan durable medical equipment (DME) benefit, however, may be covered under the CCC Plus Waiver. Modifications may be made to a Member's primary residence or primary vehicle and must be of a remedial nature or medical benefit to enable the Member to function with greater independence. EM services must not be duplicative in homes where multiple waiver individuals reside. EM may not be used for general maintenance or repairs to a home, to increase the square footage of a home, or to purchase or repair a vehicle; however, it may be used for the repair of an accessibility feature (i.e., repair of a ramp or a van lift).

EM must be provided in conjunction with at least one (1) other qualifying CCC Plus Waiver service. EM may be covered up to a maximum of $5,000 per individual per fiscal year (July 1st through June 30th of the following year). Costs for EM must not be carried over from one (1) fiscal year to the next.

5.12.2.13 Assistive Technology (AT)

Assistive Technology (AT) not covered under the Medicaid State Plan DME benefit may be covered under the CCC Plus Waiver for Members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the Member's residence to specifically increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live.

AT are considered portable devices, controls, or appliances which may be covered up to a maximum of $5,000 per Member per fiscal year (July 1st through June 30th of the following year). The costs for AT must not be carried over from one (1) fiscal year to the next. When two (2) or more Members live in the same home (congregate living arrangement), the AT must be shared to the extent practicable and consistent with the type of AT provided.

AT must be provided in conjunction with at least one (1) other qualifying CCC Plus Waiver service. All AT requires an independent evaluation by a qualified professional who is knowledgeable of the

recommended item prior to authorization of the device. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

For children under the age of twenty-one (21), AT must be covered through EPSDT, and is not a CCC Plus Waiver covered service.

5.12.2.14 Personal Emergency Response System (PERS)

PERS is an electronic device that enables Members to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to those Members who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time. PERS services are also limited to those individuals ages fourteen (14) and older. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance. PERS must be provided in conjunction with at least one (1) other qualifying CCC Plus Waiver service.

The Contractor must assist members in accessing PERS when it is an identified need and included in the Member's ICP.

5.12.2.15 Private Duty Nursing (PDN)

PDN is a skilled nursing service ordered by a physician in the Plan of Care and provided by a licensed Registered Nurse (RN) or by a Licensed Practical Nurse (LPN). This service is provided to Members in the technology dependent subgroup who have serious medical conditions and complex health care needs. PDN is used as hands-on Member care, training, consultation and oversight of direct care staff, as appropriate. Adult Members who may qualify for PDN coverage must meet the criteria as described in 12 VAC 30-120-1720(B)(1)(c)(7). Members under the age of twenty-one (21) receive PDN coverage through EPSDT.

PDN hours through the CCC Plus waiver for adult Members are determined by medical necessity on the DMAS-108 form. All Members receiving PDN services must have a trained primary caregiver who must ensure that all hours not provided by a RN or LPN will be provided and must be documented in the provider's records along with a back-up plan.

5.12.2.16 Transition Services

The Contractor must provide Transition Services, including set-up expenses, for Members who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, which may include an adult foster home, where the person is directly responsible for his own living expenses. These services could include security deposits and the first (1^{st}) month's rent that are required to obtain a lease on an apartment or home; utility deposits; essential/basic household furnishings (furniture, appliances, window coverings, bed/bath linens or clothing); items necessary for the individual's health, safety, and welfare such as pest eradication and one (1) time cleaning prior to occupancy; fees to obtain a copy of a birth certificate or an identification card or driver's license; and other reasonable one (1) time expenses incurred as part of a transition.

Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition plan development process, are clearly identified in the transition plan and the person is unable to meet such expense, or when the services cannot be obtained from another source. See Section 8.10, Transitional Care Management.

5.12.2.17 LTSS Documentation Requirements

The following is the minimum documentation to be retained in the Member's Record by the Contractor. The Department reserves the right to adjust the chart as regulations and/or policy manuals are changed. The Department's forms may be found on the Department's provider portal.

Documentation	Frequency
RN Supervisory Visit (DMAS-103 for PDN/Tech Assisted Members)	Monthly for Members receiving PDN
Plan of Care (CMS-485) (Orders for skilled nursing services that include a specific number of nursing hours per day (i.e., not a range of hours)	Every sixty (60) calendar days
Plan of Care (DMAS-97 A/B; DMAS-7A)	Every twelve (12) months or more frequently as needs change
Telephone Communications with individuals/caregivers, providers, physicians, etc.	Daily or as needed
Initial Screening* (UAI, DMAS-95 [as applicable], DMAS-96, DMAS-97, DMAS- 108/109 as appropriate, MD order for Tech subgroup admission, etc. as applicable)	On admission
LOC Review	Annually and if there is a lapse of LTSS services > thirty (30) calendar days
Hospital summaries, discharge orders, additional medical record information (i.e. tests, procedures, etc.)	Hospital admissions, change in health status
Service Authorization Documentation	Initial, renewal, Change in hours or provider
Correspondence with Individual/Caregiver (letters)	Enrollment, Disenrollment, Change in provider, Change in hours, as occurs
Medicaid LTC Communication Form (DMAS- 225)	Enrollment, Disenrollment, other circumstances noted in Section 5.12.4.1, Long-Term Care Communication Form – DMAS-225

Documentation	Frequency
Health Risk Assessment	Refer to the Model of Care Assessment and Individualized Care Plan Expectations table
Individualized Care Plan	Refer to the Model of Care Assessment and Individualized Care Plan Expectations table
Interdisciplinary Care Team Report	As needed

*When available for Members who had services prior to the Member's Managed Care Program effective date.

5.12.3 Nursing Facility and Long-Stay Hospital Services

The Contractor must provide coverage for skilled and intermediate Nursing Facility (NF) care, including for dual-eligible Members after the Member exhausts their Medicare covered days. The Contractor must have contractual agreements with the Nursing Facility and payment for services must be made to NFs directly by the Contractor.

The Contractor, in conjunction with the Nursing Facility agreement, must:

1. Make a good faith effort to contract with physicians and ancillary providers who contract with NFs. Regardless, the Contractor must ensure that their Members residing in a Nursing Facility have timely access to all services, including when a Nursing Facility's provider refuses to treat the Member;
2. Work with NFs to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services;
3. Ensure that individuals in nursing facilities are assessed for, have access to, and receive medically necessary services for medical, and behavioral health conditions;
4. Have specific criteria and metrics to evaluate NF quality;
5. Promote innovative payment strategies to facilitate quality improvement with NFs; and
6. Establish specific resources and assistance for alternate placement of Members.

The Contractor must work with the NF to coordinate reassessments (functional and medical/nursing needs) for continued NF placement, including the incorporation of all MDS guidelines/timeframes for quarterly and comprehensive assessments, as well as ICP development.

5.12.3.1 **Specialized Care Nursing Facility Units and Long-Stay Hospitals**

The Contractor must coordinate with the Specialized Care Nursing Facilities and the Long-Stay Hospitals (LSH) to ensure that the needs of the Members (adults and children) are met.

This population has medical/nursing needs to exceed the needs of a typical nursing facility resident; this program was developed to address the more significant medical/nursing needs for these individuals.

Two (2) LSH serve individuals with complex medical/nursing needs: Hospital for Sick Children, located in Washington, DC, primarily serves pediatric individuals; Lake Taylor, located in Norfolk, Virginia serves

adults and children. The Contractor must work closely with these two (2) facilities to ensure Members receive the full scope of services needed and as covered under this Contract.

The Contractor must work with the Members and facilities to explore the option of discharge to a less restrictive setting and the setting must ensure the medical/nursing needs can be met for the individuals. The target population for specialized care and LSH includes individuals who may require mechanical ventilation, complex tracheostomy, comprehensive respiratory therapy, comprehensive rehabilitation services, and other life-sustaining services and treatment. The Contractor must ensure the health, safety, and welfare and needs and preferences of these Members including their family/representative involvement in any potential discharge.

The Contractor must incorporate all activities associated with traditional nursing facility individuals when working with individuals receiving services through either specialized care or LSH. The individuals must meet the underlying criteria for nursing facility placement in addition to requiring the level of care for specialized care or LSH.

Currently, the Department has a limited number of nursing facilities who have an add-on agreement to provide services under the specialized care program. The Contractor may contact the Department should they wish to add a nursing facility to provide specialized care services that is not currently enrolled with VA Medicaid as a Specialized Care Nursing Facility. The facilities must meet the minimum requirements as outlined for fee for service specialized care providers. The Contractor must work with the Department regarding the addition and approval of new specialized care providers.

The Contractor must not seek to add any additional LSHs to the program. The Department limits LSH participation to the two (2) currently enrolled providers.

5.12.3.2 **Out-of-State Placements**

The Contractor must limit out-of-state nursing facility placements to providers who are also enrolled as a provider in the Medicaid fee-for-service program. The provision for participation as a fee-for-service provider must be included in the Contractor's agreement with the out-of-state nursing facility provider to ensure that the member is held harmless from any liability other than the member patient pay, including in circumstances where the Member's Managed Care enrollment with the Contractor is interrupted.

For consideration of out-of-state nursing facility placement, the Contractor must ensure that the Member's needs cannot be met within the Commonwealth before considering out-of-state placement. The Contractor must document supporting evidence that there are no in-state resources prior to approving an out-of-state placement. The process for an out-of-state placement requires that the Contractor:

1. Notify the Department within two (2) business days of a request for an out-of-state placement;
2. Work with the Department on any out-of-state placement requests/referrals; and
3. Immediately following the Contractor's notification to the Department of a referral for an out-of-state placement, the Contractor must follow the Department's written guidance for out-of-state nursing facility placements. The Contractor may not approve an out-of-state placement

without DMAS approval. At a minimum, the process must include the participation and involvement of the Regional Transition Care Manager.

When considering an out-of-state facility, the facility must meet all the standard licensing and certification requirements within that state and have an active license to operate within that state.

Out-of-state placement into a Nursing Facility would follow all established processes and procedures as those followed by in-state nursing facilities. The Contractor must be prepared to participate in the admission, care planning and discharge process for the Members. Placement in an out-of-state facility does not relieve the Contractor of their responsibilities to the Member.

The Contractor must have agreements in place with out-of-state providers that ensures all provider participation requirements are satisfied prior to placement of any individual in a nursing facility.

5.12.3.3 Out of Area Placements

The Contractor must consider the needs of the Member when the Member cannot be adequately served in a facility located within the Member's permanent area of residence. Relocation to a facility in another region is allowable when the Member and/or the Member's representative agree that it is in the Member's best interest or there are no available beds in facilities able to meet the Member's needs within the region of the Member's residence.

The Contractor remains responsible for all services required under this Contract for its enrolled Members including when the Member resides in a Managed Care program region that is different from the region associated with Member's address of record in the Medicaid system. For example, a Member who resides in a nursing facility in Richmond, where the individual's address in the Medicaid system is located in the Tidewater region is not a reason for disenrollment from the Contractor.

5.12.3.4 Nursing Facility Admissions and Discharges

In order to receive nursing facility care, specialized care, or long-stay hospital services, an individual must meet the Nursing Facility-level of care (LOC). Admission requires a completed LTSS screening performed by a hospital or community team, prior to a nursing facility admission. The Nursing Facility LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital as described in Section 5.12.1, LTSS Screening Requirements.

In accordance with Code of Virginia §32.1-330(G), if a member is admitted to a skilled nursing facility for skilled nursing services and such individual was not screened but is subsequently determined to have been required to be screened prior to admission to the skilled nursing facility, then the nursing facility LTSS Screening team may conduct a screening after admission. In these circumstances coverage of institutional LTSS shall not begin until six (6) months after the initial admission to the skilled nursing facility. During this six-month period, the nursing home in which the individual resides shall be responsible for all costs indicated for institutional long-term services and supports that would otherwise have been covered by the Contractor, without accessing patient funds. Six (6) months after the date of admission to the skilled nursing facility, and as indicated through the eligibility determination, coverage of such services shall begin by the Contractor. To the extent that sufficient evidence is provided to

indicate that the admission without screening was of no fault of the skilled nursing facility, coverage of institutional LTSS will begin immediately upon the completion of the LTSS screening indicating nursing facility level of care pending the financial eligibility determination.

The Contractor must enter NF admissions and discharges into the Virginia Medicaid Web Portal. The Contractor must also enter changes to the NF level of care into the Virginia Medicaid Web Portal when a Member transitions between a skilled Medicare stay and a custodial Medicaid stay, or vice versa. Such NF admission/discharge and change transactions must be entered by the Contractor no later than two (2) business days of notification of admission/discharge or level of care change. Nursing facilities are responsible for notification to the appropriate MCO via the DMAS-80 form for admissions, discharges, or changes in level of care. In the event a DMAS-80 form is not received from the NF, the Contractor is responsible for entering the NF admission or discharge into the Virginia Medicaid Web Portal within two (2) business days of validating the member's NF status. Also refer to Section 5.12.1, LTSS Screening Requirements and Section 5.12.8, *Entry Into the Virginia Medicaid Web Portal*, for additional information on the level of care entry process.

The Contractor must submit the DMAS-225 to LDSS for all NF admissions or discharges within five (5) business days of receipt of the notice of the admission. For DMAS 225 information see Section 5.12.4.1, Long-Term Care Communication Form – DMAS-225].

5.12.3.5 Contractor Attendance at Care Plan Meetings

The Contractor must arrange with the NF to attend (either in-person or via teleconference) any and all care plan meetings for Members who are receiving NF services. Attendance at the care plan meetings will ensure that the NF is current with the care needs of the Member and will provide access to the Contractor by NF staff to discuss service options. Because of the flexibility of the Managed Care program, the Contractor may have access to a wider variety of services which could be offered to the NF on behalf of their enrolled Member.

The Contractor must actively participate in all care planning meetings by providing feedback regarding the status of the Member's care needs. The Contractor must coordinate outside care needs with the NF for their Member.

5.12.3.6 Extraordinary Care Management During Involuntary Relocation

The Contractor must be prepared to assist in the event that a NF's provider agreement with Medicare and/or Medicaid is terminated due to failure to meet licensure and certification requirements. The Contractor must be involved in any decisions regarding the relocation of Members under their care, to include natural disasters which require relocation.

The Contractor must also work with the Member and the NF to advocate on behalf of the Member in any circumstance where a NF attempts to involuntarily transfer or discharge a Member, and to ensure that a safe discharge plan is in place prior to the Member's NF discharge.

The Contractor must work with the NF and the identified relocation team which may include a combination of individuals from the Department, the Department for Aging and Rehabilitative Services

(DARS), the local Departments of Social Services, and the Long-term Care Ombudsman (either at the state or local level).

Relocation may consist of moving the Member to a different NF or discharging the Member home with waiver services. The Contractor must ensure that the Member is afforded the right to make informed choices about the settings in which they live and receive services. The Contractor must coordinate with the NF and relocation team in order to ensure that the needs and informed choices of the Members are addressed and that the Members and their representatives are aware of any activities associated with relocation.

5.12.3.7 Review of Section Q of Minimum Data Set (MDS)

The Contractor must ensure that Section Q of the MDS is completed and must participate in any discussions with the NF and any Members expressing an interest in returning to the community. The Contractor's Care Manager must independently assess the member's interest in discharge (see Section 8.9, Transitional Care Management). The Contractor must be prepared to offer transition services for discharge to the community if appropriate and the Member will be receiving CCC Plus waiver supports. The Contractor must support the Member's right to choose the setting in which he/she receives care and must work to ensure that the care received is in the least restrictive setting to ensure the Member's health, safety and welfare.

The Contractor must review with the Nursing Facility, and the Member or the Member's authorized representative, on at least an annual basis (or at such time as the interest is expressed by the Member) and whenever the Member expresses an interest in being discharged, any and all options for discharge from the NF. During regularly scheduled reassessments, the Contractor must explore the Member's interest in transitioning to the community even if Section Q information is not available.

5.12.3.8 Nursing Facility Mutual Aid Agreements

The Contractor must work collaboratively and proactively with its NF providers to support the mutual aid agreement (MAA) process for its membership. The MAA is a voluntary agreement between the disaster struck facility and one (1) or more receiving facilities for the purpose of providing mutual aid at the time of a disaster.

The Long-Term Care Mutual Aid Plan is an acceptable mutual aid agreement between facilities. The MAA addresses the loan of medical personnel, pharmaceuticals, supplies and equipment, and temporary residence for transferred residents. The disaster struck facility does not "discharge" its residents and the receiving facility does not "admit" the residents transitioning from the disaster struck facility. The receiving facility acts as a "contractor" to the disaster struck facility. The Contractor must ensure that reimbursement for NF care continues to the disaster struck facility (Member's facility of record) for NF Members who transition temporarily to an alternate facility under a mutual aid agreement in the event of a disaster. The Contractor must continue to reimburse the Member's facility of record for up to thirty (30) calendar days, including in circumstances where services are furnished by a receiving facility through a mutual aid agreement.

The Care Manager must continue to work closely with the Member throughout the MAA disaster transition process. This provision does not preclude the Contractor from its contractual obligation and

ability to ensure, for example through ongoing care coordination and transition planning, that Members continue to receive appropriate high quality care, consistent with the Member's needs and preferences. All NF treatment rules described in this contract remain in full effect throughout the MAA disaster related transition. If the disaster struck NF determines that it is not able to reopen within thirty (30) calendar days, it must discharge the individuals and work with the Contractor and the Member on long-term services and support placement options of their choice including home- and community-based services (HCBS) waiver, Program for All-Inclusive Care for the Elderly (PACE), or admission to other NFs.

This provision does not preclude a Member, based on the Member's preference, from transitioning to the community with home- and community-based services (waivers or PACE) or admission to other NFs. Reimbursement to the disaster struck nursing facility must cease when an individual is discharged.

5.12.4 Eligibility for Medicaid Coverage of Long-term Care Services

5.12.4.1 Long-Term Care Communication Form - DMAS-225

The Medicaid LTC Communication Form (DMAS-225) is used by the local Department of Social Services (LDSS) to inform LTSS providers of Medicaid eligibility and to exchange information. The Contractor must ensure that a completed DMAS-225 is in the record of each Member receiving NF, hospice or waiver services.

When a Member enrolled with the Contractor is determined to be newly eligible for LTSS, the Contractor must submit a DMAS-225 form to the LDSS eligibility worker, in order for the eligibility worker to re-evaluate Medicaid eligibility and determine the Patient Pay amount. The Contractor is required to adhere to the regulations regarding the collection of Patient Pay. Refer to Section 13.2, Patient Pay.

Immediately upon initiation of long-term care services, and within no more than five (5) business days from receipt of notice of initiation of long-term care services (NF, hospice or waiver services), the Contractor must send a DMAS-225 to the eligibility unit of the appropriate local Department of Social Services (LDSS) indicating the Contractor's first date of long-term care service delivery. The LDSS eligibility worker will complete a Medicaid eligibility redetermination and Patient Pay determination. The Contractor must not contact the LDSS inquiring about the status of the form prior to thirty (30) business days after submission. The Contractor must not require providers to submit the DMAS-225 to the Contractor or to LDSS. A copy of the completed DMAS-225 must be kept by the Contractor in the Member's file.

The Contractor must notify the LDSS via the DMAS-225 of information pertaining to the following circumstances and to exchange information, other than patient pay information:

1. There is a change in the LTC provider, including when an individual moves from CCC Plus Waiver to a nursing facility or the reverse;
2. Notification of a change in the enrollee's physical residence (e.g., out-of-state, in-state, incarceration);
3. There are changes in the patient's deductions (e.g., a medical expense allowable);
4. There are changes in eligibility status;
5. There are changes in third party liability; and

6. Any other changes that could impact Medicaid eligibility.

The Contractor must notify the LDSS via the DMAS-225 of the last date of long-term care service delivery when any of the following circumstances occur:

1. An individual dies (include the date of death); or
2. An individual is discharged or discontinued from services. The date of discharge or discontinuation should be the last date that long-term care services were rendered. This includes when the individual is discharged from one (1) provider to another.

The Contractor must send the DMAS-225 to LDSS within five (5) business days of the above status changes. The Contractor must ensure that the health plan contact information is listed on the form and that the form is completed in its entirety. The DMAS-225 is submitted only for Members who receive LTSS service (NF, hospice or waiver services). See Broadcast DMAS-31 regarding use of the DMAS-225 by Managed Care organizations located here.

5.12.4.2 Special Rules Related to Financial Eligibility for Long-Term Care

In rare circumstances, individuals who are Medicaid-eligible for most services may be determined by DSS to not be eligible for LTSS. For example, a Medicaid applicant (or spouse) who transfers ownership of his/her property within the "look back period" without receiving adequate compensation may be ineligible for Medicaid to pay for long-term care during a penalty period. There is no transfer penalty imposed on Medicaid eligibility for care other than long-term care. In this scenario, the long-term care service is considered non-covered. The LTSS provider is allowed to bill the Member for these as non-covered services if the provider has informed the Member prior to LTSS admission that if the Member is found by DSS to not be financially eligible for Medicaid funded long-term services, the Member will be held financially liable for the costs of long-term services. The information is detailed in the Virginia Department of Social Services Medicaid Eligibility Manual, Chapter M1450.000, available on the Department's website here.

5.12.5 Consumer Direction and Contract with the Fiscal/Employer Agent (F/EA)

The Department offers home- and community-based support services, approved by the Centers for Medicare and Medicaid Services pursuant to §1915(c) of the Social Security Act, for Medicaid individuals who would otherwise require a level of care provided in institutional settings the opportunity to remain in their homes and communities. Eligible Members may choose the Consumer-Directed model of service delivery for their personal care and respite services in which the Member, or someone designated by the Member, employs attendants and directs their care. The Member will receive financial management support in their role as employer by the Contractor's Fiscal/Employer Agent (F/EA) vendor.

The Contractor must subcontract with a qualified vendor who will operate as its F/EA Fiscal/Employer Agent (F/EA) vendor under Section 3504-1 of the IRS code, including Agent Employment Tax Liability proposed Regulations (REG-137036-08) issued by the IRS on December 12, 2013 and Revenue Procedure 70-6.

5.12.5.1 F/EA Requirements

The Contractor must comply with all requirements related to the F/EA, as detailed in this section.

A qualified F/EA vendor must have a separate Federal Employer Identification Number (FEIN) for the sole purposes of filing federal tax forms (IRS Forms 2678, 940, 941, W-2 and W-3) and paying federal taxes (Federal income tax withholding, FICA and FUTA) on behalf of the Members (employers) it represents as Agent.

The F/EA must obtain a FEIN for each Member or the Employer of Record and maintain copies of the FEIN, IRS FEIN notification, and copy of the filed form SS-4, in the Member's file.

A qualified F/EA must have significant experience in withholding, filing, and paying state income and employment taxes for employers and Personal Care Assistants (employees).

Financial Management Services, provided by the F/EA for eligible Members include:

1. Pre-employment services, including enrolling Members (employers) and their Personal Care Assistants (employees);
2. Criminal, child abuse and neglect, and other State and Federally required background checks;
3. Processing employee timesheets;
4. Deducting, filing, and paying State and Federal income and employment taxes and other withholdings;
5. Paying Personal Care Assistants (employees);
6. Providing customer service through a Call Center;
7. Providing training on F/EA enrollment and payroll processing procedures to Members and Service Facilitators or the Designated Entity responsible for supporting the Medicaid Member in managing his or her Personal Care Assistants; and
8. Providing an electronic visit verification (EVV) system compliant with the 21st Century Cures Act for personal care services.

The Contractor must have policies and procedures (including timeframes), and internal controls for implementing F/EA services that includes defined processes for all required IT and data exchange processes. The Contractor must submit for approval to the Department the policies and procedures for handling Consumer-Directed services and the F/EA as required by the Cardinal Care Technical Manual. The Contractor must have a dedicated project manager for Consumer-Directed services.

The Department reserves the right to conduct a readiness review of the Contractor's F/EA operations when deemed necessary, including any major system or service change, occurring during or after the Contractor's subcontracting with a new vendor. The Department will issue specific readiness review requirements under separate guidance to the extent they are applicable for implementation of F/EA services. Readiness reviews could be conducted up to sixty (60) days prior to the Contractor's implementation of a new F/EA services vendor.

5.12.5.2 Self-Service Web Portal and Website

The Contractor's F/EA must have a secure system, policies, procedures and internal controls for implementation and maintenance of a self-service web portal for Members, their employees, and services facilitators or other designated entities (i.e., Care Managers, staff of the F/EA, etc.). The portal must be integrated with the F/EA's financial management, enrollment, and electronic visit verification systems.

The roles based self-service web portal must be user-friendly, and accessible twenty-four (24) hours a day, seven (7) days a week, except for planned maintenance periods.

The self-service web portal must provide users with real time visibility of consumer-directed services information including:

1. Enrollment status;
2. Employer and employee demographics;
3. Timesheets;
4. Service authorization;
5. Service use;
6. Paystubs;
7. Tax;
8. Patient pay (if applicable);
9. Garnishments;
10. Withholdings; and
11. Year-end tax.

The Contractor's F/EA must post the following information to a website or incorporate in the web portal:

1. Routine program updates and communications;
2. User tutorials and technical assistance;
3. Applicable manuals;
4. Instructions for web portal access;
5. Alerts for program, payroll, tax, website maintenance periods, and other changes affecting Medicaid individuals and employees; and
6. Instructions on how to obtain information in non-English languages.

5.12.5.3 Service Initiation/Enrollment System

The Contractor must establish a process for F/EA service initiation for the Member. Services may be initiated by the services facilitator or other designated entity. The process must include verification of Member demographics including the Virginia Federal Information Processing Standards (FIPS) Codes and a process to notify the appropriate entity when a request is incomplete or contains errors. All service initiation requests must be processed including data verification and entry into the F/EA data base within three (3) business days of the receipt of the request.

5.12.5.4 Member/Employer Enrollment Packet Requirements

The Contractor's F/EA must develop, distribute or make available in electronic format, enrollment packets for each Member referred to by the designated entity within three (3) business days. The enrollment packet must be prepopulated to the maximum extent possible. The enrollment packet must be presented in a format that is easily understood. At a minimum, the packet must contain the following:

1. Introductory letter;

2. All required state and federal tax forms;
3. F/EA services, roles and responsibilities information;
4. Applicable federal forms to complete, sign, and submit;
5. Customer service contact information and hours of operation;
6. Criminal background, child abuse and neglect central registry information and requirements;
7. Information on the federal List of Excluded Individuals and Entities (LEIE);
8. Description of payroll periods, timesheet due dates and timelines for processing and payment distribution;
9. Notice of Discontinued Employment form; and
10. Electronic visit verification information.

5.12.5.5 Personal Care Assistant/Employee New Hire Packet Requirements

The Contractor's F/EA must develop, distribute or make available in electronic format, new hire packets for each employee within three (3) business days of receipt of the request. The hire packet must be prepopulated to the maximum extent possible. The hire packet must be presented in a format that is easily understood. At a minimum, the packet must contain the following:

1. Introductory letter;
2. F/EA services, roles and responsibilities information;
3. Customer service contact information and hours of operation;
4. Criminal background, child abuse and neglect central registry information and requirements;
5. Information on the federal List of Excluded Individuals and Entities (LEIE);
6. Required federal employment eligibility, tax, and related forms that the employee must sign and submit with accompanying instructions;
7. Required state forms with accompanying instructions;
8. Description of payroll periods, timesheet due dates and timelines for processing and payment distribution;
9. Direct deposit information and debit card options;
10. Notice of Discontinued Employment form;
11. Disclose employee's relationship to the employer per IRS Publication 15-Circular E Form;
12. Verification methods in place to verify a live in attendant's legal name and physical address. Forms of identification can include but are not limited to driver's license, voter registration card, banking statement, credit card statement, utility bill statement, and cell phone statement;
13. Enrollment options when internet access in unavailable; and
14. Electronic visit verification information.

5.12.5.6 Background Checks

State and Federal laws and regulations (Federal list of Excluded Individuals and Entities, or LEIE) require prospective Personal Care Assistants to pass background checks. Background checks include Virginia State Police Criminal Background checks; Virginia Department of Social Services Child Abuse and Neglect Central Registry checks when the Member is under the age of eighteen (18); the Federal list of Excluded Individuals and Entities (LEIE) database checks; and, employment eligibility checks.

Background checks are required at the time of initial employment, re-employment by the same employer, and employment by another Member. Personal Care Assistants may work and be paid for services for up to thirty (30) calendar days pending the results of criminal and child abuse and neglect background checks.

Personal Care Assistants must be terminated from employment and are prohibited from receiving payment effective the date of discovery of a barrier crime or a founded complaint by the DSS child protective services central registry by the Contractor's F/EA.

The Contractor's F/EA must be obligated to perform and pay for reference checks. Members must not be charged for the cost of background checks. The Contractor's F/EA must have controls for processing all required employee background checks that minimally includes:

1. Criminal, child abuse and neglect, and federal LEIE database background checks for prospective employees;
2. Maintaining results in each employee's file and in the employer and/or employee's web portal self-service account;
3. Written notification to the employer, upon discovery, when the results of the background check disqualify the employee from employment; and
4. A system for blocking the employee in the F/EA payroll system from receiving payment effective the date that adverse findings are received by the F/EA.

5.12.5.7 Electronic Visit Verification

The Contractor's F/EA must have an EVV system that will electronically verify and collect data and meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). Refer to Section 11.14, Electronic Visit Verification.

5.12.5.8 Contractor Database and Automated Payroll Systems

The Contractor's F/EA must have an automated system that has the capacity to exchange files with the Contractor. The automated payroll system must verify data to ensure accurate payroll. The system must receive, verify and maintain electronic Service Authorizations authorized by the Contractor. The system must have the ability to request and receive eligibility and patient pay data as established by the Contractor.

The Contractor's F/EA must conduct twice monthly payroll that meets federal and state Department of Labor and Industry wage, hour, and pay date requirements for hourly employees. Prior to payment, timesheets must pass all system edits and are paid in accordance with the appropriate pay rate.

The Contractor's F/EA payroll processing system must have the ability to calculate and make accurate payments to employees. The Contractor must calculate and make accurate payments to attendants who live in the home of a Medicaid individual and work more than forty (40) hours in one (1) work week to be compensated at the regular hourly rate in accordance with Fair Labor Standards Act (FLSA) and the Department guidelines. Employees who live in the home of the Member are exempt from overtime payments in accordance with the FLSA. Overtime pay is not permitted for any employee who lives in the home of the Member.

The Contractor must calculate and make accurate payment to attendants who are authorized to receive time and a half up to sixteen (16) hours for a single attendant who works more than forty (40) hours per work week.

The Contractor's F/EA must have a payroll and audit process, claims and billing process, and distribution system that has the capacity to provide sick leave to providers of consumer-directed personal, respite or companion care, in accordance with the Code of VA, Title 40.1, Chapter 3, Article 2.1. The Contractor's F/EA must ensure that, at a minimum, the following requirements are met:

1. Attendants who work on average at least twenty (20) hours per week where the average number of hours worked is calculated by using a calendar quarter as the reference period;
2. The determination of eligibility for paid sick leave must be conducted at the end of the calendar quarter and is based on hours worked that have been reimbursed;
3. Time worked during the quarter that is reimbursed more than twenty (20) days after the end of the calendar quarter will not be included in the determination of paid sick leave eligibility for the calendar quarter;
4. Upon meeting the average of twenty (20) hours per week in any calendar quarter, employees must continue to accrue sick leave until the termination of employment;
5. Eligibility for an attendant to accrue sick leave must be determined on an annual basis at the beginning of every fiscal year.
6. Eligible attendants must accrue a minimum of one (1) hour of paid sick leave for every thirty (30) hours worked for all employees. Paid sick leave must be carried over to the year following the year in which it was accrued. Sick leave must not be counted as time worked in determining eligibility for paid sick leave for any subsequent period;
7. An employee must not accrue or use more than forty (40) hours of paid sick leave in a fiscal year;
8. The F/EA must create a process and system edits that will disallow accrued sick leave balances to be payable upon termination or resignation;
9. Paid sick leave must begin to accrue when the first shift worked is submitted and approved by the employer;
10. Hours are accrued on a fiscal year schedule July 1st – June 30th;
11. Attendants with a failed criminal background result do not qualify for sick leave payment;
12. An employer must not provide all paid sick leave at the beginning of the year;
13. Sick leave balances must be displayed on the attendant pay stub;
14. Sick leave balances must be available to the EOR;
15. The Contractor is not required to collect documentation to justify the paid sick leave has been used for a specific purpose;
16. Attendants may use sick leave in fifteen (15) minute increments;
17. Sick leave must not be counted as time worked and must not be included in the calculation for overtime payments;
18. An attendant must submit sick leave hours used within thirty (30) days. Sick leave hours submitted for payment after thirty (30) days will be denied;
19. Sick leave must be incorporated in the billable rate calculations and deposited into a non-interest bank account;

20. The Contractor must provide the sick leave accrual and utilization report to the Department on a quarterly basis. The elements to be added to the monthly scorecard report include:
    a. Accrual amount earned during the quarter
    b. Accrual amount used during the quarter
    c. Accrual amount earned year-to-date
    d. Accrual amount used year-to-date;
21. Sick leave must not apply to the Difficulty of Care (DOC) tax exemption. Sick leave is taxable income;
22. Employee Sick Leave accruals must be specific to the Employer (EOR) relationship;
23. A F/EA to F/EA process must be developed for transition attendants; and
24. Direct deposit and debit card payroll solutions must be made available to all attendants.

The Contractor's F/EA must capture the following data elements in the payroll database:

1. Medicaid Individual and Employer of Record (EOR)

    a. Name;
    b. Medicaid ID number;
    c. Eligibility status;
    d. Birth date;
    e. Social Security Number;
    f. Demographics and contact data;
    g. FIPS codes;
    h. FEIN;
    i. Individual's relationship to employee(s);
    j. Individuals relationship to EOR;
    k. Enrollment data;
    l. Enrollment status;
    m. Enrollment and Tax forms completion status; and
    n. Tax filing data.

2. Services

    a. Procedure codes and names;
    b. Waiver types;
    c. Patient pay (if applicable);
    d. Service Authorization (SA) Number;
    e. SA units and date ranges; and
    f. SA hours used and balance.

3. Employee

    a. Name;
    b. Employee ID Number;
    c. Social Security Number;
    d. Demographics;
    e. Enrollment Date;

f. Enrollment and Tax Forms Completion Status;
g. Enrollment Status;
h. Background Check Status and Results;
i. Pay Rates (Northern Virginia and rest of State);
j. Billable Rates (Northern Virginia and rest of State);
k. Payroll Schedule;
l. Pay Period;
m. Tax Status;
n. Employment Agreement Signed;
o. Tax Filing, Exemptions, Allowances, and Withholdings;
p. Garnishments and Liens; and
q. Employee Pay Distribution - Bank Account/Debit Card Transit Number.

4. Timesheet and Payroll

a. Timesheet Number;
b. Timesheet Authorized Signatures;
c. Dates Worked;
d. Hours Worked;
e. Timesheet Status;
f. Timesheet Pend Reasons;
g. Timesheet Import Type – Web, Manual;
h. Journal Posting Dates;
i. Pay Date;
j. Check/EFT/Debit Card Payments;
k. Payment Authorized/Blocked;
l. Check Number; and
m. Pay Check Amounts.

5. Services Facilitator (if applicable)

a. Agency Name;
b. ID Number; and
c. Demographics and Contact Data.

5.12.5.9 Patient Pay Through the F/EA

Some Medicaid individuals receiving Consumer-Directed services have Patient Pay responsibilities for services received, as determined by local Department of Social Services eligibility workers. Patient Pay is a source of payment that is reported as income on the employee's W-2 and deducted for the employee's net (not gross) wages.

Should the Contractor choose to withhold patient pay from consumer-directed payments, the Contractor must develop a policy and procedure describing how the F/EA must accurately deduct Patient Pay amounts from employees' paychecks. The Member is responsible for paying the patient pay to the attendant. The F/EA must make any remaining payments owed to the attendant.

5.12.5.10 Pay Rates and Administrative Services Organization (ASO) Payments for F/EA Services

The Contractor's reimbursement for consumer-directed personal care and respite must be the same as the Department's reimbursement. The Contractor must have two (2) employee pay rates:

1. A higher rate for employees of Members residing in Northern Virginia; and
2. A base rate for employees of Members residing elsewhere in the State. Billing rates are reviewed and adjusted in accordance with pay and tax rate changes. Data elements must be determined by the Department and include unduplicated waiver Members service types, employees, timesheet dates, hours worked, net pay billable rates, and amounts billed. Refer to the listing of CD pay rates here.

The F/EA must submit timely, accurate, and complete reports and refunds to each Contractor as defined in the F/EA Reports and Refunds due to the Contractor chart below. The Contractor must provide the Department with written quarterly reports of findings and recommendations within thirty (30) days of receipt of a complete submission from the F/EA in accordance with the reports schedule.

F/EA Reports and Refunds Due to the Contractor	Quarter Ending	Contractor Report and Refund Due
Quarterly Payroll Register Quarterly Payroll Tax Reconciliation Summary IRS Form 941 VA-5 VEC-FC-21/20	March 31 June 30 September 30 December 31	May 20 August 20 November 20 February 20
Monthly Bank Statements for the Quarter Monthly Bank Reconciliations for the Quarter Quarterly Check Register Monthly Cleared Checks Reports for the Quarter Listing of Uncashed and Cancelled (Voided) Checks over one hundred and eighty (180) calendar days from Issue Date Employer Tax Filing Penalties and Interest Incurred Report and refund	March 31 June 30 September 30 December 31	May 20 August 20 November 20 February 20
Amounts due to (from) Contractor's Payroll Tax Reconciliation Report	March 31 June 30	May 20 August 20

Refund due to Contractor for Uncashed and Cancelled (Voided) Checks over one hundred and eighty (180) calendar days from Issue Report and refund to Contractor or proof of credit to the CD-Services Payroll Payment Account for bank penalties and interest incurred	September 30 December 31	November 20 February 20
Copy of the Annual FUTA Tax Return with proof of receipt of payment from the IRS.	Annual	February 20
Refund, to Contractor, for employer portion of annual, over collected FICA immediately following F/EA's refund, for overpaid taxes, from the IRS	Annual	April

5.12.5.11 **Tax Processes, Reconciliation, and Refunds**

The Contractor must ensure the following responsibilities are met and scope of services are performed in accordance with the Department's requirements. The Contractor's F/EA must have a system, policies and procedures, timeframes and internal controls for the following:

1. Withholding taxes and filing IRS form 941, Employers Quarterly Federal Tax Return and IRS form 941 Schedule R, Allocation Schedule for Aggregate Form 941 Filers or Report of Tax Liability for Semi-weekly Schedule Depositors Schedule B (as applicable depending upon required deposit frequency) in the aggregate, with its separate FEIN for all individuals it represents and maintain a copy of each IRS form;
2. Paying FICA and federal income tax withholding in the aggregate for all individuals it represents using the F/EA's separate FEIN and for maintaining relevant documentation;
3. Withholding and filing IRS for 940, Schedule R, to pay FUTA in the aggregate in an accurate and timely manner and maintain relevant documentation;
4. Paying FUTA in the aggregate, per IRS depositing rules, and for maintaining relevant documentation;
5. Obtaining employer registration numbers for state income and unemployment tax withholding, filing, payment, and retiring registration numbers when the individual no longer is an employer, and maintaining relevant documentation;
6. Withholding and filing state income tax withholding for all employees, per state requirements and for maintaining relevant documentation;
7. Paying state income tax withholdings in the aggregate using the F/EA's Fiscal/Employer Agent State Withholding Account Number per state requirements and maintaining relevant documentation;
8. Withholding and filing state unemployment insurance for each individual it represents per Virginia Department of Labor and Industry requirements and maintaining relevant documentation;

9. Paying state unemployment taxes in the aggregate using the F/EA's Employer Agent State Withholding Account Number for each individual per Virginia Department of Labor and Industry requirements and maintaining relevant documentation;
10. Managing all garnishments, levies and liens on employee's payroll checks in an accurate and timely manner, as permitted by the Code of Virginia and Virginia Department of Labor and Industry and maintaining relevant documentation;
11. All federal tax deposits must be made by electronic funds transfer per IRS requirements; and
12. Investigate and resolve uncashed or cancelled (voided) checks as required by § 55-210.1 -§ 55-210.30 of the Code of Virginia and 42 CFR §433.30.

The Contractor must provide to the Department quarterly reviews and analysis of F/EA withholdings and tax processes and supporting documents including withholdings, tax filings, and payments of State and Federal income and employment taxes. The Contractor must require the F/EA to ensure the accuracy and timeliness of all enrollment and tax obligations. Refer to the Cardinal Care Technical Manual for the required format.

The Contractor must ensure the following responsibilities are met and scope of services are performed in accordance with the Department's requirements. The Contractor's F/EA must have a system, policies and procedures, timeframes and internal controls for the following:

1. Identifying employees due FICA refunds, determining their current mailing address and refunding FICA to applicable employees who did not earn the required annual gross wage amount for which employer and employee FICA is required to be calculated, withheld, and deposited for employees, per IRS requirements and maintaining relevant documentation;
2. Preparing, filing, and distributing IRS form W-2, Wage and Tax Statement, for employees per IRS Instructions for Agents for electronic filing when processing 250 or more IRS form W-2's by January 31st of each year and maintaining relevant documentation;
3. Preparing, filing, and distributing IRS form W-3, Transmittal of Wage and Tax Statements, in the aggregate for all Members per IRS Instructions for Agents and maintaining relevant documentation;
4. Preparing, filing, and distributing IRS form VA-6, Employer's Annual or Final Summary of Virginia Income Tax Withheld Return, and form W-2, state copy, and maintaining relevant documentation;
5. Complying with all applicable state and federal laws and requirements for transferring employer and employee records and information to another F/EA Vendor when applicable;
6. The F/EA must provide the Contractor with a copy of the Annual FUTA tax returns, with proof of receipt of payment from the IRS;
7. The F/EA must provide the Contractor with an electronic VEC-FC-21/20 copy of the employers Quarterly Tax Report, including proof of funds received, by the Virginia Employment Commission;
8. The F/EA must provide the Contractor with an electronic copy of form 941-Employer's Quarterly Federal Tax Return, including proof of funds received by the Internal Revenue Service and any amended returns;

9. The F/EA must provide the Contractor with an electronic copy of form VA-5 Employer's Return of Virginia Income Tax Withheld, with proof of funds received by the Virginia Department of Taxation;
10. The F/EA must provide to the Contractor, a report of all penalties and interest incurred on federal and state employer tax filings during the quarter that are not shown on the forms submitted. The report must include an explanation of each charge and its disposition; and
11. The F/EA must provide to the Contractor, a Quarterly report of uncashed or cancelled (voided) checks beyond a period of one hundred eighty (180) calendar days from the issuance date including the amount refunded.

5.12.5.12 Customer Service Call Center

The Contractor must ensure that Members have access to consumer-directed F/EA information available by telephone. The Contractor must provide and maintain a Call Center for F/EA services through a dedicated toll-free number. The Contractor must provide for language translation services and use Virginia Relay Service for Deaf and Hard of Hearing. The Call Center must provide twenty-four (24) hours a day, seven (7) days a week access to timesheet and payroll inquires.

5.12.5.13 Satisfaction Survey

The Contractor must assess Member and attendant satisfaction with F/EA services including but not limited to enrollment, timesheet (clock-in/clock-out), electronic visit verification, payroll services, tax processing, call center responsiveness and customer service, and web-based services and information.

The Contractor must ensure a minimum sample of ten percent (10%) of the total number of unduplicated, active Members who had paychecks issued to employees at any time during review period. Survey specifications must be reviewed and approved by the Department prior to conducting the survey. Survey results must be provided to the Department annually on October 1st.

5.12.5.14 Employment and Earnings Verification

The Contractor's F/EA must have a system for completing employment verifications, Social Security earnings verifications, and other ancillary requests within the timeframes established by the requestor. The Contractor must attend Virginia Employment Commission (VEC) hearings upon request from VEC.

5.12.5.15 Training, Education and Outreach

The Contractor must ensure the following responsibilities are met and performed in accordance with the Department's requirements. The requirements may be performed by the Contractor, the Contractor's F/EA, or Subcontractor as approved by the Department.

1. Prepare written communication, participate in stakeholder meetings, training sessions and provide web-based outreach and training materials, as approved by the MCO, for users of the system;
2. Provide initial, refresher, and ongoing system training at least annually to Members, employees, and Services Facilitators (as applicable); and

3. Provide a detailed plan for initial and ongoing training, including a training manual and web-based training models. The Vendor F/EA must address how questions will be received and answered upon completion of implementation and ongoing support initiatives.

5.12.5.16 Disaster Recovery

The Contractor must require the F/EA to develop a Disaster Recovery Plan that complies with federal guidelines 45 CFR §164.308, identifying every resource that requires backup and to what extent the backup is required. The Disaster Recovery Plan must at a minimum, include daily backups in the event of a system failure and include offsite electronic and physical storage located in the United States. The Disaster Recovery Plan must identify the software and data backup requirements, demonstrating the ability to connect and interface with the system in the event of system failure. The Disaster Recovery Plan must be provided to the Department during readiness review.

5.12.5.17 Quality Assurance Plan

The Contractor must have an internal Quality Assurance (QA) plan and system in place with documented policies and procedures and internal controls for all key deliverables and requirements as described in the scope of work for Consumer-Directed Services. The QA plan must be submitted to the Department during readiness review and the results must be provided to the Department quarterly. The QA plan must at a minimum include the following:

1. Ten percent (10%) per quarter sampling of each key operations area;
2. Performance analysis as compared to each performance standard;
3. Outcome measurement tools;
4. F/EA Vendor annual performance review results; and
5. F/EA staffing requirements that mirror industry standards.

The Contractor must, at any time a deficiency in the F/EA's performance is identified, request a Corrective Action Plan to address noncompliance. The Contractor must notify the Department of F/EA noncompliance on a monthly basis, outlining the approach to resolving the issues.

5.12.6 Hospice

Managed Care program Members who elect to enter hospice care will remain enrolled in the Managed Care program. A Member may be in a waiver and receive hospice services. The Contractor must cover all services associated with the provision of hospice services for its enrolled Members. The Contractor must ensure that children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. The Contractor is responsible for providing information to Members about the availability and function of hospice services. Refer to Attachment E Cardinal Care Summary of Covered Benefits Chart for coverage details regarding hospice services, including when services will be available in the Member's home, an inpatient facility, or a NF.

To receive inpatient hospice services, an individual must be enrolled in the hospice level of care (LOC). The admitting facility's information is submitted by the hospice agency to the Contractor via a 421a, hospice admission form. The Contractor must enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of notification of admission/discharge.

5.12.7 Refusal of LTSS Waiver Services or Annual LOC

The Contractor must submit notification to the Department for individuals who have refused services or refused Annual LOC evaluation, according to the specifications contained in the Cardinal Care Technical Manual. The Department will review the notifications submitted and provide follow-up instruction to the Contractor regarding the Member's CCC Plus Waiver status after receiving the notification. The Department will outline the notification communication details and requirements through separately issued guidance.

5.12.8 Entry into the Virginia Medicaid Web Portal

The Contractor must enter hospice, NF specialized care and LSH hospital admissions, discharges and changes, admissions into excluded NFs, and CCC Plus Waiver admissions directly into the Virginia Medicaid Web Portal (LTC Tab). The Contractor must not enter LOC benefit information until the applicable services (NF, specialized care, LSH, CCC Plus Waiver, and Hospice) have started. The Contractor must only enter changes into the Department's Portal for the dates of service when the Member is enrolled with the plan. The Contractor must not attempt to void any LOC benefit entered in error but must notify the Department at the time of occurrence by email. The Contractor must not enter these changes into the Portal for dates of service when the Member was receiving Medicaid Fee-For-Service or was enrolled with a different health plan. Should the Contractor have difficulty entering changes into the Portal, the Contractor must notify the Department by email.

5.12.8.1 **Nursing Facility (Including Specialized Care and Long-Stay Hospital)**

The Contractor must enter Nursing Facility, specialized care, and LSH admissions and discharges into the Virginia Medicaid Web Portal. The Contractor must also enter changes to the NF level of care into the Virginia Medicaid Web Portal when a Member transitions between a skilled Medicare stay and a custodial Medicaid stay, or vice versa. Such admission/discharge and change transactions must be entered by the Contractor no later than two (2) business days of notification of admission/discharge. The Contractor must provide outreach and education to providers who do not notify the Contractor promptly. Also refer to Section 5.12.1, LTSS Screening Requirements.

1. For specialized care admissions, the "change source code" must be entered to identify the level of Specialized Care being authorized; and
2. For LSH admissions, the provider NPI submitted on the DMAS-80 must be entered or clarification must be requested from the provider. Lake Taylor has both a standard NF NPI which is excluded and an included LSH NPI. Accurate portal entry is required in order to prevent member exclusion from Managed Care.

5.12.8.2 **CCC Plus Waiver**

The Contractor must enter CCC Plus Waiver enrollments directly into the Virginia Medicaid Web Portal. Such admission and change transactions must be entered by the Contractor no later than two (2) business days of notification of the initiation of Waiver services, often the date the initial service authorization is processed. Also refer to Section 5.12.1, LTSS Screening Requirements.

The Contractor must not enter CCC Plus Waiver discharges into the Virginia Medicaid Web Portal.

Prior to making any enrollment entries, the Contractor must contact the Department Care Management Unit by email for clarification in any instance where the Contractor is unsure of or requires Department guidance or clarification on the CCC Plus Waiver eligibility criteria.

5.12.8.3 CCC Plus Waiver LOC Changes

The Department's Care Management Unit will monitor the Contractor's performance for accuracy of LOC entries, especially with the application of CCC Plus with PDN (Waiver LOC A) criteria. As part of the Care Management oversight in this area, the Department will retrospectively review the portal entries and may request a copy of Member records for further review. The Contractor must submit complete clinical records upon request for the Department's review. The Department will review the submitted clinical documentation to ensure that the Contractor is applying the Department's LTSS benefit plan criteria correctly. The Department will provide follow-up technical assistance to the Contractor as appropriate.

The Contractor must contact the Department's Care Management Unit by email or phone for clarification in any instance where the Contractor is unsure of or requires guidance or clarification on the CCC Plus Waiver criteria, prior to enrollment entries, especially but not limited to the CCC Plus with PDN benefit (Waiver LOC A).

5.12.9 Reporting of LTSS Service Reductions and Denials

The Contractor must report LTSS service reductions, suspensions, or terminations to the Department on a monthly basis as described in the Cardinal Care Technical Manual. The Department will review a sample of the Contractor's LTSS authorizations that include a reduction, suspension, or termination in personal care and/or private duty nursing services to ensure that reductions, suspensions and terminations were done appropriately. This review will also include a determination of whether, consistent with 42 CFR §438.420, enrollees were provided all appeal rights afforded through the Contractor and State Fair Hearing process with the ability to continue services, in accordance with 42 CFR §438.420, during the appeal.

5.12.10 Waiver Assurances

The Department will meet Federal requirements for all Medicaid Waivers that provide the Department with authority to implement the Managed Care program and any component of the Managed Care program such as ARTS. The Contractor must fully comply and implement to the Department's satisfaction any delegated activities by the Department for any Federal waiver requirements. An example of these requirements is the HCBS waiver assurances under the following domains:

1. Level of Care;
2. Service Plan;
3. Qualified Providers;
4. Health and Welfare;
5. Financial Accountability; and
6. Administrative Authority.

The Contractor must conduct quality management reviews for the HCBS waivers and programs. Quality management reviews (QMRs) focus on the development and implementation of the plan of care (POC). Reviewers determine if the plan is person-centered, based on the assessment, and whether it addresses the individual's needs and personal goals. Provider documentation of services is reviewed to determine if services were delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan and delivered by qualified providers. QMR details are discussed with the provider at an exit conference during the review and are further explained in a letter sent to the provider. These reviews will be monitored by the Department in accordance with parameters required through the Department's waiver application and related policies and procedures. The Contractor must follow all of these quality assurance procedures and protocols, which are provided by the Department in the Cardinal Care QMR Technical Guide.

The Contractor must report on the Waiver assurance measures according to the requirements and timelines described in the Cardinal Care Technical Manual.

5.13 Maternal and Infant Health Services

5.13.1 Maternity Care

The Contractor must develop a comprehensive Maternity Care program which includes the provision of prenatal and postpartum services for pregnant individuals in the Managed Care program, including care management for high-risk pregnant individuals and infants (See Section 8.12.2, Care Management for High-Risk Pregnant Individuals and Infants). The Contractor must ensure that in the provision of services the Maternity Care program aligns with and advances the following goals:

1. Ensure access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant individuals;
2. Ensure an increase in postpartum care including maternal mental health screenings;
3. Reduce early elective deliveries;
4. Reduce infant mortality and morbidity;
5. Reduce low birth weight premature infants and neonatal intensive care unit stays;
6. Support health equity;
7. Support lower C-Section rates;
8. Increase family planning access;
9. Increase HEDIS scores related to maternity;
10. Implement Addiction and Recovery Treatment Services (ARTS), specifically for pregnant individuals with substance use disorder (SUD);
11. Increase screenings for SUD for both high-risk and non-high-risk mothers (Monthly Maternal Reports);
12. Increase outreach and education, including the use of social media, to pregnant individuals; and

Collaborate with the Department on initiatives targeted to pregnant and parenting individuals. When the Department determines a pregnant individual's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum individual, the Contractor must:

1. Inform mother/parent/guardian that in order for the newborn to be covered, the mother/parent/guardian must report the birth of the child by either calling the Cover Virginia Call Center at (855) 242-8282 or by contacting the Member's local Department of Social Services.
2. Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290;
3. Cover services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; and
4. Cover prenatal and infant programs as outlined in this contract.

See Section 10.7.3, Maternity Reporting and the Cardinal Care Technical Manual for information about the measures the Department uses when determining the quality of the Maternity Program.

For individuals enrolled in FAMIS MOMS, covered services are the same as the covered services within the Medicaid Managed Care program in accordance with 12 VAC 30-141-820. FAMIS MOMS enrolled Members are eligible for Residential Treatment Services (ASAM Levels 3.3 to 3.7) furnished in an IMD (see Attachment E, Cardinal Care Summary of Covered Benefits Chart).

Individuals enrolled in FAMIS PC will receive the same comprehensive benefits as FAMIS MOMS throughout the pregnancy and birth, with a sixty (60) day postpartum period under the new FAMIS Prenatal Coverage. Refer to Attachment E, Cardinal Care Summary of Covered Benefits Chart for more information about covered benefits for these populations.

5.13.1.1 Prenatal Care Requirements

The Contractor must have written policies and procedures that outline how the Contractor will provide access to prenatal services for all pregnant individuals, including identifying and tracking the needs of high-risk Members, which must be submitted to the Department in accordance with the requirements contained in the Cardinal Care Technical Manual. At a minimum, the policies and procedures must outline how the following requirements will be met:

1. Within ten (10) days of identification, the Contractor must send information to pregnant individuals to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services and ensure continuity of care and care coordination services are handled appropriately, including stratifying the risk level of the pregnancy;
2. The Contractor must cover all obstetric and gynecological services as stated in Section 5.13.2, Obstetric and Gynecologic Services;
3. The Contractor must ensure that the travel time and distance standards are met as stated in Section 7.2.1, Member Travel Time and Distance Standards;
4. The Contractor must ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant Members as listed in Section 7.2.14, Appointment Timeliness Standards.
5. The Contractor must 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, tobacco cessation, and family planning), etc.;

6. The Contractor must ensure that every pregnant member is advised of the value of HIV testing as set forth in 12 VAC 30-50-510 and must request that each pregnant Member consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Pregnant Members must have the right to refuse consent to testing for HIV infection and any recommended treatment; Documentation of such refusal must be maintained in the Member's medical record;
7. The Contractor must ensure service authorization requirements do not apply to basic prenatal care as stated in Section 6.1, Service Authorization;
8. The Contractor must cover the services of certified nurse-midwives as stated in Section 5.13.1.4, Ancillary Services;
9. The Contractor must disseminate information about the WIC Program to potentially eligible women, infants, and children; and
10. The Contractor must make its best effort to contact the high-risk member and/or the member's physicians to identify and assess the specialized needs of the member (medical, psychosocial, nutritional, etc.).

5.13.1.2 Community-Based Doula Services

The Contractor must provide community-based Doula services as a covered service to address many of the drivers of poor maternal and child health outcomes. Community-based Doulas or "Doulas" are individuals based in the community who offer a broad set of non-clinical pregnancy-related services centered on continuous support throughout pregnancy and in the postpartum period. Emotional, physical, and informational supports provided by Doulas include childbirth education, lactation support, and referrals for health or social services. Like other community health workers, Doulas provide culturally congruent support to pregnant and postpartum individuals through their grounding within the unique cultures, languages, and value systems of the populations they serve.

The Contractor must collaborate with the Department to review and approve specific policies and plans regarding the contracting, reimbursement, recruitment, and training of Doulas. The Contractor will have a designated contact and point person available to assist Doulas for the first twenty-four (24) months of the program. The Contractor will work with Department and VDH on communication, training and education of providers, member and Doulas. The Contractor will work with the Department on network adequacy and reporting.

Medicaid is the primary payer for doula services as these services are not covered under commercial insurance.

Subsequent, Postpartum, and Multiple Visit Doula Requirements

The Contractor must provide support for Doulas who will conduct up to nine (9) touchpoints with the Member. These nine (9) touchpoints do not require service authorization and include eight (8) prenatal / postpartum visits in addition to one (1) Doula touchpoint (attendance) at delivery. Doula visits beyond the "visit limit" of eight (8) prenatal/postpartum visits and one (1) attendance at delivery may be authorized if medically necessary. The "visit limit" applies to a Doula-Member pair; if a Member receives care from more than one (1) Doula, each Doula's visits to the Member count only toward that individual

Doula's visit limit. Doula services can only be provided in the community, in clinicians' offices (if a Doula is accompanying the Member to a clinician visit) or in the hospital.

Subsequent prenatal service visits:

1. Must be conducted at least one (1) day after Doula's initial prenatal service visit, and no later than the date of delivery;
2. Up to three (3) subsequent prenatal visits can be billed; and
3. Attendance at delivery (vaginal); Attendance at delivery (cesarean).

Postpartum service visit:

1. Must be conducted no earlier than the date of delivery, and no later than one hundred eighty (180) days after date of delivery; and
2. Up to four (4) postpartum visits can be billed.

Multiple visits are not allowed in the same day except when:

1. A prenatal Doula visit occurs early in the day, and an attendance at delivery Doula visit later in the day; or
2. An attendance at delivery Doula visit occurs early in the day, and a postpartum Doula visit later in the day.

See Attachment E, Cardinal Care Summary of Covered Benefits Chart for a list of covered Doula services.

Doula Qualifications

Community-based Doula services will be delivered by providers with training as outlined by the Department and certified by the Virginia Department of Health (VDH) or designated certifying board. Upon implementation of the state Doula certification and registration process as established by VDH, a Doula must meet the qualifications and education requirements established by VDH through the state Doula certification and registration process in order to be enrolled as a Doula, as defined herein, under the Virginia Medicaid program. In order to receive reimbursement from Medicaid, Doulas must enroll as a Medicaid provider and complete the Federal and State screening. Doulas must submit documentation demonstrating state Doula certification as part of the Medicaid provider enrollment process.

Referrals to Doulas

All Contractors must use the Department-issued Doula recommendation form. The Contractor must be prepared to be billed directly by Doulas for services as long as those services were referred by: Physicians, Certified Professional Midwives, Certified Nurse Midwives, licensed midwives, nurse practitioners, physician assistants, and other Licensed Mental Health Professionals (LMHPs: physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed substance abuse treatment practitioner, licensed marriage and family therapist, and certified psychiatric clinical nurse specialist). These licensed provider types are best positioned to ensure that the Member who accesses Doula services also accesses key maternal and child health clinical services a physician or other licensed provider might provide acting within their scope of practice.

5.13.1.3 Maternal Mental Health Screenings and Referrals

The Contractor must, through agreements with its providers, make every reasonable effort to screen pregnant individuals (or refer to an appropriate practitioner to screen) for mental health concerns in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. The Contractor must have a process to refer individuals who screen positive for mental health concerns to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment. All Contractor staff conducting these screenings must be trained in the administration of such screens and must have the necessary training to ensure appropriate Member support and treatment for identified mental health concerns.

5.13.1.4 Ancillary Services

1. **Certified Nurse-Midwife:** The Contractor must cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260;
3. **Day and Residential Treatment for Substance Use Disorder:** Day and residential treatment for substance use for pregnant and postpartum individuals must be covered as outlined in the ARTS requirements; and
4. **Expanded Prenatal Care Services:** The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510:
    a. Nutritional assessment, counseling, and follow-up, as well as blood glucose meters;
    b. Addiction and recovery treatment services;
    c. Patient education in areas such as labor and delivery, Lamaze, planned parenthood, smoking cessation, substance abuse, and child rearing; and
    d. Household maintenance services for pregnant individuals, primarily in third trimester, who need bed rest.

5.13.1.5 Postpartum Services

The Contractor must promote and incent access to and adherence to timely and adequate postpartum services. Strategies may include scheduling postpartum visits before discharge, telephone reminders, member incentives, etc. The Contractor must have written policies and procedures that outline how the Contractor will provide access to postpartum services, which must be submitted to the Department in accordance with the requirements contained in the Cardinal Care Technical Manual. At a minimum, the policies and procedures must outline how the following requirements will be met:

1. **Early Discharge Follow-up Visit:** The Contractor must cover at least one (1) early discharge follow-up visit 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 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 must 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;

2. **Lactation Consultation and Breast Pumps:** The Contractor must cover lactation consultation and breast pumps;
3. **Substance Use Intervention:** The Contractor must develop care management and coordination structures to manage pregnant and postpartum populations with histories of or current substance use. These structures must focus on planning strategies to facilitate a recovery environment that addresses improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches;
4. **Family Planning Services:** The Contractor must cover family planning services as stated in 7.2.5, Family Planning Service Access;
5. **Transition Planning:** The Contractor must assist pregnant members who are twelve (12) months postpartum and who may qualify for another Medicaid aid category with assistance in transitioning to that aid category (Medicaid Expansion). The Contractor must develop a transition plan to assist members to assure that their newborn child is enrolled in Medicaid, if eligible, and submit it to the Department. Refer to the Cardinal Care Technical Manual for report specifications;
6. **Well Visits:** The Contractor must work to ensure that the Member is aware of standards for well visits and ensures utilization in accordance with Section 5.13.3.4, Well Baby and Well-Child Care . The Contractor must include in care management efforts for postpartum individuals, efforts to connect them with ongoing wellness and preventive appointments as clinically appropriate;
7. **Safe Sleep Practices:** Through its Safe Sleep program, the Contractor must educate parents and caregivers regarding the steps they can take to prevent infant sleep-related death and to emphasize safe sleep practices; and
8. **Plans of Safe Care:** The Contractor must ensure that care management staff include a plan of safe care for children who are both living with a Member receiving a positive screen for substance use disorder and/or safety planning for the Member's potential child.

5.13.1.6 Maternity Reporting for Pregnant and Postpartum Individuals

The Contractor must report monthly to the Department information on services for all high-risk and non-high-risk infants and pregnant and postpartum individuals, as outlined in the Cardinal Care Technical Manual.

The Department is working with the Centers for Medicare and Medicaid Services (CMS) to finalize the evaluation design for the twelve (12) month postpartum coverage extension for the 1115 demonstration. The evaluation will measure Virginia's progress in meeting the following goals: 1) Promote continuous coverage and continuity of care for women in the postpartum period; 2) Increase access to medical and behavioral health care services and treatments for women in the postpartum period; 3) Improve health and financial outcomes for postpartum Medicaid and CHIP enrolled women; 4) Improve health access and health outcomes for infants of postpartum Medicaid and CHIP enrolled women; 5) Advance health equity by reducing racial/ethnic and other disparities in maternal health coverage, access, and outcomes as well as infant health outcomes among postpartum Medicaid and CHIP enrolled women and their infants.

The Contractor agrees to cooperate with the Department to provide data and information to support required federal reporting on demonstration goals.

5.13.2 Obstetric and Gynecologic Services

The Contractor must cover routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered Members. See Section 22, Definitions for the definition of "health care services." The Contractor must permit any female member aged 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. The Contractor must reimburse OB/GYN services in at least the amount reimbursed under the Medicaid fee schedule. In accordance with 42 CFR §438.206(b), 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.

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.

5.13.2.1 **Mammograms and Mastectomies**

In accordance with 12 VAC 30-50-220(B)(1), the Contractor must cover screening mammograms for female Members ages thirty-five (35) and over, consistent with the guidelines published by the American Cancer Society, and for FAMIS Members as medically appropriate. The Contractor must meet all requirements set forth in 12 VAC 30-50-220.

The Contractor must 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 and Va. Code § 32.1-325(A)(13). The Contractor must cover reconstructive breast surgery in accordance with 12 VAC 30-50-140, and must cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

5.13.3 Family Planning

The Contractor must cover family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions. See 12 VAC 30-50-130. The Contractor must provide appropriate family planning and/or health services based on the Member's desire for future pregnancy and must assist the Member in achieving her plan with optimization of health status in the interim. The Contractor must provide education on available family planning services. Covered services include family planning services, including drugs, supplies, and devices by network and out-of-network providers provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 CFR §441.20. Consistent with 42 CFR §441.20, the Contractor must

provide coverage for its enrolled Members for methods of family planning including but not limited to barrier methods, oral contraceptives, vaginal rings, contraceptive patches and long acting reversible contraceptives (LARCs). Use of long acting reversible contraceptives should be encouraged and barriers such as service authorization or quantity limits must not be required for approval. The Contractor must cover 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.

In accordance with 1902(a)(23) of the Social Security Act and 42 CFR §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. Federal law (42 CFR §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.

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.

5.13.3.1 Hysterectomies

The Contractor may not impose a thirty (30) day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor must 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.

5.13.3.2 Sterilizations

The Contractor must not perform sterilization for a Member under age twenty-one (21). The Contractor must comply with the requirements set forth in 42 CFR §441, Subpart F, as amended, and must comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, § 54.1-2976. Pursuant to 42 CFR §441.258, the Contractor must ensure that the consent form (DMAS-3004) is obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the Member being informed, the Member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. Pursuant to 42 CFR §441, Subpart F as amended, the Contractor must comply with State and Federal reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department as required by the Cardinal Care Technical Manual.

5.13.3.3 Abortions

The Contractor is prohibited from covering abortion services other than as described in Attachment E, Cardinal Care Summary of Benefits Chart. The Contractor must submit to the Department 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 at the time of the request.

5.13.3.4 Well Baby and Well-Child Care

The Contractor must cover all routine well baby and well-child care recommended by the American Academy of Pediatrics Advisory Committee including routine office visits with screenings; health assessments; physical exams; routine lab work; age-appropriate immunizations; lead testing and investigation, and well-child services per Attachment E, Cardinal Care Summary of Covered Benefits Chart. The Contractor must ensure the provision of services meets EPSDT and HEDIS scheduling.

The following services must be rendered for the routine care of a well-child:

1. Well-child visits rendered at home, office and other outpatient provider locations are covered at birth and months, according to the American Academy of Pediatrics recommended periodicity schedule;
2. Annual vaccinations without limitations to age, and immunizations in accordance with the American Academy of Pediatrics recommended immunizations for children and adolescents. ;
3. 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; and
4. Periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services must include diagnosis of and treatment for defects in hearing, including hearing aids.

5.13.3.5 Infant Care

The Contractor must develop a comprehensive Infant Care program for the provision of services to infants ages zero to three (0-3) years in the Managed Care program. The Contractor must ensure that any strategies and innovations implemented in the provision of services align with and advances the following goals:

1. Increase in infant immunizations;
2. Increase in well visits and required EPSDT screenings;
3. Implement safe sleep initiatives;
4. Provide early intervention services;
5. Provide services for substance-exposed infants (SEI) and infants with Neonatal Abstinence Syndrome, including care management as described in Section 8.12.2, Care Management for High-Risk Pregnant Individuals and Infants;
6. Reduction in infant death;
7. Early detection, screening and intervention; and
8. Infant and early childhood mental health, including trauma-informed care, ACEs and resilience.

5.13.3.6 Women, Infants, and Children (WIC) Referrals

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 WIC, administered by the Virginia Department of Health (VDH). The Contractor must refer potentially eligible women, infants, and children to the WIC Program, as described in Section 8.2, Care Coordination.

5.13.3.7 Safe Sleep 365 Program

The Contractor must develop a comprehensive Safe Sleep program that educates Members on and encourages safe sleep practices. For additional information or resources, the Contractor may reference the Virginia Department of Social Services' Safe Sleep 365 Virginia program. The Safe Sleep 365 Virginia program is designed to educate parents and caregivers about steps they can be taken to prevent infant sleep-related deaths. It also emphasizes simple practices all Virginians can employ to provide safe and healthy environments for infants during sleep.

5.14 Non-Emergency Medical Transportation Services (NEMT)

With the exception of FAMIS Children, the Contractor must cover emergency, urgent, and NEMT to ensure that Members have necessary access to and from providers of covered medical, behavioral health, dental, CCC Plus Waiver services, and LTSS services, per 42 CFR §440.170(a) and 12 VAC 30-50-530 in a manner that seeks to ensure the Member's health, safety, and welfare. The Contractor must maintain an adequate transportation network to cover all approved transportation requests. The Contractor is encouraged to enter into contracts with taxis, commercial carriers, public agencies, nonprofit and for-profit private agencies, and public carriers. The Contractor must ensure that covered transportation services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

The Contractor must cover NEMT transportation services within at least equal amount, duration, and scope available under the Department's Fee-For-Service program, as described in 12 VAC 30-50-530, and including, but not limited to, the following modes of transportation: emergency and non-emergency air ambulance, emergency and non-emergency ground ambulance, public transit, stretcher vans, wheelchair vans, mini-vans, sedans, taxis, transportation network companies (TNCs) and volunteer drivers (defined in Section 22, Definitions, and on the Department's Transportation website. With prior approval from the Contractor, family and friends must also be able to transport Members and receive gas and/or mileage reimbursement.

The Contractor must provide the NEMT benefit to all carved-out services as described in Section 5.2, Carved-Out Services, except for DD Waiver services which are the responsibility of the Department's Fee-For-Service transportation broker. The Contractor will not be responsible for transportation to or from DD Waiver services for Members enrolled in the Community Living (CL), Building Independence (BI), and Family and Individual Supports (FIS) Intellectual and Developmental Disabilities (DD) Waivers. DD Waiver services when covered through EPSDT will be the responsibility of the Contractor.

5.14.1 Transportation Provider Network Capacity

The Contractor must recruit, credential, and maintain providers as well as negotiate reimbursement to ensure an adequate network of qualified NEMT providers to furnish high quality transportation services that are safe, reliable, and on-time for Medicaid and FAMIS MOMS and FAMIS PC Members. Capacity must include:

1. Sedans;
2. Vans;
3. Mini-buses;
4. Wheelchair vans;
5. Stretcher vans;
6. Ambulances (non-emergency ambulance services, Basic Life Support (BLS), Advanced Life Support (ALS), Paramedic ALS Intercept (PI), and Specialty Care Transport (SCT), as defined in 42 CFR §414.605;
7. Innovative alternate transportation (e.g., fixed-route public transportation, volunteer drivers, vouchers, and gas and/or mileage reimbursement);
8. Taxicabs (the use of metered taxis must be limited to safety net/last resort, unless specifically authorized by the Department);
9. Bariatric transportation. Upon request the Contractor, broker, or internal transportation services must describe its capacity (including providers of bariatric transport and equipment available) to transport bariatric patients throughout the Commonwealth of Virginia. The provider must meet the requirements and guidelines established for bariatric transport by the Virginia Department of Health, Office of Emergency Medical Services; and
10. Transportation Network Companies (TNC) - Type 1 and Type 2 as described by the Department and to be used as a provider of last resort. Must be approved by the Department prior to utilization in the MCO NEMT program.

The Contractor, through its internal transportation services or a broker, which must have a broker's license from DMV and be registered with the State Corporation Commission of Virginia, must ensure that it has a sufficient number of vehicles and drivers available to meet the timeliness requirements for access to care standards as described in Section 7.2.1, Member Travel Time and Distance Standards. If an area has been identified as having insufficient transportation resources, the broker or internal transportation services will have ten (10) business days to recruit sufficient NEMT providers to meet the needs of the Members in the identified areas.

The Contractor must endeavor to maintain existing relationships between NEMT providers and Members and must try to accommodate a Member's request for a specific provider in the Contractor's network, to the maximum extent possible, especially for the transportation of Members with disabilities, including Alzheimer's disease and other forms of dementia.

5.14.2 NEMT Provider Contracting Requirements

The Contractor, through its internal transportation services or a broker, must ensure that all provider contracts that are entered into comply with all terms and conditions of the Contractor's broker or

internal transportation services contract. The Contractor must process all complete provider enrollment packets within thirty (30) calendar days of receipt. All documentation that is required for enrollment must be current and within ninety (90) days of the date of the application. Any provider that is approved, or denied, to provide NEMT services must be notified within fifteen (15) days of the date of the approval or denial. Approved providers must have a contract negotiated and executed within thirty (30) days of approval notification. The Contractor must make available to the Department, upon request, a provider applicant tracking system for the enrollment process with real time access.

No contracted providers are permitted to deliver NEMT transportation services before driver and vehicle requirements are completed, contracts are executed, and the provider is approved by the Contractor or its broker. The Contractor must ensure that there is a reevaluation and notification process for renewal of contracts and rate negotiation.

5.14.3 Monitoring and Oversight of NEMT Provider Contracts

The Contractor, through its internal transportation services or broker, must document its provider monitoring and oversight strategy, which must include procedures and personnel related to monitoring and oversight of the delivery of provider services. The Contractor must conduct monthly written performance reviews with providers taking into consideration quality of service, on-time performance, company safety (accidents/incidents), and other NEMT contract requirements. The Contractor must have a system in place to track and exclude suspended or terminated providers or drivers from participating in any Virginia Medicaid NEMT covered services upon notification by the Department. The Contractor must report to the Department, upon request, subsequent suspensions or terminations of providers and drivers for various safety or erroneous acts.

5.14.4 NEMT Provider, Driver, and Attendant Enrollment

The Contractor must ensure that NEMT providers, drivers, volunteer drivers, independent drivers, TNCs and attendants are enrolled per the Department's NEMT requirements listed here.

NEMT providers, drivers, volunteer drivers, independent drivers, taxi, TNC and attendants must be included in the MCO NPPR file and/or listed as non-par providers. The MCO or NEMT Broker must maintain enrollment files. Refer to the Cardinal Care Technical Manual.

5.14.5 Out-of-State Provider Requirements

At times, covered Medicaid services may include transportation services to and from out-of-state medical facilities for treatment that is not available in Virginia and is approved in advance by the Contractor. The Contractor must honor authorizations, as outlined in this Contract, for out-of-state treatment, including transportation services and per diem and lodging expenses.

The Contractor may authorize out-of-state NEMT services to enrolled Department providers located in cities and counties on or near the Virginia state border (District of Columbia, Kentucky, Maryland, North Carolina, Tennessee, and West Virginia). The Contractor must also enroll bordering out-of-state ambulance companies, as needed, for facility-to-facility transfers that occur within the bordering state boundaries. For any NEMT providers accepting out-of-state trips, the Contractor must ensure the

provider is authorized to accept such out-of-state trips including, but not limited to US DOT Regulations, and applicable federal, state and local licensing requirements.

5.14.6 Monitoring and Oversight of NEMT Provider Vehicle Requirements

The requirements listed below include training, licensing, vehicle inspection, registration, and insurance coverage. These requirements should be included in all agreements with NEMT providers. The Contractor may establish additional driver, vehicle, attendant and insurance requirements. The Contractor, broker, or internal transportation services must ensure that for all NEMT providers:

1. All provider vehicles are field monitored for regulation compliance;
2. All vehicles are titled and licensed by the Virginia Department of Motor Vehicles to operate in Virginia and have the proper operating authority or meet DMVs exception criteria for state and local license "Exempt Operations" section titled Exempt Passenger Carrier Operations;
3. Vehicles garaged in adjacent localities in adjoining states meet State inspection and safety requirements;
4. Those transportation providers with "taxi" license plates are in compliance with state and local ordinances for taxis and are currently licensed by the local taxi authority, if one (1) exists, in the jurisdictions in which they operate;
5. Transportation Network Companies meet driver and vehicle requirements outlined in this Contract and as required by DMV;
6. The correct and current USDOT Number as an Interstate Carrier from the Federal Motor Carrier Safety Administration (FMCSA) if the provider is assigned trips that cross the Virginia border;
7. Provide copies of required permits and licenses from the counties and cities in which they operate to the Contractor; and
8. Have contracted providers, drivers, and vehicles that can access military installations to transport Members.

5.14.7 Back-Up Services

The Contractor, through its internal transportation services or broker, must have contingency plans for unexpected peak transportation demands and plans for back-up drivers, (e.g. TNCs), for instances when a vehicle is late or is otherwise unavailable for service.

The Contractor, through its internal transportation services or broker, must ensure that NEMT providers immediately give notice of a breakdown, accident, incident, or any other problems that might cause a trip delay beyond the scheduled and contracted window of time for pick up and/or arrival. Immediately after the Contractor, through its internal transportation services or broker, is notified of a delay, the Contractor through its internal transportation services or broker, must notify the Member or authorized representatives and the facilities or families at the destination points, and document the notification. Other transportation should be arranged to ensure the transport is recovered. Ultimately, it is the responsibility of the Contractor, through its internal transportation services or broker, to make sure trips are provided and to have a continuity of operations plan in place for recovery of trips to ensure Member safety and timely recovery of trips.

After any delay in scheduled Member pick-up, the Contractor, through its internal transportation services or broker, must secure alternate transportation and notify appropriate parties of any changes. In the event alternate transportation cannot be secured, a follow-up call must be made to all appropriate parties to notify and reschedule. The follow-up call must be documented.

5.14.8 Ambulance Transports To and From Bordering States

The Contractor, broker, or internal transportation services must ensure the following non-emergency ambulance transport guidelines are followed:

1. Ambulance transports originating in Virginia going to out-of-state Medicaid services can be conducted by a Virginia Office of Emergency Medical Services (OEMS) licensed Ambulance Company if the transport originates and returns to a Virginia address (i.e. Bristol, VA to Greensboro, NC and Greensboro, NC back to Bristol, VA);
2. Ambulance transports originating at an out-of-state address going to another out-of-state address must be completed by an ambulance company licensed in that state. Unless the Ambulance company is licensed to do so, Virginia ambulance companies cannot transport out-of-state to out-of-state addresses (i.e. Virginia Medicaid Member in a Greensboro, NC hospital needs to be transported to Duke University Medical Center then back to Greensboro, NC);
3. Unless the Ambulance company is licensed to do so, an out-of-state licensed ambulance company cannot enter the Commonwealth to transport Medicaid Members Virginia to Virginia (i.e., Greensboro based ambulance company going to Bristol, VA to transport Member to Abingdon, VA and back to Bristol, VA); and
4. Virginia ambulance companies can cross the border to bring a Member back to Virginia (i.e., VA Medicaid Member in Duke Hospital being discharged back to a Virginia address).

5.14.9 Transportation National Provider Identifier (NPI)

All transportation providers must have an individual NPI which can be secured through the submission of a "National Provider Identifier (NPI) Application/Update Form" which can be found here.

5.14.10 Transportation Needs of Member

The Contractor must provide services by assigning and scheduling trips on a per-trip or recurring basis with the most appropriate cost-effective NEMT provider, consistent with the transportation needs of the Member. Consideration must be made regarding:

1. **Level of Assistance:** Member assistance requested or when necessitated by the Member's mobility status or personal condition. This includes door-to-door and hand-to-hand assistance. Curb-to-curb is the default level of assistance. At the time of scheduling, the Contractor, through its internal transportation services or broker, must ask the Member or the Member's representative if special assistance is needed; and
2. **Members with Disabilities**: Members with a physical, sensory, intellectual, developmental, or cognitive disability. Members with disabilities, especially those residing in nursing facilities, dialysis or attending Day Support programs or Adult Day Health Care programs, may require door-to-door or hand-to-hand transportation assistance.

Level of assistance needs include the following and must be based upon consideration of the Member's needs and condition:

1. **Hand-to-Hand Transportation:** 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;
2. **Door-to-Door Service:** Transportation provided to Member who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver exits the vehicle and assists the passenger from the door of the pick-up point (e.g., residence), escorts the passenger to the door of the vehicle and assists the passenger in entering the vehicle. Assisting the Member with door-to-door service does not include the lifting of any Member. Drivers, except for ambulance or stretcher van personnel, should not enter a residence; and
3. **Curb-to-Curb Service:** The default level of assistance. Transportation provided to Members who need little if any assistance between the vehicle and the door of the pick-up point or destination. The assistance provided by the driver includes opening and closing the vehicle doors, helping the passenger enter or exit the vehicle, folding and storing the Member's wheelchair or other mobility device as necessary. Assisting the passenger with curb-to-curb service does not include the lifting of any Member. Drivers are to remain at or near their vehicles and are not to enter any buildings.

5.14.11 Travel Time on Board

For multi-passenger trips, every effort must be made by the Contractor, through its broker or internal transportation services, and the NEMT providers to ensure Members do not remain in the vehicle for more than forty-five (45) minutes plus direct travel time for transport of the Member. No Member should have a travel time on board of more than one (1) hour fifteen (15) minutes unless the trip is a long distance trip.

5.14.12 Late or Missed Trips

The Contractor must ensure that no more than 0.25% of all trips are late and no more than 0.25% of trips are missed per day. The Contractor must ensure that its broker reports the percent of all trips late or missed in accordance with the requirements contained in the Cardinal Care Technical Manual. Subsequent trip legs must be at the scheduled return time or within forty-five (45) minutes of a "will call" to the ride assist for a return trip.

The Contractor must report the total number of missed trips and types of trips missed. The report must include information on the resolution. The report must be submitted in accordance with the requirements contained in the Cardinal Care Technical Manual. The resolution information must be member-focused and must identify follow-up contacts with the Member as well as additional information regarding rescheduled appointments, strategies for ensuring standing trips are covered in the future, etc. For Member no-shows for critical services such as dialysis, chemotherapy, etc., the resolution information must describe if the Member made it to the appointment by alternate means or reason for no-show, etc. Reporting of missed trips must be Member-specific.

5.14.13 Transportation Services for Minors

The Contractor must authorize transportation services for children under the age of eighteen (18). The Contractor must have guidelines that include transporting children by themselves to after school Medicaid programs with an attendant or escort. If an escort cannot be found, then the Contractor must work with the Member/designated representative to identify and secure an attendant to ensure timeliness and reduce behavioral problems while in route. An escort or personal assistant is a parent, caregiver, relative or friend who is authorized by the Contractor to accompany a Member or group of Members who have special needs or who are minor children (defined as under age eighteen (18)). No charge must be made for escorts or personal assistants.

5.14.14 Passenger Safety Requirements

The Contractor, through a broker or internal transportation services, must ensure the NEMT providers, and attendants comply with the following passenger safety requirements:

1. Passengers must have their seat belts buckled at all times while they are inside the vehicle. The driver must assist passengers who are unable to fasten their own seat belts;
2. The driver must not move the vehicle until all passenger seat belts have been buckled;
3. The number of persons in the vehicle, including the driver, must not exceed the vehicle manufacturer's designed seating capacity;
4. Upon arrival at the destination, the vehicle must be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination;
5. Vehicles should always be visible by the driver; and
6. If passenger behavior or other conditions impede the safe operation of the vehicle, the driver must park the vehicle in a safe location out of traffic and notify his dispatcher to request assistance. Member behavior issues are to be reported to the Contractor.

5.14.15 Attendants

The use of a transportation attendant must be prior approved by the Contractor, through its internal transportation services or broker. The transportation attendant can be an employee of a transportation provider and is responsible for assisting the driver and accompanying a Member or group of Members during transport while ensuring safe operation of the vehicle and the Members. The Contractor, through its internal transportation services or broker, must submit attendant claims as part of encounters. The attendant, when required, must be identified and provided for the Member's transportation needs within five (5) business days of approval.

5.14.16 Transportation Information Management System (TIMS)

The Contractor must provide and maintain, through a broker or internal transportation services, a fully automated integrated TIMS sufficient to meet the needs of the NEMT program in the Commonwealth. TIMS must be provided to transportation providers, Members, and end users at no cost for access, applications, software, technology, interface and Contractor's proposed devices. The Contractor must ensure that the TIMS interface of proprietary or its broker software with a transportation provider's software will be at no charge to providers or Members. The Contractor must ensure that its internal transportation services' or broker's TIMS system at a minimum includes the following:

1. Optimized Automated Scheduling;
2. Member Management;
3. Import, Export, Collect Data and Files;
4. Transportation Network Management and Support;
5. Member Data Elements;
6. Member Interface Application to Manage Trip Reservations;
7. Member Interface Application to Seek Gas Reimbursement; and
8. Global Positioning Systems (GPS) tracking of vehicles.

5.14.17 Transportation Expenses

In accordance with 42 CFR §440.170, transportation expenses are furnished only to a Contractor enrolled provider and include:

1. The cost of transportation for the Member by ambulance, taxicab, common carrier, or other appropriate means;
2. The cost of meals and lodging in route to and from medical care, and while receiving medical care;
3. The cost of an attendant to accompany the Member, if medically necessary; and
4. The cost of the attendant's transportation, meals, lodging, and salary if the attendant is not in the Member's family.

Administrative costs are the Contractor's costs of the transportation operations, not including expenses or payment to transportation providers or subcontractors for direct services. If the Contractor operates a pool of volunteer drivers, the administrative costs associated with the Contractor's volunteer management (e.g., volunteer recruitment, screening, training) are administrative costs, while the costs associated with a volunteer's mileage or reimbursement of other expenses are considered direct service costs. Expenses such as mailing, delivery of bus passes, tickets, and/or gas cards are administrative costs. The actual purchase of bus passes, tickets or tokens, gas cards are direct service costs.

Gas reimbursement can be used for transportation to covered services that can be provided safely by a spouse, by the parent or guardian of a minor child, or by the Member. Family members and friends are also able to receive gas reimbursement for transporting Members to their Medicaid covered services. The family member or friend must call the Contractor, through its internal transportation services or broker, before transport to receive authorization and instructions to receive the gas reimbursement. The driver must have a valid operator's license and there must be an available registered vehicle at the home. The vehicle must be in operable condition and available for use at the time of the appointment.

5.14.18 NEMT Driver and Provider Outreach, Training, and Education

The Contractor, through its internal transportation services or broker, must ensure that all NEMT drivers, including any taxi company or independent (i.e., broker driver) drivers, providing NEMT services and attendants receive or have received initial orientation training and ongoing refresher training. The Contractor, through its internal transportation services or broker, must ensure drivers who perform transports for CCC Plus Waiver enrolled Members, Members with dementia or cognitive impairments, or

Members who require hand-to-hand or door-to-door level of assistance complete appropriate training prior to performing any trips for those levels of assistance.

Specific requirements and training elements for NEMT driver and provider outreach and education can be found on the Department's NEMT website.

Trainings, at a minimum, must cover the following:

1. Passenger Assistance Safety and Sensitivity training (PASS) or equivalent;
2. 2Basic first aid training;
3. Defensive driving training;
4. HIPAA training; and
5. Wheelchair securement training (if applicable).

5.14.19 Driver, Attendant, and Vehicle Requirements

The Contractor, through its internal transportation services or broker, must ensure compliance with the Department's minimum program requirements for drivers, attendants, and vehicles, as described on the Department's NEMT website.

The Contractor, through its internal transportation services or broker, must conduct all driver and attendant credentialing reviews prior to implementation and at least annually thereafter. All the records of these reviews must be maintained by the Contractor. The Contractor must assure compliance with driver requirements. This includes criminal background checks, drug screens, DMV and National Database driving record, and all requirements as described on the Department's NEMT website.

The Contractor, through its internal transportation services or broker, must verify that all vehicles meet the requirements for licensing, vehicle inspection, registration, and insurance coverage as described on the Department's NEMT website. The Contractor, through its internal transportation services or broker, must ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits. The Contractor, through its internal transportation services or broker, must include these requirements in all of its NEMT provider contracts.

The Contractor, through its internal transportation services or broker, must ensure that all vehicles transporting Members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

The Contractor, through its internal transportation services or broker, must abide by Department of Motor Vehicle (DMV) rules in the Code of Virginia with respect to non-emergency transportation requirements. The Code of Virginia §§46.2-2000.1 and 46.2-2001.2 exempts certain providers such as nonprofits (e.g., AAAs, CSBs) from Intrastate Operating Authority and from requiring "For Hire" plates. The list of exempt provider types can be found in the "Intrastate Operating Authority - Exempt Operations" section titled Exempt Passenger Carrier Operations on the DMV website.

5.14.20 Honoring the Office of Emergency Medical Services (OEMS) Licenses of Ambulance Companies

The Contractor's NEMT program is required to honor the OEMS license of the ambulance company as the only requirement for provider enrollment. The OEMS is the governing state sister agency that ensures ambulance companies maintain employee, vehicle compliance, and licensing requirements. If OEMS finds the ambulance company out of compliance, OEMS is the governing authority that will take action.

When the Contractor updates or enrolls ambulance companies, it must require a copy of the ambulance company's licenses from the VDH Office of Emergency Medical Services (OEMS). The OEMS license ensures the ambulance company employees and vehicles meet or exceed the Commonwealth OEMS requirements to conduct business as a licensed ambulance company.

The Department's NEMT OEMS requirement can be found on the Department's NEMT website.

5.14.21 Option to Leverage Two (2) Types of Transportation Network Companies (TNCs)

If the Contractor elects to utilize a TNC for its Members, the Contractor must provide written notice to the Department through the submission of a TNC Project Plan in accordance with the requirements contained in the Cardinal Care Technical Manual, which must be reviewed and approved by the Department. TNCs may be used as a provider of last resort or for trip recovery if the Member meets the criteria to ride with a TNC. Members requesting that they not ride with a TNC should not be permitted to utilize a TNC. The Contractor must adhere to the TNC requirements listed on the Department's NEMT website.

The Contractor's TNC Project Plan must be sent via email to transportation@dmas.virginia.gov sixty (60) days prior to the startup of the TNC. See the Cardinal Care Technical Manual for TNC Report and TNC Project Plan specifications. The Department reserves the right to adjust/add/remove limitations as well as rescind the use of TNCs, if necessary, at any time during this or future contracts.

5.14.22 Transportation Provider and Driver Trip Logs

The Contractor must require that transportation providers maintain trip logs or TIMS system integration of GPS tracking of Member pick up and drop off times. The Contractor must provide training, support and periodic refresher training to ensure compliance. The Department, as part of monitoring this Contract, may audit the log or GPS reporting for compliance and completeness. See the Cardinal Care Technical Manual for specifics. The Contractor must:

1. Ensure that all information trip logs are complete and accurate;
2. Ensure that trip logs or GPS report is approved by the Department are maintained and available in an easily retrievable electronic format for no less than five (5) years; and
3. Provide training, support and regular monthly monitoring for trip log or GPS system/software compliance to all transportation providers.

5.14.23 NEMT Signature Requirement Waived

The NEMT requirement for Member signatures on trip logs or trip manifests is waived for NEMT providers who have software, scheduling systems, apps, or a device that does not capture Member signatures (i.e. Jaunt, Community Service Boards, and Transportation Network Company), or for NEMT providers who have fully automated routing software capable of tracking vehicles with Global Positioning Systems (GPS) and that are able to capture trip arrival and trip completion times that have been acknowledged by the driver. The Contractor must ensure, through its broker or internal transportation services, that providers in these categories are subject to validation audit, utilizing a statistically significant random sample, to ensure Members were transported. The Department may request the list of providers who are waived and subject to the validation audit. The Contractor must submit to the Department its audit policies and procedures that reflect how the Contractor will validate Members were transported by providers who are waived from the signature requirement in accordance with the requirements contained in the Cardinal Care Technical Manual.

5.14.24 Annual Reporting Requirements

The Contractor must submit to the Department a report of its transportation services as outlined in the Cardinal Care Technical Manual. Additionally, the Contractor will provide its policies and procedures for review and approval, including requirements for how far in advance individuals need to call to schedule and receive routine, non-emergency, urgent, and/or emergency transportation services, as required by the Cardinal Care Technical Manual.

See the Cardinal Care Technical Manual for NEMT program specifications. (For additional information on NEMT provider enrollment requirements, NEMT driver education and training requirements, instructions for TNC utilization, ambulance on bordering states, and NEMT definitions see the Department's website – NEMT).

5.14.25 Reporting on Transportation Provided to Individuals Enrolled in DD Waivers

As required per a Department of Justice settlement agreement, the Contractor must report on the quality of transportation provided to individuals in DD Waiver services.

The Contractor must work collaboratively to support the Department in responding to the Department of Justice (DOJ), the Joint Legislative Audit and Review Commission (JLARC), the Virginia General Assembly, individuals, organizations, agencies, facilities and medical service providers that deliver services to Virginia Medicaid DD Waiver Members, in accordance with the DOJ agreement and any and all subsequent recommendations of the Independent Reviewer. In following with these requirements, the Contractor must:

1. Identify individuals enrolled in DD Waivers receiving NEMT services;
2. Analyze the delivery of transportation services for DD Waiver Members; and
3. Evaluate the quality of the transportation services provided to individuals in DD Waiver services by the Contractor.

In addition, the Contractor must, at a minimum, collect and provide the following data to the Department specifically for individuals enrolled in any of the DD Waivers, and receiving transportation through the Contractor for non-waiver services:

1. Accident/injury reports for DD Waiver population, listing each accident and/or injury of each DD Waiver Member;
2. All transportation related complaints received from DD Waiver individuals;
3. Conduct a satisfaction survey of a sample of the DD Waiver individuals receiving transportation services through the Contractor and provide a summary to the Department in accordance with the requirements outlined in the Cardinal Care Technical Manual; and
4. Provide an analysis of the activities that the Contractor has in place that support the goal of ensuring that DD Waiver Members have access to transportation services that are of "good quality, appropriate, available and accessible to the DD population." The analysis should include suggestions for improvement.

Reports must be submitted quarterly, on the following schedule:

4th Quarter – for October, November, December - by January 15th
1st Quarter – for January, February, March - by April 15th
2nd Quarter – for April, May, June - by July 15th
3rd Quarter – for July, August, September - by October 15th

The Department reserves the right to revise the reporting requirements at the recommendations of the Independent Reviewer or as negotiated for the settlement.

5.14.25.1 Participation in a Transportation Workgroup and Transportation Collaborative

The Contractor must participate in both ad-hoc transportation workgroup and quarterly Transportation Collaborative meetings, led by the Department, to review and assess transportation issues, guidelines, metrics, and other facets of transportation services guiding strategy and outcomes.

5.15 Pharmacy Services

As set forth in 12 VAC 30-50-210 and 42 CFR §438.3(s)(1), and in compliance with Va. Code §38.2-4312.1, the Contractor must cover all medically necessary legend and non-legend Food and Drug Administration (FDA) approved drugs for Members. Legend drugs for which Federal Financial Participation is not available must not be covered, pursuant to the requirements of §1927 of the Social Security Act and OBRA 90 §4401.

The Contractor must allow access to all medically necessary non-formulary or non-preferred drugs, other than those excluded from coverage. See Section 5.15.2, Pharmacy Exclusions. The Contractor may subject non-formulary or non-preferred drugs to service authorization consistent with the requirements of this Contract.

The Contractor is prohibited from imposing copayments on any medications or prescription drugs covered under this Contract.

The Contractor must reimburse services provided by a pharmacist, pharmacy technician, or pharmacy intern in accordance with Code of Virginia § 32.1-325(K).

The Contractor must maintain its own individual pharmacy program, separate from other Managed Care organizations, inclusive of individual drug pricing policy and processes. The Contractor is prohibited from creating pools to leverage negotiations on drug pricing.

The Contractor shall cover buprenorphine containing drugs, naltrexone, and methadone when provided as part of Medication Assisted Treatment (MAT) program which includes psychosocial therapy at rates no less than the Medicaid Fee-for-Service fee schedule, described in 12VAC30-80-40, in place at the time of service. The Contractor must permit claims for the preferred product for treatment of Opioid Use Disorder (OUD) - Suboxone® film as well as generic buprenorphine/naloxone sublingual tablets– to be approved for all in-network and out-of-network prescribers. This requirement does not apply to preferred injectable medications for opioid use disorder, which must only be covered by MCO in-network prescribers. The Contractor must not require a service authorization for preferred injectable medications for opioid use disorder. The only prerequisites will be the REMS criteria from the specialty pharmacy. Claims for the mono-buprenorphine product written by Preferred Office-Based Opioid Treatment (OBOT) providers must process without service authorization restrictions while other in-network and out-of-network would be limited to a pregnancy diagnosis and/or nine (9) month prenatal vitamin lookback.

5.15.1 Legend and Non-Legend Drug Coverage: Common Core Formulary

The Contractor is required to maintain a formulary to meet the unique needs of the Members they serve; at a minimum, the Contractor's formulary must include all preferred drugs on the Department Preferred Drug List (PDL), also known as the Common Core Formulary (CCF). The Department PDL is available here. The CCF will not apply to dual-eligible Members who have a pharmacy benefit covered by a Medicare Part D plan.

The Department PDL/CCF is not an all-inclusive list of drugs for Medicaid Members. The Contractor must develop a comprehensive formulary that includes drug classes not included on the CCF. The Contractor must include the Department Preferred Drug List (PDL) as a "common core" formulary for all Members enrolled in the Managed Care program who have a pharmacy benefit covered by the Contractor's Medicaid plan. The plans are responsible for one hundred percent (100%) accuracy for all PDL coding changes based on drug files provided by the Department and $5,000 in liquidated damages will be deducted from the capitation rate in the next quarter for each coding error. Contractors are responsible for reporting all pharmacy coding errors via email to the DMAS Pharmacy Department and the Contract Compliance Teams within one (1) business day of discovery. Within two (2) Days of discovery, the Contractor should report the number of members affected by the error. The contractor must submit a formal corrective action plan (CAP) within forty -eight (48) hours, clearly outlining the proposed correction and the expected completion date. DMAS staff will grant approval of the CAP or suggest modifications upon review.

By October 1 of the contract year, the Contractor must post a copy of their January 1 formulary to enable Members to make informed choices during open enrollment related to their medication coverage. The formulary is permitted to be updated as needed over time, and accordingly should be

labeled that it is subject to change. The Contractor must have an updated link to their formulary available on their website. The Contractor must submit its complete formulary to the Department biannually after review by its P&T Committee and inform the Department of all changes to its formulary. The formulary must be provided to the Department no later than sixty (60) calendar days after the Department provides the full PDL coding files in January and July. The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including service authorizations and quantity limits. The Contractor must submit changes for review and approval via email at least forty-five (45) calendar days prior to the effective date of the change. The Department will respond within fifteen (15) calendar days.

5.15.1.1 Formulary Closed Classes (the Department-Defined)

The Department will define closed classes on the CCF. The Contractor must not add or remove drugs, including alternative dosage forms, to closed drug classes on the CCF. The Contractor must not solicit additional rebates or discounts for drugs in closed classes on the CCF. The Supplemental PDL will not apply to dual-eligible Members.

The Department requires a ninety-five percent (95%) compliance rate to the closed classes of the Department PDL. The only exception will be for established pharmacological treatment regimens, which must be continued for up to thirty (30) days when a Member transitions from another plan. The Contractor will be assessed $25,000 in liquidated damages per quarter for failure to meet the compliance rate. The $25,000 will be deducted from the capitation rate in the next quarter.

5.15.1.2 Formulary Open (Non-Closed) Classes

The Contractor may add drugs to their formulary in CCF open (non-closed) drug classes. For open drug classes on the CCF, the Contractor retains the ability to negotiate rebates or discounts. All drug rebates and discounts must be reported to the Department as defined in Section 5.15.10, *Drug Rebates*.

5.15.1.3 Preferred Drug Access Requirements

The preferred drugs, as defined on the Department PDL and the Common Core Formulary, may still be subject to edits, including, but not limited to, service authorization requirements for clinical appropriateness as determined by the Department P&T Committee. The Contractor must assure that access to all preferred drugs from the Department PDL is no more restrictive than the Department PDL requirements applicable to the preferred drug and that no additional service authorization criteria or clinical edits are applied. In addition, the Contractor must comply with the CMS requirement that health plans may not use a standard for determining medical necessity for a non-preferred drug that is more restrictive than is used in the state plan.

5.15.1.4 Contractor Responsibility to Deploy Changes to the Department PDL

If the Department makes any changes to its PDL, the Contractor must have sixty (60) calendar days after notification of the changes to the PDL to comply with the Department changes.

5.15.2 Pharmacy Exclusions

The Contractor must exclude coverage for the following:

1. Drugs used for anorexia or weight gain;
2. Drugs used to promote fertility;
3. Agents whose primary purpose is cosmetic, including but not limited to hair growth. Agents used in the treatment of covered Gender Dysphoria services are not primarily cosmetic;
4. 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;
5. 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;
6. Drugs which have been recalled;
7. Experimental drugs or non-FDA-approved drugs, except for children and youth covered under EPSDT; and
8. Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

5.15.3 Medication Therapy Management (MTM)

The Contractor must implement an MTM program within the first ninety (90) days of operation. The MTM program must include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists. The Contractor's MTM program must meet or exceed the requirements described in 42 CFR §423.153(d)(1) and is applicable to all eligible Members.

Reimbursement for MTM services provided by participating pharmacists must be separate and above dispensing and ingredient cost reimbursement.

The Contractor's MTM program must be developed to identify and target Members who would most benefit from these interactions. The Contractor must provide the Department with information on the number and type of interventions performed and annual outcomes, as required by the Cardinal Care Technical Manual.

5.15.4 Utilization Management for Pharmacy Services

As described in the Code of Virginia § 38.2-3407.15:2 and Section 1927(d)(5) of the Social Security Act, the Contractor must follow service authorization procedures and requirements for covered outpatient drugs. The Contractor must incorporate these requirements into its pharmacy benefit manager (PBM) contracts. The Contractor must not require a pharmacy service authorization as secondary payer as long as the primary payer has made any payment for the cost of the medication.

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 medically necessary drugs based upon a case-by-case review of the individual child's needs, such as for off-label use. In accordance with Section 1902(a)(85) of the Social Security Act and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and

Communities (SUPPORT) Act, the Contractor must ensure review of antipsychotic agents for appropriateness for all children 18 and under including foster children, based on approved indications and clinical guidelines.

In accordance with 42 CFR §438.3 and 438.210(d), the Contractor must provide responses for all covered outpatient drug authorizations by telephone or other telecommunication device within twenty-four (24) hours of a request for authorization, in accordance with Section 1927(d)(5)(A) of the Social Security Act.

The Contractor must submit all pharmacy service authorization and step therapy policies, procedures and any associated criteria to the Department for review and prior approval, as required by the Care Management Solution (CRMS) Technical Manual. The Contractor must submit any proposed pharmacy program changes, such as pill-splitting programs, quality limits, etc. to the Department for review and approval at least forty-five (45) days prior to implementation.

The Contractor must have in place policies and procedures to ensure the continuity of care for Members with established pharmacological treatment regimens. The Contractor must also ensure that it is able to process pharmacy claims using either the Medicaid ID or the MCO ID number and must comply with all transitional refill requirements as described in Section 8.11.1, Continuity of Care Upon Enrollment.

The Contractor must 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 a service authorization ends). The Contractor may require service authorizations as a condition of coverage or payment for a covered outpatient drug.

5.15.4.1 Response to Service Authorizations and Denial of Services

Pursuant to Section 1927(d)(5) of the Social Security Act and 42 U.S.C. 1396r-8, the Contractor must provide a response by telephone or other telecommunication within twenty-four (24) hours of a service authorization. If additional documentation is needed from the provider, the provider has seventy-two (72) hours to respond to the Contractor. If no response is received within seventy-two (72) hours, the request is considered denied. In accordance with 42 CFR §438.210(c) if the Contractor denies a request for service authorization, or authorizes a service in an amount, duration, or scope that is less than requested, the Contractor must issue a Notice of Adverse Benefit Determination within twenty-four (24) hours of the denial to the prescriber and the Member. The Notice of Adverse Benefit Determination must include appeal rights and instructions for submitting an appeal in accordance with the requirements described in Section 9, Grievances and Appeals. The Department reserves the right to conduct random reviews to ensure that enrollees are being notified in a timely manner, in accordance with 42 CFR §438.228.

5.15.4.2 Emergency Supply

A seventy-two (72) hour emergency supply of a prescribed covered pharmacy service must be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, determines that the Member's health

would be compromised without the benefit of the drug. For unit-of-use drugs (i.e., inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the seventy-two (72) hour supply.

5.15.4.3 Notification Requirement

The Contractor must have policies and procedures for general notifications to participating providers and Members of revisions to the formulary and service authorization requirements. Written 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.

5.15.5 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).

In accordance with § 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 as described in Section 6.2, Patient Utilization Management and Safety (PUMS) Program for Members. Information may only be obtained by a current employee of the Contractor who is also a physician, pharmacist or designated and authorized professional licensed by the Department of Health Professions.

The Contractor must give notice to Members that information may be requested from the PMP by a licensed physician, pharmacist, or designated and authorized professional licensed by the Department of Health Professions. 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.

5.15.5.1 Process for Contractor Access to the PMP

The Contractor must provide to the Department, in the format specified by the Department of Health Professions, an actively maintained list of up to eight (8) pharmacist or designated and authorized professional licensed by the Department of Health Professions employed by the Contractor who will be utilizing the PMP. PMP access login credentials will be provided by the Department of Health Professions and must not be delegated to or used by other staff. The Contractor, and its employees accessing the PMP, must 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 must 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 the Department involvement.

5.15.6 Prescription Supply Requirements

The Contractor must limit coverage:

1. To a maximum of a thirty-four (34) day supply of medication per prescription per Member in accordance with the prescriber's orders and subject to the Board of Pharmacy regulations, unless otherwise stated below; and
2. Of select maintenance legend and non-legend drugs identified in the "DMAS 90 Day Medication Maintenance List" to a maximum of a ninety (90)-day supply per prescription per patient after two (2) thirty-four (34) day or shorter duration fills.

The Contractor must cover prescriptions of contraceptives for up to a twelve (12) month supply for beneficiaries in the Medicaid and CHIP programs.

5.15.7 Pharmacy and Therapeutics (P&T) Committee

The Contractor must have a P&T Committee that will ensure safe, appropriate, and cost-effective use of pharmaceuticals for the Virginia Medicaid Members of this Contract. The P&T Committee must 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 must meet at least semi-annually.

The Contractor's P&T Committee must be comprised of physicians, pharmacists or nurse practitioners holding valid professional licenses. The Committee must include at least one (1) practitioner in each of the following specialties: pediatrics, gerontology/geriatrics, and psychiatry. The Contractor must require all individuals participating in the P&T Committee to complete a financial disclosure form annually which is reviewable by the Department upon request.

5.15.8 Drug Utilization Review (DUR) Program

In accordance with 42 CFR §438.3(s)(4) and (5), the Contractor must 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 and the DUR Board.

The Contractor's DUR program must comply with the requirements in the federal Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Public Law 115-271). The Contractor's DUR program, at a minimum, must include all of the DUR activities conducted by the Department.

The Contractor's DUR Board will meet at least semi-annually. The DUR Board must include a voting representative from the Department. The Contractor must ensure that the Department receives meeting notification and associated meeting materials at least seven (7) business days prior to the meeting. 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 is not required to have a separate DUR Board. The Contractor may utilize its P&T Committee or comparable committee to fulfill the DUR program requirement. 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.

Pursuant to 42 CFR §456.712, The Contractor must submit to the Department a copy of its CMS DUR Annual Report, a detailed description of its DUR program activities, 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 must require all individuals participating on the DUR Board to complete a financial disclosure form annually which is reviewable by the Department upon request.

5.15.9 Interventions to Prevent Controlled Substance Abuse

The Contractor must comply with all Department- approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the Department's website.

The Contractor must educate providers and Members about the risk factors for opioid-related harms and provide management plan strategies to mitigate risk including but not limited to checking the prescription drug monitoring program, benzodiazepine and opioid tapering tools, physician/patient opioid treatment agreements, and the offering of naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages or concurrent benzodiazepine use, are present.

The Contractor or its Pharmacy Benefits Manager must implement point-of-sale denial edits consistent with the Department-approved clinical criteria detailed in the Department 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 must have in place authorization procedures to override any of the denials when the prescriber provides compelling clinical documentation and medical necessity for the override.

5.15.10 Drug Rebates

Pursuant to Section 1927 of the Social Security Act, all outpatient drugs dispensed to Members covered by the Contractor (excluding FAMIS Children and FAMIS MOMS as described in Attachment D, FAMIS Program Exceptions, and including where the Contractor paid as the primary and/or secondary payer under this Contract) must be subject to the same rebate requirements as the State and the State must collect such rebates from pharmaceutical manufacturers. Drug utilization encounter data must include all drugs dispensed at point-of-sale (POS) and those administered in a provider's office or other outpatient setting, including outpatient clinics. For the purpose of this Contract the term "dispense" is defined to include the terms "provide" and "administer."

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 code. In accordance with Section 1927(b)(1)(A) of the Social Security Act, 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 code must be submitted with a valid NDC and NDC units on each claim line. If the drug administered is comprised of more than one (1) ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a separate claim line using the same HCPCS code.

Managed Care encounter claims are required to be submitted in a timely manner and in full compliance with the Department's published Companion Guide (NCPDP Payer Specifications). In accordance with 42 CFR §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. 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. Any impact to the collection of manufacturer rebates allowed under federal law that is the result of delayed encounter claim submission to the Department or the omission of required claim-level data elements will be assessed at the full amount of lost manufacturer rebates.

Consistent with 42 CFR §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 must be treated as a compliance violation. The Contractor must 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. Refer to the Cardinal Care Technical Manual for reporting requirements.

If a Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the Contractor must ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This must 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 Department pharmacy benefit.

The Contractor (and/or its Pharmacy Benefits Manager) must make available two (2) pharmacy representatives (one (1) primary and one (1) 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.

5.15.11 Requirements for Contractor's Pharmacy Benefits Manager

Any agreement between the Contractor and a pharmacy benefits manager (PBM) must include provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the Contractor's Managed Care plan. The agreement must be reviewed and approved by the Department.

The Contractor PBMs may not restrict access for medications to their Specialty Pharmacy network unless the medication is designated as limited distribution by the manufacturer, or with Department approval. The Contractor must submit its Specialty Pharmacy Drug Distribution List biannually by September 1 and March 1. The Contractor must submit changes for review and approval via email at least forty-five (45) calendar days prior to the effective date of change. The Department will respond within fifteen (15) calendar days. Clinical information collected by the specialty pharmacy must not exceed what is deemed medically necessary to ensure the proper dispensation and utilization of the prescribed medication. The Department may assess and amend the data collection process of the MCOs specialty pharmacy at any time to prevent unnecessary delays in therapy due to the request of extraneous information.

5.15.12 Reporting Requirements for Contractor's Pharmacy Benefit Manager

In accordance with Item 317.T, Chapter 1289, 2020 Virginia Acts of Assembly, for Contractor's Pharmacy Benefit Manager, the Contractor must report as follows for all pharmacy claims:

1. 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 Cardinal Care Technical Manual;
2. 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 Contractor must report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The Contractor must submit such reports in accordance with the requirements in the Cardinal Care Technical Manual; and
3. For dual-eligible enrollees, the Contractor must report on pharmacy claims paid through Medicaid.

5.16 Telemedicine and Telehealth

Telemedicine is a service delivery model that uses real time two (2) way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (see temporary exception for audio-only telecommunications in this Section) to link the Member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) means the use of digital technologies to collect medical and other forms of health data from patients in one (1) location and electronic transmission of that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data including, but not limited to, weight, blood pressure, pulse, pulse oximetry, blood glucose; treatment adherence monitoring; and communication of updates to the care plan with or without digital image upload.

The Contractor must provide coverage for telemedicine and telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor must provide telemedicine and telehealth services regardless of the originating site and regardless of whether the patient is accompanied by a health care provider at the time such services are provided. The Contractor also must encourage the use of telemedicine and telehealth to promote community living and improve access to health services. The Contractor cannot require providers to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

The Contractor must allow the prescribing of controlled substances via telemedicine and requires such scripts to comply with the requirements of § 54.1-3303 of the Code of Virginia and all applicable federal law.

In accordance with 2023 General Assembly action amending Va. Code § 32.1-325 and upon CMS approval of a required State Plan Amendment, the Contractor will be prohibited from requiring a health care provider duly licensed by the Commonwealth who provides health care services exclusively through telemedicine services to maintain a physical presence in the Commonwealth in order to be considered eligible for enrollment as a Medicaid provider. The Contractor will also be prohibited from requiring a telemedicine services provider group with health care providers duly licensed by the Commonwealth to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group. The Department will notify the Contractor upon approval of the State Plan Amendment that this policy must be implemented.

The Department's Medicaid Manuals and Memos on telemedicine specify the types of providers that may provide Medicaid covered telemedicine and telehealth services. The Contractor may propose additional provider types for the Department to approve for use.

The decision to participate in a telemedicine or telehealth encounter will be at the discretion of the Member and/or their authorized representative(s), for which informed consent must be provided, and all telemedicine and telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department's program requirements. Covered and reimbursed services include:

1. Synchronous audio visual telemedicine, including originating site fees;
2. Store-and-Forward Applications: The Contractor must reimburse for all store-and-forward services covered through the Medicaid fee-for-service program, including, but not limited to, tele retinal screening for diabetic retinopathy in a way that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor cannot

be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. The Contractor may also reimburse for additional Store-and-Forward Applications, including but not limited to, teledermatology and teleradiology;

3. Remote patient monitoring (RPM), including 2024 amendments to Va. Code § 32.1-325 requiring remote ultrasound procedures and remote fetal non-stress tests;
4. Audio-only services;
5. Provider-to-provider consultations as covered by the Medicaid fee-for-service program;
6. Virtual check-ins with patients; and
7. The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the Member's primary care physician.

The Department's guidance on coverage for the above-listed telehealth services is described in previously published Medicaid Memoranda, Provider Manuals and regulations and is updated as new authorities and funding are provided to the Department. The Contractor will be required to provide coverage for the above-listed telehealth services in a manner that is no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Cardinal Care fee-for-service program.

All telemedicine and telehealth services must be provided in a manner that meets the needs of Members and is consistent with Model of Care requirements.

5.17 Coverage of Services in Connection with Clinical Trials

The Contractor must cover routine patient costs furnished in connection with a Member's participation in a qualifying clinical trial, as defined in Section 22, *Definitions*, SMD # 21-005, and the Virginia Medicaid State Plan. Routine patient costs include any item or service provided to the Member under the qualifying clinical trial that are needed to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that such items or services are otherwise covered outside the course of participation in the qualifying clinical trial. The Contractor is not required to provide coverage for any investigational item or service that is the subject of the qualifying clinical trial or for any service that is not otherwise covered under this Contract. The Contractor is not required to cover any items or service needed solely to satisfy data collection and analysis for the qualifying clinical trial, or for any services that are not used in the direct clinical management of the Member. (Also see Section 6.1.2, *Expedited Authorization Decisions*, and Attachment E, *Cardinal Care Summary of Covered Benefits Chart*).

5.18 Children's Vision Services

The Contractor must 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. The Contractor must submit a *Vision Services Plan,* as described in the Cardinal Care Technical Manual, that details the Contractor's plan and related efforts to increase utilization of vision services for children.

Pursuant to Item 304.OOOO.3 of the 2022 Acts of Assembly, the Contractor must ensure that a variety of lens and frames are available to children receiving vision services in any setting.

5.18.1 Mobile Vision Clinics

In accordance with Item 304.OOOO of the 2022 Acts of Assembly, effective September 1, 2022, the Contractor must work with the Department to expedite the enrollment and credentialing of mobile vision providers in its network, inclusive of provider agreements for mobile vision services provided to eligible children on school grounds in localities where local school divisions or schools have written agreements with mobile vision providers. Mobile vision providers, subject to such agreements, will provide comprehensive vision services including, at a minimum, a comprehensive vision exam in compliance with recognized clinical standards to include the use of a binocular indirect ophthalmoscope and/or a wide-angle retinal imaging system as well as lenses, frames, and fittings. These mobile vision services will be provided without any service authorization requirements.

Any donated goods or services are not Medicaid/FAMIS covered and must not be reimbursed by the Contractor. Initial vision screenings that occur prior to a comprehensive vision exam are the responsibility of the school and are not eligible for Medicaid reimbursement.

The Contractor will report to the Department on utilization of mobile vision services as described in the Cardinal Care Technical Manual.

5.19 Traumatic Brain Injury Waiver and Services

The Department, in conjunction with relevant stakeholders, has been instructed to convene a workgroup to develop a plan to operate a waiver program designed to address the needs of individuals with traumatic brain injury (TBI). As requested, the Contractor must work with the Department in the development and operation of a TBI waiver, brain injury facility-based services and the targeted case management service.

6. UTILIZATION MANAGEMENT REQUIREMENTS

The Contractor must authorize, arrange, coordinate, and provide to Members all medically necessary covered services as specified in this Contract. The Contractor's Utilization Management (UM) program must demonstrate that Members have equitable access to all services covered under this contract, as described in the attached Cardinal Care Summary of Covered Benefits Chart in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

In accordance with 42 CFR §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, and in accordance with 42 CFR §438.210(a)(2), the Contractor must ensure that services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

The Contractor's UM program must reflect current NCQA accreditation standards. The UM program must have mechanisms to detect underutilization and overutilization of care including, but not limited to, provider profiles. If the Contractor delegates (subcontracts) responsibilities for UM to a

subcontractor, the Contract must have a mechanism in place to ensure that the standards described in this Contract are met by the subcontractor.

The Contractor must have a written UM program description which includes policies and procedures to evaluate medical necessity, criteria used, information source, and the processes used to review and approve or deny the provision of medical, mental health, and SUD services. Consistent with CMS guidance found in The Parity Compliance Toolkit: Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and CHIP, the policies and procedures must describe the processes, strategies evidentiary standards and other factors used to develop and apply the UM program. The Contractor must establish explicit processes for monitoring the consistent application of clinical practice guidelines across UM decisions. The Contractor must submit all applicable policies and procedures to the Department for review and approval regarding its UM program as required by the Cardinal Care Technical Manual. The policies and procedures must include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of services.

In accordance with 42 CFR §438.910(d), the Contractor may not impose NQTL's for behavioral health benefits in any classification (inpatient, outpatient, emergency care or prescription drugs) 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 behavioral health 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.

6.1 Service Authorization

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions. See Section 6.1.6, *Service Authorization and Medical Necessity Criteria*. Service authorizations must not exceed two (2) years in duration with the exception of pharmacy which must not exceed one (1) year in duration. Refer to the Cardinal Care Technical Manual and the CRMS Technical Manual.

In accordance with 42 CFR §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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. Additionally, pursuant to 42 CFR §438.210(e), 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 service authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §438.910(d) and 438.3(n)(1). In accordance with 42 CFR §438.210(c), the Contractor must 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. In accordance with 42

CFR §438.915, in the case of denial by the Contractor of reimbursement or payment for services for mental health or substance use disorder benefits, the Contractor must notify the Member and provider in writing of the determination. For Adverse Benefit Determination notice requirements, refer to the relevant sections of the Medicaid Memo of March 9, 2021 and see Section 9.4, *Notice of Adverse Benefit Determination*.

The Contractor must ensure that the service authorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Refer to Section 5.16, *Pharmacy Services*, for provisions regarding authorizations for prescription drugs and Section 5.5, *Behavioral Health Services*, for provisions regarding authorizations for MHS.

In accordance with UM 4: Factor 2, the Contractor must use licensed health care professionals to make UM decisions. For Behavioral Health Services, including Mental Health Services (MHS) a clinical interpretation and clinical judgement from a mental health professional or physician is required for service authorization approvals or denials. The Contractor may employ UM reviewers of behavioral health services and MHS who are licensed health care professionals in a state other than Virginia, however those individuals must be licensed in a state in the United States, the license must be in good standing, and he/she must report to a mental health professional who is licensed in Virginia.

The following timeframes for decision requirements apply to service authorization requests, per 42 CFR §438.210.

6.1.1 Standard Authorization Decisions

For standard authorization decisions, the Contractor must 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 (1) the Member or the provider requests extension; or (2) the Contractor justifies to the Department upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the Member's interest (i.e., ARTS or Pharmacy specifics requirements).A service authorization is not required for hospice services, but the Contractor must establish the level of care needed in order for hospice services to begin. Additionally, the Contractor must enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of notification of admission/discharge. Refer to Section 5.12.8, *Entry Into the Virginia Medicaid Web Portal*.

6.1.2 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, physical or 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 (three (3) calendar days) after receipt of the request for service. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the Member requests an extension or the Contractor justifies to the Department upon request a need for additional information and how the extension is in the Member's interest. In accordance with SMD # 21-005, for a Member participating in a qualifying clinical trial as defined in Section 22, the Contractor must expedite

and complete a service authorization review related to the qualifying clinical trial within 72 hours, including when the qualifying clinical trial is performed by out of network or out of state providers.

If the Contractor delegates (subcontracts) responsibilities for UM to a subcontractor, the Contract must have a mechanism in place to ensure that these standards are met by the subcontractor.

6.1.2.1 Extending Timeframe for Service Authorization Decision

In accordance with 42 CFR §438.404(c)(4), if the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 CFR §438.210(d)(1), it must:

1. Give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and,
2. Issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

6.1.3 Provisions for EPSDT-Related Service Authorizations

In addition to the traditional review for medical necessity, service authorization requests for Medicaid Members under age twenty-one (21) that do not meet the Contractor's general coverage criteria must be reviewed under EPSDT criteria. Denial for services to individuals under age twenty-one (21) cannot be given until the EPSDT secondary review has been completed.

The Contractor must submit its EPSDT Review Process Policy and Procedures to the Department for review and approval prior to implementation, upon a revision, or as requested.

The Contractor's EPSDT Review Process Policy and Procedures must comply with the federally mandated EPSDT criteria. Pursuant to 42 CFR §438.210, the Contractor's EPSDT review process must ensure that an adverse benefit determination on a service request for a child under age twenty-one (21) is not issued until the case is first reviewed by a physician who has appropriate expertise in addressing the child's medical, behavioral health, or long-term services and supports needs. The Contractor's EPSDT review process must ensure that no service authorization request for a child is denied as "out-of-network" and/or "experimental" or "non-covered," unless specifically noted as non-covered or carved out of this Contract. Refer to Section 5.2, *Carved-Out Services*.

The Contractor's EPSDT review policies and procedures must also allow providers to contact Care Coordinators or Care Managers to explore alternative services, therapies, and resources for Members. The Contractor must also ensure that care coordination is provided and referrals are made to other clinically appropriate services.

The Contractor's EPSDT Review Process Policy and Procedures must ensure that any denial notice, including for non-covered, out-of-network, and/or experimental services, explains that EPSDT criteria was applied and cites the reason the requested service was determined to not meet EPSDT criteria. The notice must reflect that a Secondary Review was performed using the EPSDT correct or ameliorate standard and explain how it was applied to the facts. The notice must comply with federal and state regulatory requirements, as well as guidance issued by DMAS.

The Contractor is permitted to deny a service specifically noted as a carved-out service under Section 5.2, *Carved-Out Services*. Additionally, the Contractor must inform Members that although a service is carved out and therefore not covered under the Contractor's managed care health plan, it may be available through the Department's fee for-service program. The Contractor must provide referrals and assistance to facilitate timely member access to carved-out services.

6.1.4 NCQA Service Authorization Standards

The Contractor must ensure that its service authorization policies and procedures meet NCQA standards. The Contractor is responsible for determining the classification (i.e., urgent versus non-urgent) and type (i.e., concurrent versus preservice). This however does not preclude a provider from indicating the need for an expedited review as described in Section 6.1.2, *Expedited Authorization Decisions*, and 42 CFR § 438.210(d)(2).

There will be no extensions to the timeframes below due to weekends or holidays. Current NCQA service authorization timeliness standards are as follows:

Classification	Type	Timeliness	Extension
Physical/Non-Behavioral Health			
Urgent	Concurrent	72 hours (3 calendar days)	14 calendar days
	Preservice	72 hours (3 calendar days)	14 calendar days
Non-urgent	Preservice	14 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days
Behavioral Health including Mental Health and ARTS Services			
Urgent	Concurrent	72 hours (3 calendar days)	14 calendar days
	Preservice	72 hours (3 calendar days)	14 calendar days
Non-urgent	Preservice	14 calendar days	14 calendar days
Post Service	N/A	30 calendar days	14 calendar days

Urgent requests are requests for medical care or services where application of the timeframe for making non-urgent or non-life threatening care determinations could:

1. Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment;
2. Seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state; or
3. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

The Contractor must respond to the provider's service authorization submission with the results of the Contractor's independent assessment following NCQA requirements for urgent preservice and concurrent decisions within seventy-two (72) hours of the request for placement at Mental Health Intensive Outpatient and Mental Health Partial Hospitalization programs. The Contractor must respond to the provider's service authorization submission within three (3) calendar days for requests for placement at Mental Health Intensive Outpatient and Mental Health Partial Hospitalization Program as these services are deemed as urgent. Physical and behavioral health care or services to accommodate transitions between inpatient and institutional setting to home/community must also be considered urgent preservice requests. The Contractor must review the requests on an individual basis and determine the length of treatment and service limits are based on the individual's most current clinical presentation

The Contractor shall comply with all NCQA UM standards related to determining if a request meets urgent or non-urgent criteria. This includes but is not limited to: UM 2: Clinical Criteria for UM Decisions and UM 4: Appropriate Professionals. The Contractor must be able to accept all requests from a provider for expedited review as described in 6.2.10.2 Expedited Authorization Decision Timeframe and 42 CFR § 438.210(d)(2). The Contractor's UM policies and procedures must include a description of the standards used to determine if a request meets urgent or non-urgent criteria.

Non-urgent requests are requests for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

6.1.5 Service Authorization Data Requirements

The Contractor must:

1. Collect and maintain one hundred percent (100%) of all service authorization data for services authorized, pending, denied or partially denied for members;
2. Ensure that service authorization data includes utilization data for all claims associated with services provided pursuant to the specific authorization; and
3. Submit complete, timely, reasonable, and accurate service authorization data to the Department daily in the form and manner specified by the Department in the CRMS Technical Manual. Standard formats, required data elements, and other submission requirements must be detailed in the Cardinal Care Technical Manual.

6.1.6 Service Authorization and Medical Necessity Criteria

In accordance with 42 CFR 438.210, the Contractor must use medical necessity criteria that are approved by the Department and are no more restrictive than the Department's service authorization criteria, as reflected in any laws, regulations and interpretations referenced in Section 1.1, *Applicable Laws, Regulations, and Interpretations*. The Contractor's medical necessity criteria must not prevent the services furnished from reasonably achieving their purpose, must not prevent services supporting individuals with ongoing or chronic conditions or who require long-term services and supports from being authorized in a manner that reflects the enrollee's ongoing need for such services and supports, and must not prevent family planning services from being provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.

Consistent with 42 CFR §438.210(a)(5)(i), the Contractor's medical necessity criteria must not be more restrictive than the Medicaid FFS Medicaid program criteria, including, but not limited to, quantitative and non-quantitative treatment limits, as indicated in any laws, regulations and interpretations referenced in Section 1.1, *Applicable Laws, Regulations, and Interpretations*.

In accordance with § 438.236, the Contractor's medical necessity guidelines must be evidence-based and at a minimum:

1. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
2. Are adopted in consultation with contracting health care professionals in the Contractor's service area;
3. Are developed in accordance with standards adopted by national accreditation organizations;
4. Are updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
5. Are applied in a manner that considers the individual health care needs of the Member.

The Contractor must use ASAM criteria for medical necessity determinations for all Addiction and Recovery Treatment Services (ARTS) to any Member or contracting provider upon request.

Consistent with 42 CFR §438.210 the Contractor must ensure that coverage decisions are based upon medical necessity and the contractor:

1. Must 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;
2. 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;
3. Must ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports 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;

4. Must 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; and
5. Must 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;
    d. in the case of EPSDT, correct, maintain or ameliorate a condition; and
    e. opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

6.1.7 Mental Health Services Registrations and Authorizations

All MHS services will require a service authorization or registration to qualify for reimbursement. Providers are required to perform an assessment as described in the Mental Health Services Manual prior to submitting a request for MHS. The Contractor must follow the service authorization or registration requirements in accordance with the ARTS and MHS *Doing Business with the MCOs Spreadsheet*, which can be found on the DMAS website at this link. "Register" or "Registration" means the provider's notification to the Contractor that an individual will be receiving services that require a registration but do not require service authorization. Discretion with the utilization management requirements described below is allowed by the Contractor with Department approval.

6.2 QI for Utilization Management Activities

The Contractor must utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations. The QI activities for the UM program must include:

1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
2. At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of long-term services and supports representative of the Contractor or subcontractor, with substantial involvement in the UM program; and
3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and must address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

6.3 Patient Utilization Management and Safety (PUMS) Program for Members

The Contractor must have a Patient Utilization and Safety Management (PUMS) Program 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. Note that Members with an active cancer diagnosis are excluded from the PUMS program.

6.3.1 Placement into a PUMS Program

Members may be placed into a PUMS program for a period of twelve (12) months when any of the following triggering events occur:

1. The Contractor's 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 in excess of what is normally medically necessary, including the minimum specifications found in the ARTS Technical Manual;
2. 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 behaviors or patterns that indicate the Member should remain in the PUMS Program;
3. The Contractor is required to utilize the Prescription Monitoring Program (PMP), described in Section 5.15.5, *Prescription Monitoring Program (PMP)*, when evaluating PUMS Members; and
4. Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

PUMS Placement Criteria:

1. **PUMS1 Opioid Use Disorder (OUD) Case Management:** The Contractor may review any Members receiving OUD and provide case management;
    a. Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three (3) years; pregnant individuals with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate; and
    b. Clinical expertise and judgment must be used to identify and manage any Members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").
2. **PUMS2 High Average Daily Dose**: $\geq$ ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days;
3. **PUMS3 Opioids and Benzodiazepines concurrent use**: at least one (1) Opioid claim and fifteen (15) day supply of Benzo (in any order);
4. **PUMS4 Doctor and/or Pharmacy Shopping**: $\geq$ three (3) prescribers OR $\geq$ three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days;

5. **PUMS5 Use of a Controlled Substance with a History of Dependence, Misuse, or Poisoning/Overdose:** Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Misuse or Dependence in the past three hundred and sixty-five (365) days; and
6. **PUMS6 History of Substance Use, Use or Dependence or Poisoning/Overdose:** Any Member with a diagnosis of substance use, substance misuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

6.3.2 PUMS Program Details

Once a Member meets the PUMS placement requirements, the Contractor may limit a Member to a single pharmacy, primary care provider, 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. The Contractor will limit a Member to providers and pharmacies that are credentialed in their network.

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

6.3.3 Temporary Change to PUMS Status

If a Member is referred to an ARTS Residential Treatment Facility and needs to continue medication management via a single pharmacy, the Residential provider must contact the MCO to request the pharmacy be updated to one (1) that the Residential provider utilizes, so that the Member may continue the current medical regimen. The provider may contact the health plans and the Contractor to update the Member's preferred pharmacy while the Member is in the residential treatment program.

Upon discharge from the Residential Treatment Facility, the provider must notify the Member's MCO of the discharge so that the Member's pharmacy provider may be updated based on the Member's choice and proximity to their place of discharge. This task must be included in the discharge planning process.

6.3.4 PUMS Member Rights Notifications and Requirements

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

1. A brief explanation of the PUMS program;
2. A statement that the Member was selected for placement into the program;
3. An explanation that the decision is appealable;
4. A statement that the Contractor must provide appeals rights to Members placed in the PUMS Program, information regarding how the Member may submit an appeal request to the Contractor, the Member's right to directly request a State Fair Hearing after first exhausting the Contractor's appeals process, and information regarding how the Member qualified for the PUMS based on the minimum criteria;

5. 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; and
6. 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) calendar days of enrollment into the PUMS program, the Contractor may select one for the Member.

6.3.5 PUMS Reporting Requirements

1. **Annual PUMS Plan:** The Contractor must 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 use disorder treatment and recovery services, etc.) as required by the Cardinal Care Technical Manual; and

2. **Monthly Reporting:** The Contractor must report a detailed summary of Members enrolled in its PUMS program as required by the Cardinal Care Technical Manual.

7. PROVIDER NETWORK AND ACCESS TO CARE

7.1 Provider Network

The Contractor is required to establish a network of providers to meet the complex needs of its Members, including those with limited English proficiency or physical or mental disabilities, as prescribed in 42 CFR §438.206(b)(1). The Contractor must establish, maintain, and monitor its network in accordance with this Contract and any and all applicable federal and state laws, regulations, guidance and policies. The Contractor's network must comply with all standards and requirements enumerated in this Contract, which the State has defined to meet or exceed Federal network adequacy standards at 42 CFR §438.68,42 CFR §438.206. and 42 CFR §438.207. Network adequacy will be assessed along a number of dimensions, including: whether there are an adequate number of providers in each specialty; hours of operation; whether providers are or are not accepting new patients; accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); time in which a Member can schedule and receive Covered Services; and geographic proximity to beneficiaries (provider to Members or Members to provider).

Pursuant to 42 CFR §438.207, the Contractor must regularly assess and certify through submission of quarterly reports to the Department the adequacy of its provider network and notify the Department of any major initiatives or changes to program design (e.g., expanded benefits) that could impact its network adequacy. Refer to the Cardinal Care Technical Manual for network reporting format requirements. The Department will review and reserves the right to request changes to the provider network, which must be completed within specified timeframes.

The Contractor may request the Department grant exemptions to any of the network requirements described below, inclusive of provider types and services new to Managed Care, through submission of the Cardinal Care Network Exemption Request Form as described in Section 7.2.15, *Exceptions to Access*

Standards. Upon identification of any network deficiencies, either by the Contractor or by the Department, the Contractor must report the deficiency or respond to the Department as soon as possible and no later than five (5) business days from the identification. If applicable, this response must include the submission of an exemption request for any circumstance whereby the Contractor is unable to meet the Department's time and distance standards as indicated in Section 7.2.1, *Member Travel Time and Distance Standards*. Such a request may be granted only in circumstances in which there exists a shortage of the number of providers in a specialty practicing in the region (i.e., a provider shortage area). The Contractor's request for exemption must also identify the Contractor's strategy for ensuring timely access to care for all contract covered services.

The Contractor will also be required to develop and maintain a Provider Engagement Plan that outlines the Contractor's plan for engagement with and recruitment of providers in each specialty where the Contractor is deficient, providers in each specialty where there may be the potential for inadequacy or insufficient access based on the Contractor's current network, and for provider types identified by DMAS in order to ensure that the Contractor has an adequate network of providers. Such Provider Engagement Plan must be submitted to the Department in accordance with the requirements contained in the Cardinal Care Technical Manual.

The Department is the sole determiner of the Contractor's network adequacy. The Department reserves the right to set network adequacy for new population group expansions.

The Contractor will be subject to escalating compliance enforcement actions, sanctions and/or liquidated damages set forth in Section 17, *Oversight*, if the Contractor violates any provider network requirements or if the Contractor's Member has experienced problems accessing necessary services due to lack of an adequate provider network.

7.1.1 General Network Provisions

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 ensure that Members are able to access and receive the full continuum of covered services, as described in Section 5, *Benefits and Services*. The Contractor must have in place written policies and procedures for temporary coverage of services in the case of unexpected PCP absence (e.g., due to death or illness).

The Contractor must maintain its own provider network processes, separate from other Managed Care organizations, including distinct recruitment, credentialing and contracting reviews, policies, and processes.

In accordance with 42 CFR §438.68, in establishing and maintaining its network, the Contractor must consider all of the following elements:

1. The anticipated Cardinal Care enrollment;
2. The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Cardinal Care program population to be served and the existing patterns of utilization, including in localities that fall adjacent to another region and localities that border with other States;

3. The number and types (in terms of network training status, experience, and specialization) of network providers required to furnish the services covered under this Contract;
4. The number of network providers who are not accepting new membership from the Contractor;
5. The geographic location of network providers and members, considering distance, travel time, and the means of transportation ordinarily used by members;
6. The ability of network providers who have the demonstrated capacity to actively deliver services within the model of care, ensure physical access, reasonable accommodations, culturally competent communications~~,~~ and accessible equipment for members with physical or mental disabilities;
7. The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
8. The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;
9. Elements that support a Member's choice of provider;
10. Strategies that ensure the health and welfare of the Member and support community integration of the Member; and
11. Other considerations that are in the best interest of the Members with special health care needs.

The Contractor is not required to contract with all willing providers; however, its network must meet the access to care standards described in Section 7, *Provider Network and Access to Care*. This Contractor must operate statewide. The Department reserves the right to freeze enrollment in any locality where the Contractor is determined by the Department to not meet network adequacy standards. Statewide network insufficiencies may result in compliance action as described in Section 1, *Scope of Contract*.

7.1.2 Provider Choice Standards

The Contractor must provide Managed Care Members with a choice of providers as described below, including providers who will travel to the Member's home to provide services.

Provider Choice for Members Traveling to Providers Standards	
Standard	**Service Type**
At least two (2) providers for each provider type in accordance with appointment standards, as specified in Section 7.2.14, *Appointment Timeliness Standards*, and time and distance standards specified in Section 7.2.1, *Member Travel Time and Distance Standards*	1. Primary Care Provider (PCP), adult 2. Pediatrician 3. OBGYN 4. Behavioral Health (mental health and substance use disorder) 5. Other Providers Including pediatric and adult Specialists (see reporting requirements in the Cardinal Care Technical Manual)
At least one (1) provider for each provider type in accordance with time and distance standards	See reporting requirements in the Cardinal Care Technical Manual.

Provider Choice for Members Traveling to Providers Standards	
Standard	**Service Type**
specified in Section 7.2.1, *Member Travel Time and Distance Standards*	

Many Cardinal Care services are provided in the Member's home. The Contractor must ensure that Cardinal Care providers who are not located in the city/county of the Member's residence are willing and able to serve Members of that city/county in their homes.

Provider Choice for Providers that Serve Members In Their Homes	
Standard	**Service Type**
At least two (2) providers for each type of service in each Cardinal Care locality	1. Early Intervention 2. Doula 3. Home Health 4. LTSS – Personal Care, Respite Care and Skilled Respite Care 5. LTSS – Private Duty Nursing, Congregate Nursing, and Congregate Respite Nursing 6. LTSS – Services Facilitation 7. MHS – Except for Mental health case management, which is provided by the local Community Services Board and is exempt from the two (2) provider requirement and is described further in Section 22, *Definitions* and Attachment E, *Cardinal Care Summary of Covered Benefits Chart*.
At least one (1) provider for each type of service in each Cardinal Care locality	1. LTSS – Assistive Technology Only 2. LTSS – Personal emergency response systems (PERS) 3. LTSS – Environmental Modification, 4. Durable Medical Equipment (DME) and Supplies

The Contractor may need to submit more than the minimum number of required providers within a given locality to ensure that Members have access within the contractually required appointment standards and time and distance standards described in this Section.

7.1.3 Primary Care Provider Assignment

In accordance with 42 CFR §438.3(l), the Contractor must offer each Member 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 7.2.1, *Member Travel Time and Distance Standards*.

With the exception of dual-eligible Members, the Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) at the date of enrollment. If eligible Members do 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, MTR information received from the Department, etc.), language needs (to the extent they are known), age and sex, enrollment of family Members (e.g., siblings), and area of residence. The Contractor must notify the Member in writing, on or before the effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

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 facilitate the process to make the Member's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

The Contractor must have:

1. At least one (1) full time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Members; and
2. At least (1) full time equivalent (FTE) pediatric PCP for every 1,500 Members under the age of eighteen (18).

The PCP to member ratio caps may be exceeded only in cases where mid-level practitioners are used to support the PCP's practice or where assignments are made to group practices.

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 Cardinal Care program Members under enrollment by the Contractor. If necessary to meet or maintain appointment availability standards set forth in this Contract, the Contractor must 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. These reporting requirements are captured in the submission of the Enrollment Broker file as well as the Provider Network file.

Providers that qualify as PCPs include:

1. Pediatricians;
2. Family and General Practitioners;
3. Internists;
4. OB/GYNs;
5. Specialists who perform primary care functions within certain provider classes, care settings, or facilities. This includes, but is not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, Free Clinics, and other similar community clinics;
6. Indian Health Care Providers, including tribal clinic providers; or
7. Other providers approved by the Department.

Children and Youth with Special Health Care Needs (CYSCN) may request that their PCP be a specialist. The Contractor must grant these PCP requests in accordance with Contractor's credentialing policies and procedures. The Contractor must make a good faith effort, including tracking claims data, conducting

care management with the family, and following up with the specialist, to ensure that children for whom the PCP is a specialist receive EPSDT services, including immunizations and dental services. For FAMIS Children, the PCP must be a specialist that is appropriate for children.

The Contractor must work closely with nursing facility providers to ensure that physicians who are credentialed with a Nursing Facility to serve as a PCP are also credentialed with the Contractor. Refer to Section 7.3.4, *Provider Credentialing Standards*.

7.1.4 Providers Caring for Victims and Perpetrators

The Contractor must 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 physical/mental abuse, neglect, and domestic violence. Such expertise and capability must include the ability to identify possible and potential victims and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of physical/mental abuse, neglect and domestic violence. The Contractor must utilize human services agencies or appropriate providers in their community and must include such providers in its network.

7.1.5 Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Community Services Boards (CSBs)

The Contractor must make a best effort to contract with the FQHCs, CSBs and RHCs available in their service area.

The Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs as required by the Cardinal Care Technical Manual. The Contractor must ensure 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 must provide supporting documentation at the Department's request.

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 will cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHCs or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of Cardinal Care Members.

The Contractor must notify the Department in writing about the type of FQHC payment arrangement it has established in accordance with the requirements of the Cardinal Care Technical Manual.

For services provided to dual-eligible Members by an FQHC, the Contractor must also comply with 42 USC § 1396a(a)(10)(E) and § 1396d(p)(3). See Section 13.4.1, *Services Provided to FQHC and RHC Members*).

7.1.6 Commonwealth Coordinated Care Plus Waiver Network Providers

The Contractor must monitor and ensure that network providers providing services to CCC Plus Waiver Members comply with the provider requirements as established in the Department's provider manuals and the following regulations: 12VAC30-120-900 through 12VAC30-120-995.

In accordance with Social Security Act Sections 1915(c), 1915(i), and 1915(k) and 42 CFR §438.3(o), the Contractor must require that all providers of CCC Plus Waiver services maintain compliance with the Home- and Community-Based Settings provisions detailed in 42 CFR §441.301(c)(4)-(5) prior to executing a provider agreement. More information is available on the Medicaid.gov website.

As part of the annual LOCERI assessment, the Contractor's Care Manager must conduct an Individual Experience Survey provided by the Department to ensure that the Member's services and supports are provided in a manner that comports with the setting provisions of the Home- and Community-Based Settings provisions outlined in 42 CFR §441.301(c)(4)-(5). The Department developed the survey in collaboration with the Cardinal Care health plans.

The Contractor is responsible for one hundred percent (100%) remediation of any instance in which the Member's services do not comport with requirements set forth in 42 CFR §441.301(c)(4)-(5).

7.1.7 Mental Health Services Providers

The Contractor must contract with DMAS enrolled Multisystemic Therapy, Functional Family Therapy and Assertive Community Treatment providers for as part of the DMAS BRAVO implementation. The Department reserves the right to require the Contractor to contract with a certain percentage of other types of MHS providers during the BRAVO implementation to ensure timely member access to these services.

7.1.8 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, take corrective action when there is a failure to comply, and must provide a monthly report by provider taxonomy code that demonstrates to the Department that these access standards are being continuously monitored by the Contractor and that standards have been met.

In accordance with 42 CFR §438.358(b)(1)(iv), the EQRO will validate network adequacy during the preceding twelve (12) months to comply with the requirements set forth in 42 CFR §438.68 and defined in Section 7, *Provider Network and Access to Care*.

For its provider network, the Contractor must:

1. In accordance with 42 CFR §438.242(b)(2-3), collect and maintain one hundred percent (100%) of all provider data for providers in that Contractor's or subcontractor's network where the Contractor has incurred a financial liability on services furnished or denied to enrollees;
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 Cardinal Care MCO

assignments and encounter processing. The first submission must be sent sixty (60) days prior to the Department's program implementation. Standard formats, required data elements, and other submission requirements as detailed in the Cardinal Care Technical Manual. ;

3. Submit a complete Enrollment Broker file, which includes the Contractor's provider network list in the Department's approved electronic specified format noted in the Cardinal Care Technical Manual sixty (60) calendar days prior to the effective date of the Contract. An updated file with all of the changes to the network must be submitted to the Department weekly thereafter or more frequently, if needed, during any program expansions (e.g., upon adding additional populations to the Cardinal Care program). The Department sends these files to the Department's contracted Enrollment Broker as data supplied to the Virginia Managed Care website and the Cardinal Care smartphone application. 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; and
4. Submit to the Department a complete provider network file on a quarterly basis. The Cardinal Care Technical Manual details the provider reporting data elements, submission requirements, including frequency of submission (ongoing) data elements, and file format. Additional required elements to be included in this provider file may be identified by the Department.
5. The Contractor must ensure compliance with federal and contractual standards for provider network enrollment into the DMAS PRSS system, as described in section 7.3.2 *Provider Enrollment into Medicaid.* The Department will use PRSS data to evaluate the Contractor's network adequacy.

In accordance with Section 4.3.8, *Provider Network Directory*, the Contractor must maintain, update, and distribute its online and printed provider directories, including updating information with provider updates.

7.2 Access to Services

7.2.1 Member Travel Time and Distance Standards

In accordance with 42 CFR §438.68(c)(1), the Contractor must ensure that the travel time and distance standards described in this Section are met for services in which the Member travels to receive care, as described in Section 7.2.1, *Member Travel Time and Distance Standards*. Travel time must be determined based on driving during normal traffic conditions (i.e., not during commuting hours). Travel time and distance standards do not apply to providers who travel to provide a service (e.g., PERS, home health, personal care, respite).

The Contractor must contract with a sufficient number of providers and facilities to ensure that at least eighty percent (80%) of its Members within a county or independent city can access primary care within the time and distance services described below. In addition, travel time and distance for all other providers in which the Member travels to receive covered benefits must not exceed the standards below for at least seventy-five percent (75%) of its enrolled Members.

Member Time & Distance Standards

Standard	Distance	Time
Urban:		
1. PCPs, Adult	15 Miles	30 Minutes
2. Pediatricians	15 Miles	30 Minutes
3. Other Providers Including Specialists (see reporting requirements in the Cardinal Care Technical Manual.	30 Miles	45 Minutes
Rural:		
1. PCPs, Adult	30 Miles	45 Minutes
2. Pediatricians	30 Miles	45 Minutes
3. Other Providers Including Specialists (see reporting requirements in the Cardinal Care Technical Manual	60 Miles	75 Minutes
*All zip codes for the regions of Southwest and Roanoke/Alleghany are considered rural.		

7.2.2 Twenty-Four (24) Hour Coverage

Pursuant to 42 CFR §438.3(q), the Contractor must maintain adequate provider network coverage to make services included in the Contract available twenty-four (24) hours per day, seven (7) days a week when medically necessary. The Contractor must make arrangements to refer Members seeking care after regular business hours to an appropriate provider within twenty-four (24) hours per the standard set in Section 5.7.1, *Payment of Emergency Services*. The Contractor may direct the Member to go to an emergency department for potentially emergent conditions and this may be done via a recorded message.

7.2.3 Urgent Care Access

All Managed Care program enrolled Members must have access to at least one (1) urgent care facility (where available) to alleviate inappropriate use of hospital emergency rooms. These facilities must meet time and distance standards for care. Urgent care transportation must be provided for medically necessary care, using the lowest possible transportation acuity level. To alleviate emergency department visits, the Contractor must have a network of providers to cover after-hours urgent care services for Members. Appointments for urgent care and symptomatic office visits must be available as soon as the symptom demands but in no event more than twenty-four (24) hours of the Member's request. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting.

7.2.4 Inpatient Hospital Access

The Contractor must maintain in its network a sufficient number of inpatient hospital facilities. The Contractor must 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 ability of Members to access

services, and the units or capacity of services or members covered. Any physician who provides inpatient services to the Contractor's Members must have admitting and treatment privileges at a minimum of one (1) general acute care hospital.

7.2.5 Family Planning Service Access

In accordance with 42 CFR §438.206(b)(7), the Contractor's network must include sufficient family planning providers to ensure timely access to covered services.

7.2.6 Mental Health Services Access

The Contractor's MHS network must ensure sufficient Member access to high quality service providers with demonstrated ability to provide evidence-based treatment services that consist of person-centered, culturally competent and trauma-informed care using a network of high quality, credentialed, and knowledgeable providers in each level of care within the access to care and quality of care standards as defined by the Department. The Department will periodically review and monitor the Contractor's network adequacy for MHS, based on its network submission per Section 7.1.8, *Assurances That Access Standards Are Being Met*.

7.2.7 Early Intervention Service Access

In order to ensure adequate early intervention provider participation, the Contractor must adhere to the Department's early intervention coverage rules and must comply with special payment provisions described in Section 12.2.4.4, *Early Intervention Payments*.

7.2.8 LTSS Access

The Contractor must ensure that it develops and maintains a network of high quality waiver and non-waiver service providers, with sufficient capacity to serve its full Managed Care membership, within the access standards defined in this Contract. In order to ensure adequate LTSS provider participation, the Contractor must adhere to continuity of care standards and special payment provisions and must provide dedicated training and technical assistance to LTSS providers. See Section 2.12.3.1, *Dedicated Assistance for LTSS Providers*.

7.2.9 Out-Of-Network Services

The Contractor must cover, pay for, and coordinate all care in all of the following circumstances:

1. When the Contractor has authorized services to be received from an out-of-network provider;
2. When emergency and family planning services are rendered to a Member by a non-participating provider or facility, as set forth in this Contract;
3. 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;
4. When the needed medical services or type of provider (in terms of training, experience, and specialization), necessary supplementary resources, or services furnished in facilities or by practitioners outside the Contractor's network are not available in the Contractor's network;

5. When the Contractor cannot provide the needed specialist, as specialist is defined in this Contract, within the Contract distance standard of more than thirty (30) miles in urban areas or more than sixty (60) miles in rural areas;
6. During the Member's continuity of care period when the Member's provider is not part of the Contractor's network, has an existing relationship with the Member, and has not accepted an offer to participate in the MCO's network (See Section 8.11.1, *Continuity of Care Upon Enrollment*);
7. In accordance with Sections 8.10.3, *Transition from NF to Community*, and 8.11.4 *Members in NFs*;
8. When the Department determines that the circumstance warrants out-of-network treatment;
9. When a provider is not a part of the Contractor's network, but is the primary provider of services to the Member, provided that:
    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;
    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) calendar days (after being given the opportunity to select a provider who participates);
10. Pursuant to 42 CFR §438.52(b)(2)(ii)(D), 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; and
11. Pursuant to 42 CFR §438.52(b)(2)(ii)(C) the only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.

Pursuant to 42 CFR §438.206(b)(5), the Contractor must require out-of-network providers to coordinate with the Contractor for payment and ensure the cost to the Member is no greater than it would be if the services were furnished within the Contractor's network. The Contractor must reimburse out-of-network providers at the fee-for-service rate in effect on the date of service. For CCC Plus Waiver and home health services, the rate must include the Northern Virginia differential.

7.2.9.1 Mental Health or Substance Use Disorder Out-of-Network Providers

In accordance with 42 CFR §438.910(d)(3), the Contractor must 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.

7.2.10 Covered Out-Of-State Services

The Contractor is not responsible for services obtained outside the Commonwealth except under the following circumstances:

1. Necessary emergency, crisis, or post-stabilization services;

2. Where it is a general practice for Members in a particular locality to use medical resources, including family planning, in another state;
3. The required services are medically necessary and not available in-network and within the Commonwealth;
4. While the Contractor 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; or
5. Enroll bordering out-of-state ambulance companies as needed for facility-to-facility transfers that occur within the bordering state boundaries. Virginia ambulance companies are not permitted to transport Members unless pick up or drop off addresses are located in Virginia. Virginia ambulance providers are not allowed to transfer members within the boundaries of other states.

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).

7.2.11 Specialist Accessibility for Individuals with Special Health Care Needs

When a Member with special health care needs has been identified through an assessment to need a course of treatment or regular care monitoring, and in compliance with 42 CFR §438.208(c)(4), the Contractor must have a mechanism in place to allow the Member to directly access a specialist, as appropriate for the Member's condition and identified needs. The Contractor must also share the identification and assessment results of any Member with special health care needs with other Contractors serving the Member, to ensure activities will not be duplicated, per 42 CFR §438.208(b)(3).

7.2.12 Provider Accessibility for Individuals with Disabilities

The Contractor must provide written policies and procedures to assure that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services from the Contractor in accordance with the requirements contained in the Cardinal Care Technical Manual.

In accordance with 42 CFR §438.206(c)(3), the Contractor must ensure that all network providers provide physical access, geographic access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

The Contractor and its network providers must comply with the Americans with Disability Act (ADA), 28 CFR §35.130, and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794). Accessibility includes physical accessibility of service sites and medical and diagnostic equipment. Vehicles must comply with the Americans with Disabilities Act (ADA) specifications for transportation, 49 CFR §38, subparts A and B. The Contractor must maintain capacity to deliver services in a manner that accommodates the needs of its Members by:

1. Providing flexibility in scheduling to accommodate the needs of the Members;
2. Providing interpreters or translators for Members who are deaf and hard of hearing;
3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable

accommodations will depend on the particular needs of the individual and include but are not limited to:

a. Ensuring safe and appropriate physical and communication access to buildings, services and equipment;
b. Ensuring providers allow extra time for Members to dress and undress, transfer to examination tables, and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information; and,
c. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

The Contractor must review compliance of provider accessibility at the time of credentialing and recredentialing of its providers.

7.2.13 Provider Accessibility for AI/AN Members through Indian Health Care Providers

Services provided through Indian Health Care Providers, including tribal clinic providers, are carved out of this Contract and reimbursed through fee-for-service, per the provider's agreement with the Department.

In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the Contractor must ensure the following for its AI/AN Members:

1. Offer American Indian/Alaska Native Members the option to choose an IHCP as a PCP;
2. Demonstrate the capability for an out-of-network IHCP to refer an AI/AN Member to a network provider under 42 CFR § 438.14(b)(6).
3. Provide coverage for any services provided by non-IHCPs, including service referrals by IHCPs, except where otherwise carved-out of this contract.

7.2.14 Appointment Timeliness Standards

The Contractor must arrange to provide care as expeditiously as the Member's health condition requires. Members cannot be billed for missed appointments. The Contractor must ensure that it meets the appointment timeliness standards for services described below for enrolled Members.

Service Type	Appointment Timeliness Standards
Emergency Services, including Crisis Services	1. Emergency appointments and services, including crisis services, must be made available immediately upon the Member's request
Routine Primary Care Services	1. Routine, primary care service appointments must be made within thirty (30) calendar days of the Member's request 2. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule

Service Type	Appointment Timeliness Standards
	calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.
Maternity Care	1. Prenatal care appointments must be made available to pregnant Members as follows: a. First trimester - Within seven (7) calendar days of request b. Second trimester - Within seven (7) calendar days of request c. Third trimester - Within three (3) business days of request d. High-Risk Pregnancy - Within three (3) business days of identification of high-risk to the Contractor or maternity provider, or immediately if an emergency exists
Mental Health Services	1. Behavioral health appointments must be made available as expeditiously as the Member's condition requires and within no more than five (5) business days from the Contractor's determination that coverage criteria is met
LTSS	1. LTSS must be made available as expeditiously as the Member's condition requires and within no more than five (5) business days from the Contractor's determination that coverage criteria is met

7.2.15 Exceptions to Access Standards

In accordance with 42 CFR §438.68(d), the Contractor may request an exception to the standards where there is a shortage of the provider type(s) practicing in the Contractor's service area. The Contractor's Cardinal Care Network Adequacy Exemption Request Form must include a detailed action plan for network improvement with actionable and measurable goals, and related milestones for coming into compliance. The Contractor's action plan must also explain how the Contractor will ensure that Members receive timely access to care including in any instance where an exception is granted by the Department. The Contractor must monitor and work to improve access to any provider types in which the Department grants an exception on an ongoing basis and must report findings to the Department per the action plan approved by the Department. The Department also reserves the right to establish different time and distance standards in future Contract revisions. The approved Cardinal Care Network Adequacy Exemption Request Form will only be valid for the particular submission cycle. The Department reserves the right to change or update the form used for submission.

7.3 Provider Network Management

7.3.1 Provider Recruitment and Selection

In accordance with 42 CFR §438.12, the Contractor must implement written policies and procedures for selection and retention of network providers. Consistent with 42 CFR §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 as prescribed by 42 CFR §438.12(a)(1). Additionally, pursuant to Section 1932 (b)(7) of the SSA, the Contractor must 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.

Pursuant to 42 CFR §438.12(b), this Section must 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 for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

7.3.2 Provider Enrollment into Medicaid

In accordance with 42 CFR §438.602(b), 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, the CMS Medicaid Provider Enrollment Compendium (MPEC), and Department-issued guidance memos, prior to finalizing the provider contract, the Contractor must ensure its Virginia Medicaid and FAMIS network providers are screened, enrolled (including signing a Department provider participation agreement), and periodically revalidated in the Department's Medicaid Enterprise System (MES) Provider Services Solution (PRSS). This rule applies to all network provider types and specialties. Per 42 CFR §438.608(b), this provision does not require the Contractor's network provider to render services to FFS beneficiaries.

The Contractor's providers participating within an MCO's D-SNP network that only provide Medicare services are not required to enroll in PRSS.

The Contractor's out-of-network providers are not required to submit an application and enroll as a provider in PRSS; however, the Contractor must register all its out-of-network providers using the PRSS non-par participation registration (NPPR) file.

In accordance with 42 CFR §438.602(b)(2), the Contractor may execute network provider agreements for up to 120 days, pending the provider's completion of the Department's screening and enrollment process; however, the Contractor must terminate the provider's agreement immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider. Upon such termination, the Contractor must notify affected members. The Contractor must register these providers using the NPPR process while the provider's PRSS application is pending. The Contractor must send communications and provide education/training materials regarding the Department's PRSS, as directed by, and in conjunction with, the Department, its PRSS vendor, and as required by the Cures Act.

7.3.3 National Provider Identifier (NPI)

In accordance with requirements set forth in 1932(d)(6) and 1173(b) of the Social Security Act, the Contractor must require each provider rendering services under this Contract with the exception of providers exclusively participating within an MCO's network to have a unique NPI in accordance with the system set up under Section 1173(b) of the Social Security Act or an Atypical Provider Identification Number (API), and must require that providers use these identifiers when submitting data to the

Contractor. The NPI is provided by the CMS which assigns the unique identifier through its National Plan and Provider Enumeration System (NPPES).

The Contractor must ensure that all encounters are identified with an active NPI for all health care providers. On a monthly basis, 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 must make every reasonable effort to ensure all network providers, including ancillary providers, (i.e. vision, pharmacy, etc.), are enrolled in the Medicaid program.

7.3.4 Provider Credentialing Standards

The Contractor must implement written policies and procedures for credentialing and recredentialing of acute, primary, behavioral, ARTS, and LTSS network providers and those policies and procedures must comply with Federal standards at 42 CFR §438.214 and 42 CFR §438.12, the most recent NCQA standards, and State requirements described in Code of Virginia § 38.2-3407.10:1 and in this contract.

In accordance with 42 CFR §438.214, the Contractor must implement written policies and procedures for selection and retention of network providers. In all network provider agreements, the Contractor must follow a documented process for the credentialing and recredentialing of network providers and must follow the state's uniform credentialing and recredentialing policy that addresses the health care services the provider is licensed or qualified to provide including acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate. In all network provider agreements, the Contractor must comply with any additional provider selection requirements established by the state and described in this contract.

In accordance with 42 CFR §438.12(a)(1) and 42 CFR §438.214, the Contractor's credentialing and recredentialing policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

In accordance with NCQA credentialing and recredentialing requirements, the Contractor must have the ability to determine whether providers are licensed by the State and have received proper certification or training to perform medical and behavioral health services contracted for under this Contract.

The Contractor is required to operate an online credentialing and recredentialing system. The online system must notify a new provider applicant that the application is received. The Contractor is required to offer a non-electronic based credentialing and recredentialing upon request of a provider. For applications received outside of the online system the Contractor must notify a new provider applicant within 10 days of receiving an application, either by mail or electronic mail, as selected by the applicant, that the application was received.

Beginning January 1, 2024, and in accordance with Code of Virginia § 38.2-3407.10:1, a new provider applicant's application is deemed complete within thirty (30) days of the Contractor receiving the application, unless the Contractor has provided notice that the application is not complete. Notice shall be provided by electronic mail unless the provider applicant requests notification by mail. The Contractor shall approve or deny new provider applicant credentialing applications within sixty (60) days of receiving a completed application. Additionally, claims submitted according to Contractors claims

submittal policies for services rendered during the period of a pending application shall be adjudicated and paid no later than forty (40) days after the new provider applicant is credentialed and contracted. See section 12.1.3, *Payment of New Provider Applicants*, for additional requirements regarding payment of new provider applicants.

The Contractor is required to report to the Department their compliance with the timeliness and provider requirement standards described in the preceding paragraphs as specified in the Cardinal Care Technical Manual.

If an application is denied, the Contractor must give the applicant written notice of the reason for its decision not to include an individual or groups of providers in its provider network.

The Contractor must be able to demonstrate that its network providers are credentialed as required under 42 CFR §438.214. 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. This includes program integrity-related and adverse actions as outlined in the Cardinal Care Technical Manual. The Contractor must report to the Department all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers).

The Contractor's standards for licensure and certification must be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or employment contracts.

The Contractor must continuously monitor the quality of services provided by its network providers. The Contractor's recredentialing process must include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys.

The Contractor must 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 Cardinal Care 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 or the ordering or referring provider is not credentialed by the Contractor, the Contractor may deny the claim, unless otherwise instructed by the Department.

7.3.4.1 Behavioral Health Providers

The Contractor's Behavioral Health providers, Mental Health Services (MHS), and ARTS providers (public and private) must meet any applicable DBHDS certification and licensing standards. Behavioral health providers must meet the Department's qualifications as outlined in 12VAC30-50-226, 12VAC30-60-143, 12VAC30-50-130, 12VAC30-60-61, and 12VAC30-130-5000, *et. seq*. Behavioral health providers must meet the requirements in the Department's most current behavioral health provider manuals, including the ARTS, Mental Health Services, and Psychiatric Services provider manuals found on the Virginia Medicaid Provider Portal.

7.3.4.2 CCC Plus Waiver Providers

At a minimum, recredentialing of CCC Plus Waiver providers must include verification of continued licensure and/or certification (as applicable); quality of care provided, Individual Experience Survey data, compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and compliance with the Home- and Community-Based Settings provisions outlined in 42 CFR §441.301(c)(4), in accordance with Social Security Act Sections 1915(c), 1915(i), and 1915(k), and 42 CFR §438.3(o).

7.3.5 Provider Qualifications

7.3.5.1 Mental Health Service Provider Qualifications

The Contractor must use the Department recognized licensed and credentialed treatment professionals as defined in 12 VAC 30-50-226, 12 VAC 30-50-130, 12 VAC 30-60-143, 12 VAC 30-60-61 and 12 VAC 30-130-5000, *et. seq*., and the provider manuals, supplements and appendices. The Contractor must verify that registration requirements for peer recovery specialists and qualified mental health professionals are met as directed by the Department of Health Professions in accordance with all applicable regulations.

7.3.5.2 ARTS Provider Qualifications and Annual Review

The Contractor must use Department 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; licensed, registered, and certified credentialed addiction treatment professionals as defined in 12VAC30-130-5020; and certified peer recovery specialists as defined in 12 VAC 35-250-10. In situations where a certified addiction physician is not available, the Contractor must 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 must credential ASAM Level 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4.0 and Opioid Treatment Program providers of ARTS services using the ARTS ASAM Level 2.1 to 4.0 Credentialing Form and ARTS Staff Roster available at this link.

The Contractor must credential the Preferred Office Based Opioid Treatment (OBOT) providers approved by the Department using the criteria as set forth by the Department in 12VAC30-130-5060. Approval will be based on the Office of the Chief Medical Officer's review of the ARTS OBOT Attestation Application available at this link. The Contractor must provide the Department with a report on a monthly basis of the OBOT credentialed organizations in the Contractor's network as required by the Cardinal Care Technical Manual.

The Contractor must perform an annual review on all providers to assure that the health care professionals under contract with the provider are qualified to provide ARTS and that services are being provided in accordance with contract, the ASAM criteria and set forth in 12VAC30-130-5000, the ARTS Provider Manual, the Contractor's program requirements and DBHDS licensing requirements for ASAM Levels of Care (12VAC35-46-10, 12VAC35-46-1160 through 12VAC35-46-1250).

7.3.5.3 Early Intervention Provider Qualifications

In accordance with 12 VAC 30-50-131 and 12VAC35-225 et seq., in Appendix G of the Department's Early Intervention Provider Manual, and the DBHDS Practice Manual, all individual practitioners providing Early Intervention services must be certified by the Department of Behavioral Health and Developmental Services (DBHDS) to provide Early Intervention services. Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as an Early Intervention Service Coordinator.

The Department requires that all Managed Care Organizations (MCOs) maintain a network of Early Intervention (EI) providers for the Managed Care program, certified by the Department of Behavioral Health and Developmental Services (DBHDS) and associated with a Local Lead Agency (LLA) for the catchment area in which Members reside. The Department's Early Intervention Master Roster is a database of all credentialed EI providers, professionals, specialists, and EI case managers. The Department will provide a roster to the health plans of EI providers currently certified by DBHDS.

7.3.5.4 LTSS Provider Qualifications

Provider qualification requirements for Managed Care covered LTSS services can be found at the Department's regulatory and manual citations provided in Attachment E, Cardinal Care Summary of Covered Benefits Chart.

7.3.6 Provider Agreements

In accordance with 42 CFR §§438.206 and 438.207, the Contractor's network must be supported by written agreements. The Contractor must submit for review and approval any new or revised network provider agreement template at least thirty (30) calendar days prior to the effective date of use, and upon request thereafter. The Department may approve, modify and approve, or deny network provider agreement templates under this Contract at its sole discretion. The Department reserves the right to require the Contractor to modify any provider agreement templates as the Department deems necessary or based on changes in Federal or State laws or regulations. 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 participating Members including but not limited to, the proposed provider's past performance.

The Department will approve or disapprove any new or revised agreement template within thirty (30) calendar days of 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 must be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) calendar days.

The Contractor must 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 Contractor must enter into written agreements with providers to ensure the provision of all covered services as outlined in this Contract. In accordance with 42 CFR §438.602(b)(2), the Contractor may execute network provider agreements of up to one hundred twenty (120) days while the outcome of screening, enrollment, and revalidation is pending, but must terminate a network provider immediately upon notification from the Department that the network provider cannot be enrolled, or the expiration of a single one hundred twenty (120) day period without enrollment of the provider, and notify affected Members. When contracting with providers, the Contractor must have the authority to develop alternative and varying contractual models and relations, and incentives outside of the fee-for-service structure.

The Contractor must 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 and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities. Additionally, in accordance with 42 CFR §438.206(c)(1)(ii), the Contractor must ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members if the provider serves only Medicaid and/or FAMIS members.

The Contractor's network agreement must require all providers to be screened, enrolled (including signing a Department Medicaid provider participation agreement), and periodically revalidated in the Department's MES PRSS. The contractor must comply with all Network Provider Agreement requirements, as described in Attachment C, Network Provider Agreement Requirements.

7.3.7 Termination of a Network Provider

The Contractor may terminate, suspend, sanction, and/or educate providers according to the terms described in its agreements with its network providers. The Contractor is not required to offer terminated providers appeal rights related to their termination. 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 Cardinal Care Technical Manual.

The Contractor must have in place the following written policies and procedures related to the termination of a network provider. In addition to these requirements, the Contract must also ensure compliance with the provisions of Va. Code §§ 38.2-3407.10 and 38.2-4319.

1. Pursuant to 42 CFR §438.10(f)(1), procedures to make a good faith effort to give written notice of termination of a network provider to Members. Notice must be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider;
2. Procedures to provide a good faith effort to transition each Member to a new provider within at least thirty (30) calendar days prior to the effective date of provider termination;
3. Procedures for the reassessment of the provider network to ensure it meets Provider Network and access standards established in sections 7.1, *Provider Network*, and 7.2.13, *Provider Accessibility for AI/AN Members*; and
4. Procedures for notifying the Department within the time frames set forth in this Contract and the Cardinal Care Technical Manual including but not limited to Sections 7.1, Provider Network,

7.3.4, Provider Credentialing Standards, 7.2.15, *Exceptions to Access Standards*, 7.1.8, *Assurances that Access Standards Are Being Met*; 18.2, *Program Integrity Plan*, and 18.8.1, *Quarterly Fraud/Waste/Abuse Report*.

5. Procedures to terminate the provider's agreement immediately upon notification from the State that the network provider cannot be enrolled or revalidated in accordance with 42 CFR §438.602(b), 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act

7.3.7.1 Reporting on Termination of Mental Health Service Providers

The Contractor must report to the Department on a quarterly basis on the termination of MHS providers. At a minimum, the report must include:

1. The number of providers in their network and their geographic locations;
2. The total number of provider terminations by year since fiscal year 2018 and the number terminated with and without cause;
3. The localities the terminated providers served; and
4. The number of Medicaid members the providers were serving prior to termination of their provider contract.

See the Cardinal Care Technical Manual for full reporting requirements.

7.3.7.2 Notice to the Department of Provider Termination

The Contractor must notify the Department regarding provider terminations as set forth in the Cardinal Care Technical Manual:

1. In advance of, or within at least thirty (30) business days of a contract termination that could reduce Member access to care, and at least thirty (30) business days prior to implementing any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider where the termination, pending termination, or pending modification could reduce Member access to care;
2. In advance of, or within five (5) business days where the provider termination would create any network deficiencies whereby the Contractor is unable to meet the Department's network time and distance standards in Section 7.2.1, *Member Time and Travel Distance Standards*;
3. As soon as possible and within forty-eight (48) hours of a contract termination for suspected or actual fraud or abuse per Section 19, *Provider Audits, Overpayments, and Recoveries*;
4. Immediately upon receipt of notice regarding the termination of any contracts with hospitals and health systems; and
5. Immediately and no later than twenty-four (24) hours upon receipt of notice, including notice to the appropriate authorities for any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license. See Section 7.3.4, *Provider Credentialing Standards.*

7.3.8 Screening and Excluded Entities/Service Providers

In accordance with 42 CFR §§438.610, 438.808, 431.55(h), 1001.1901, and 1002.3(b), and Sections 1903(i)(2) and 1932(d) of the Social Security Act, the Contractor must not knowingly have a relationship with any of the following:

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2. An individual or entity who is an affiliate, as defined in the FAR at 48 CFR §2.101, of a person.
3. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.
4. An individual or entity terminated, as defined in 42 CFR § 455.101, from the Medicare, Medicaid, or CHIP programs.
5. For the purposes of this Section, a "relationship" means any of the following:

    a. A director, officer, or partner of the Contractor;
    b. A subcontractor of the Contractor, as governed by 42 CFR §438.230;
    c. A person with beneficial ownership of five percent (5%) or more of The Contractor's equity; or
    d. A network provider or 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.

Pursuant to 42 CFR §455.436, the Contractor must, prior to contracting, monthly thereafter and at the time of credentialing or recredentialing, check the exclusion status of all network providers against the following lists (collectively, these lists are referred to as the "Exclusion Lists") to ensure that the Contractor does not pay federal funds to excluded persons or entities:

1. State Exclusion List;
2. U.S. Department of Health and Human Services, Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE);
3. The System of Award Management (SAM);
4. The Social Security Administration Death Master File (SSADMF);
5. To the extent applicable, National Plan and Provider Enumeration System (NPPES); and
6. Office of Foreign Assets Control (OFAC).

The Contractor must also check the Department provider file or conduct its own checks against the Federal exclusion files (named above) to ensure that any of its network providers who are "Medicaid enrolled" providers remain enrolled with the Department. The Contractor's screening process must also include: verifying licenses, conducting revalidations at least every five (5) years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high-risk, criminal background checks as required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by subcontractors and providers.

In addition, pursuant to 42 CFR §438.808(a), the Contractor must check, at least every month, the exclusion status of persons with an ownership or controlling interest in the Contractor, agents and managing employees of the Contractor, delegated entities, and subcontractors against the Exclusion Lists to ensure that the Contractor does not pay federal funds to excluded persons or entities. The Contractor must not be controlled by a sanctioned individual.

The Contractor must take appropriate action upon identification that a person, agent, managing employee, network provider, delegated entities or subcontractor appears on one (1) or more of the Exclusion Lists (each an "Excluded Person"), which may include termination of the relationship with the Excluded Person and ceasing payments owed to such Excluded Person.

The Contractor must report to the Department within two (2) business days of identification of an Excluded Person the following information:

1. The name(s) of the Excluded Person(s);
2. The amounts paid to the Excluded Person(s) over the previous twelve (12) months; and
3. The NPI of any network provider appearing on any of the Exclusion Lists and the list(s) where the network provider appeared.

Pursuant to 42 CFR §438.610(d)(2); 42 CFR §438.610(a); Exec. Order No. 12549, if the Department learns that the Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 of February 18, 1986, or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an affiliate of such an individual, the Department may continue an existing agreement with The Contractor unless the Secretary of HHS directs otherwise. However, the Department may not renew or extend the existing agreement with the Contractor unless the Secretary of HHS provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

7.3.9 Ownership and Controlling Interest

The Contractor must require its providers and subcontractors to fully comply with 42 CFR §455 Subparts B and E, which detail 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.

The Contractor must screen all individuals listed on the disclosure form. The information must be obtained through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to the Department in accordance with this Contract and relevant state and Federal laws and regulations.

7.3.10 Clinical Practice Guidelines

In accordance with 42 CFR §438.236, the Contractor must adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Members that:

1. Are based on valid and reliable clinical evidence or a consensus of health care professionals or in the relevant field;
2. Consider the needs of Managed Care Members;
3. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines;
4. Are congruent with current NCQA standards for establishing guidelines
5. Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, Virginia Department of Health or other State agencies;
6. Prior to adoption, have been reviewed by the Contractor's medical director, as well as other Contractor practitioners and network providers, as appropriate;
7. Are reviewed and updated, as appropriate, or at least every two (2) years; and
8. Are reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care professionals and providers.

For guidelines that have been in effect two (2) years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement and were updated accordingly.

The Contractor must disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees, potential Enrollees and Eligible Beneficiaries. The Contractor must make the clinical and practice guidelines available via the Contractor's web site. The Contractor must notify providers of the availability and location of the guidelines and must notify providers whenever changes are made.

The Contractor must establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services.

The Contractor must submit to the Department a copy of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, as required by the Cardinal Care Technical Manual.

7.3.11 Provider Notification of Service Changes Affecting Members

The Contractor must provide written notification to all affected participating providers at least sixty (60) days prior to the effective date of changes to any operational process that would affect services to Members, including but not limited to claims processing, service authorization requirement, etc. This requirement applies to all services covered under this Contract.

7.4 Provider Relations and Engagement

7.4.1 Provider Engagement

The Contractor must receive approval from the Department prior to providing any communication to their provider network that includes information pertaining to Federal and State laws, regulations or policies regarding the Medicaid or Children's Health Insurance Programs.

7.4.2 Provider Relations

The Contractor must provide adequate resources to support a provider relations function that will effectively communicate with existing and potential network providers. The Contractor must 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 and provide information and resources related to provider questions and concerns (such as claims, authorizations, billing). The Contractor must provide this information to potential network providers upon request. The Contractor's network provider agreement must comply with the terms set forth in Attachment C, Network Provider Agreement Requirements.

7.4.3 Provider Satisfaction Survey

The Contractor must conduct a provider satisfaction survey once every two (2) years to assess provider satisfaction, including at a minimum: satisfaction with enrollment, communication, education, complaint resolution, claims processing and reimbursement, care coordination, and utilization management. The Contractor agrees to alter and or update the survey as requested by the Department.

The survey must include a statistically valid sample of each type of its participating Medicaid providers. The Contractor must submit a copy of the survey instrument and methodology to the Department as required by the Cardinal Care Technical Manual. The Contractor must communicate the findings of the survey to the Department in writing within one hundred twenty (120) days after completing the survey. The written report must 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.

7.4.4 Provider Advisory Committee

In accordance with NCQA requirements, the Contractor must establish and maintain a provider advisory committee, consisting of network providers. At least two (2) providers on the committee must 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 must meet at least quarterly. The committee's input and recommendations must be employed to inform and direct the Contractor's quality management and activities, as well as policy and operational changes. The Contractor must provide the Department with the dates of all Provider Advisory Committee activities. The Department may conduct reviews of the membership of this committee, as well as the committee's activities or attend such meetings.

7.4.5 Provider Training, Technical Assistance and Education

The Contractor must provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. The Contractor must also establish and conduct ongoing provider education and trainings to support providers in complying with network contracts, if applicable, and applicable policies and procedures. Technical assistance must include activities such as:

1. Supporting the performance of Member needs assessments;
2. In-person and virtual trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Direct one-on-one support/assistance; and,
4. Facilitating sharing of best practices.

Unless already outlined within this Contract, the Contractor must receive approval from the Department prior to referring providers to Department staff, Department helpline, internet, or any other state and/or local agencies for Managed Care information.

The Contractor must maintain a comprehensive educational and training plan that meets the requirements of the Cardinal Care Technical Manual to ensure that all providers receive proper education and training regarding the Cardinal Care program to comply with this Contract and all applicable Federal and State requirements. This plan must include processes in place to allow a provider who has completed a training with another Contractor on a similar topic to provide proof of completing such training to prevent duplication of attending similar trainings. Such plan must be submitted to the Department consistent with the requirements in the Cardinal Care Technical Manual. The Contractor must attend meetings and forums with providers (e.g., early intervention providers, LTSS providers, mental health service providers, etc.), and other contracted MCOs as necessary, and at the Department's request, to resolve any identified issues.

At a minimum, the Contractor must develop educational and training programs that cover the following topics or issues:

1. **Member's Rights and Responsibilities;**
2. **Member's Needs Related to Access/Delivery of Services.** For example, transportation needs, physically accessible buildings and equipment, cultural competency, and other accommodations under the ADA such as sign language, interpreter services, large print, alternate language or format materials; and marketing practice guidelines and the responsibility of the provider when representing the Contractor;
3. **Eligibility and Enrollment.** Eligibility criteria, eligibility verification, and benefits; and the role of the enrollment broker as the beneficiary support system for enrollment and disenrollment;
4. **Cardinal Care Covered Services.** All covered services, including enhanced and carved-out services and related policies, procedures, and any modifications;
5. **Long-term Services and Supports:** Person-centered supports and compliance with CMS HCBS setting provisions, billing and other necessary processes as directed and/or approved by the Department;
6. **Care Management:** All required Care Management-related topics, as described in Section 8.8.4, *Care Manager Training*;

7. **Policies and Procedures.** Payment policies and procedures (e.g., claims submission, process, payment, service authorizations, and any modifications); billing instructions in compliance with the Department's encounter data submission requirements; billing and claims issues resolutions; and relevant policies and processes outlined in Medicaid manuals, memoranda, and other related Cardinal Care program documents;
8. **Grievances and Appeals.** Grievance and appeals procedures; and procedures for reporting fraud, waste and abuse; and
9. **Other.** Promoting wellness and health; and recognize and report signs of elder and child abuse/neglect and financial abuse.

7.4.5.1 MHS Provider Training

The Contractor must conduct ongoing education with mental health service providers. Training and technical assistance topics must include Managed Care model of care elements, person-centered treatment planning, culturally competent care, evidence-based service planning/treatment planning methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning and strengths based treatment goal selection, as directed and/or approved by the Department.

7.4.5.2 EPSDT Provider Training

The Contractor must maintain a comprehensive plan to ensure that all providers qualified to provide EPSDT services have access to proper education and training regarding the EPSDT benefit to comply with this Contract and all applicable Federal and State requirements. Such plan must be submitted to the Department as required by the Cardinal Care Technical Manual. The Contractor's EPSDT educational and training program will include the required topics:

1. Overview of the EPSDT benefit;
2. Eligibility criteria;
3. EPSDT screenings;
4. Diagnostic services;
5. Treatment services, including EPSDT Specialized Services;
6. Referrals;
7. Clinical trials;
8. Required services to support access;
9. Beneficiary outreach and communication;
10. Medical necessity;
11. Service authorization;
12. Utilization controls;
13. Secondary review;
14. Intersection of EPSDT and HCBS waivers;
15. Notice and appeals; and
16. Provider manuals.

The Contractor must ensure EPSDT-specific training materials are updated no less than every two (2) years or on an as needed basis if the Contractor determines the provider is noncompliant with EPSDT Federal and State requirements.

8. MODEL OF CARE

8.1 Model of Care General Requirements

The Contractor's model of care must support the Department's goals to ensure all Members' have access to equitable, high-quality care and to provide Care Coordination and Care Management services that are responsive to Members' needs and risks, which may change over time. In addition, the Contractor's model of care must prioritize continuity of care and seamless transitions for Members across the full continuum of physical health, behavioral health, pharmacy, LTSS, and social service needs. The Contractor's model of care must include effective advanced analytics and methods to target interventions and maximize the use of Care Management resources, including using data-informed solutions for identifying and stratifying populations by Member need and level of risk. The Contractor's model of care must also enable opportunities for comprehensive proactive care planning and prevention of crisis and emergency services. In general, the Department expects the Contractor's model of care to serve as part of the foundation for ensuring the delivery of high value care at the right place and right time while protecting the health, safety and welfare of Cardinal Care Members. The Contractor must demonstrate to the Department's satisfaction that its model of care, including its system of advanced analytics, meets or exceeds the contractual standards described in this Section. See Attachment I for an overview of the Department's model of care design.

The Contractor's model of care must include, but is not limited to, the following required elements:

1. Provide the full scope of Care Coordination services for all Members and Care Management for select populations as defined by the Department and other Members identified by the Contractor based on their level of need and risk;
2. Identify, assess, and stratify Members with ongoing, emerging and changing needs for Care Management at various intensity levels;
3. Include comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement for Members receiving Care Management services;
4. Integrate physical health, behavioral health, pharmacy, LTSS and social service needs into the approach to the provision of Care Management services;
5. Be responsive to the Member's needs and preferences, and take into account the Member' health, safety, and welfare;
6. Include staff and provider network training (in conjunction with the Department whenever possible) on the Cardinal Care model of care to ensure Members receive person-centered, culturally competent care through trained Care Managers; and
7. Include processes and systems of care that engage Members and family members in person-centered, culturally competent care and ensure seamless transitions between levels of care and care settings, addressing all barriers to accessing appropriate services to support Member health.

8.2 Care Coordination

The Contractor must establish policies and procedures to deliver care to, and coordinate services for, all Members, regardless of risk or need, including ensuring adherence to all provisions noted in 42 CFR § 438.208.

For all Members, the Contractor must:

1. Ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a provider formally designated as primarily responsible for coordinating the health care services furnished to the Member. See Section 7.1.3, *Primary Care Provider Assignment*.
    a. The Contractor must provide information to the Member on how to contact the designated primary care provider.
2. Ensure that each provider furnishing services to the Member maintains, shares and exchanges (e.g., with the Contractor, other providers, etc.) a Member health record in accordance with professional standards.
3. Implement procedures to ensure continuity of care and to coordinate all appropriate services the Contractor provides or anticipates providing to the Member:
    a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional states;
    b. With the services the Member receives from any other MCO, contractor or payer;
    c. With the services the Member receives in FFS Virginia Medicaid.
4. Coordinate with services provided by community and social support providers, and provide linkages and facilitate access to needed community resources (e.g., food banks/nutrition resources, housing resources, employment supports, and other federal and state safety net programs such as the Supplemental Nutritional Assistance Program).
5. Provide enrollment support for Members eligible for WIC, including making connections to application assistance resources. See Section 5.13.3.6, *Women, Infants and Children (WIC) Referrals*.
6. Make referrals to 1915(c) waiver programs, as appropriate.

In addition to the federally required care coordination provisions above, the Contractor must meet all of the Department's model of care standards, including performing screenings, health risk assessments, and health risk stratification, development and maintenance of care plans, and providing care management services as described in this Section of the Contract.

8.3 MCO Member Health Screening (MMHS)

8.3.1 Description of the MMHS

The MMHS is the Department's screening tool. The MMHS is a two-part questionnaire that all newly enrolled Cardinal Care Members must receive. Results from completed questionnaires provide initial insight on Members entering the program and the associated population, and identifies opportunities for supports, offering potential clinical pathways to improved health outcomes.

The MMHS has two parts:

1. Part 1 of the MMHS contains questions related to Member's medical or behavioral health conditions, functional impairments, and intellectual or developmental disabilities.
2. Part 2 of the MMHS contains questions regarding social determinants of health, and in conjunction with Part 1, will be used to determine whether the Member receives Care Coordination or Care Management and the appropriate level of Care Management intensity (if applicable).

The MMHS has two functions:

1. To determine medical complexity, which is related to the capitation rate paid to the Contractor for the MAGI adult (Medicaid Expansion) Members, as described in Section 3.1, *Managed Care Covered Populations;* and
2. To provide the Contractor with more information as to whether the Member should be in a Priority Population and may require Care Management and their specific needs. As specified in the Cardinal Care Technical Manual, the Contractor must send the screening information via batch file to the Medicaid system.

8.3.2 Requirements to Screen Members Using MMHS

8.3.2.1 MMHS Recipients and Completion Timeframe

In accordance with 42 CFR § 438.208(b)(3), the Contractor must make best efforts, as described in Section 8.3.2.3, *Unable to Contact for MMHS*, to complete the MMHS for all newly enrolling Members within ninety (90) calendar days of the Member's enrollment with the Contractor. The Contractor must also complete an MMHS for any existing Members enrolled as of October 1, 2023, who do not have a screening on file. DMAS will recognize the Contractor's screening tool in lieu of the MMHS for members who were not required to have the MMHS completed prior to October 1, 2023; such as non-expansion members who were formerly enrolled in Medallion. The Contractor is not required to re-administer the MMHS for Members who newly enroll if the member had an MMHS completed within the previous twelve (12) months. See Section 8.11.1, *Continuity of Care Upon Enrollment*.

The Contractor must also identify Members who would benefit from receiving the MMHS sooner than ninety (90) calendar days. The Contractor must complete the MMHS for Members who are ventilator-dependent or Members receiving private duty nursing services within thirty (30) days of enrollment. The Contractor must submit the results of the MMHS to the Department within five (5) calendar days of the date on which the screening was completed, upon the third instance of the inability to contact the Member, or the date on which the Member refused to participate. The Contractor must share results of the MMHS with the Member's Care Manager and other internal departments (as applicable) and is encouraged to share results of the MMHS with the Member's assigned PCP.

If the Member cannot be reached for completion of the MMHS after three (3) reasonable attempts, the Contractor must mail the MMHS form to the Member for completion. Robocalls or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members. All mailed MMHS forms must meet the following conditions:

1. The content of the MMHS must be maintained. If the Contractor wishes to make any changes to the MMHS the Contractor must submit the proposed changes to the Department for review and

approval thirty (30) calendar days prior to its use. The Department will review and approve according to applicable contract requirements.

2. The Contractor must include with each mailed MMHS a cover letter that meets state and federal requirements for readability. The cover letter and MMHS are considered documentation critical to obtaining services, therefore must include the appropriate taglines. The Department reserves the right to review and require adjustments to the Contractor's cover letter templates before initial use and as revised by the Contractor.
3. A mailed MMHS is considered completed by the Member on the date the Contractor receives it back from the Member. A mailed MMHS must also meet the contractually required completion timeframe, as described in 8.3.2.1, MMHS Recipients and Completion Timeframes.
4. If a Member returns the MMHS and has selected either, "Other chronic (long-term) disabling condition" under Part 1 Question 1 or "Other chronic (long-term) mental health condition" under Part 1 Question 3, the Contractor must complete a Member Complexity Attestation, and check the "Member Complexity Attestation Completed" check box. In these instances, the MMHS is not considered completed until the attestation is completed confirming the Member's information. The Contractor must maintain the status of and the Member Complexity Attestation in the Member's record for review upon audit or DMAS request.
5. All mailed MMHS forms must include a self-addressed, postage paid return envelope.

8.3.2.2 **Administration Requirements**

1. At a minimum, the Contractor must ask the Member or the Member's representative(s) all of the questions in Parts 1 and 2 when administering the MMHS. If additional questions are necessary to determine a Member's needs or risk level, the Contractor may ask additional questions as necessary.
2. The Department will give the Contractor one hundred twenty (120) calendar days' notice before making changes to the MMHS unless mandated by law.
3. The Contractor must make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and must consider a Member's physical and cognitive abilities and level of literacy in the screening process.
4. The Contractor's staff conducting the MMHS must have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.
5. The Contractor must document efforts made to outreach and conduct the MMHS for Members whom the Contractor has difficulty locating. The Contractor must document the number of attempts, types of attempts, and date(s) of attempts made to contact the Member in the Member record.
6. The MMHS may be conducted telephonically or via videoconference unless the Member's health condition(s) or place of residence requires in-person contact or where the Contractor identifies through claims or other data that telephonic/videoconference administration is not feasible.

7. When conducted face-to-face, the Contractor must conduct the MMHS in a location that meets the needs of the Member.
8. As necessary, the Contractor must use relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) in the completion of the MMHS.
9. Elements from the MMHS must be considered and incorporated into the ICP.
10. The Department reserves the right to require the Contractor to conduct rescreenings as deemed necessary.
11. The Contractor must maintain all Member Complexity Attestation documents in the respective Member's record for review upon audit or DMAS request.

8.3.2.3 Unable to Contact for MMHS

The Contractor must make reasonable efforts to contact the Member in-person, by telephone, videoconference, or by mail in order to complete the MMHS. "Reasonable efforts" are defined as at least three (3) attempts across more than one day, with more than one method of contact being employed. The Contractor must document each attempt, including what method was used on what date. If the Contractor is unable to reach the Member after reasonable efforts, the Contractor must place the Member in the Unable to Contact ("UTC") category for the MMHS.

If the Contractor is unable to contact the Member or Member's authorized representative to administer the MMHS or if the Member refuses to participate in the MMHS in its entirety, the Contractor must note this on the MMHS and the Member is assumed to be not medically complex and in Care Coordination, as defined in Section 22, *Definitions* and as identified according to Section 3.1, *Managed Care Covered Populations* and in Section 8.2, *Care Coordination*.

8.4 Care Management

The Contractor must determine which Members should receive Care Management, including identifying:

1. Individuals who meet Department-defined criteria for "Priority Populations", to include Mandatory High, Mandatory Priority and MCO-Determined Priority Populations, as described in Section 8.4.2, *Priority Populations*;
2. Other individuals who would benefit from Care Management based on the Contractor's assessment of Member need and risk, beyond those identified as Priority Populations, as described in Section 8.4.3, *Identifying Other Members Needing Care Management*.

For Members in Mandatory Priority Populations and MCO-Determined Priority Populations, the Contractor must also determine the appropriate level of Care Management intensity (i.e., low, moderate or high).

8.4.1 Risk Stratification

To determine if a Member is part of a Priority Population (Mandatory High Priority, Mandatory Priority or MCO-Determined Priority) and the Member's Care Management intensity level assignment (i.e., Low, Moderate or High), the Contractor must develop and utilize a risk scoring and stratification methodology. The Contractor's risk stratification/scoring methodology should use, as available, the

following data sources:

1. Completed MMHS results, including medically complex status;
2. Historical claims analysis;
3. Aid category, e.g. to identify at-risk populations such as foster care, aged, blind and disabled individuals, pregnant individuals;
4. Previous CCC Plus Managed Care enrollment;
5. Enrollment in a long-term services and supports program, including: the Commonwealth Coordinated Care Plus Waiver, one of the Department's Developmental Disabilities Waivers, nursing facility, long-stay hospital, hospice, personal care services through the Medicaid Works program;
6. Enrollment in the Early Intervention benefit program;
7. Pharmacy data;
8. Immunizations;
9. Lab results;
10. Admission, Discharge, Transfer (ADT) feed information;
11. Provider referrals;
12. Referrals from social services;
13. Member's zip code;
14. Member's race and ethnicity;
15. Member or caretaker request for care management;
16. Information from a Medical Transition Report;
17. Any relevant information from Complaints, Grievances and Appeals; and
18. Any known involvement from educational or judicial systems

8.4.2 Priority Populations

Members may be identified as one of three Priority Population groups for assignment to Care Management (or Care Coordination, as appropriate): Mandatory High Priority, Mandatory Priority Populations and MCO Determined Priority.

- **Mandatory High Priority Populations:** The Contractor must assign each Member identified as Mandatory High Priority to High Intensity Care Management. For Members who are assigned to the Mandatory High Priority population on a time-limited basis, the Contractor may restratify and move those individuals to lower intensity levels of Care Management based on the Member's need/risk and/or at the Contractor's discretion.
- **Mandatory Priority Populations:** The Contractor must assign each Member identified as a Mandatory Priority Population to either Low, Moderate, or High Intensity Care Management, depending on the Member's needs and risk level. The Contractor is not permitted to assign the Member to Care Coordination.
- **MCO-Determined Priority Populations:** The Contractor has discretion to assign MCO-Determined Priority Populations to Care Coordination or Care Management. If the Contractor determines a Member in this population requires Care Management, the Contractor has discretion to assign the Care Management intensity level it deems appropriate based on the Member's needs and risks. The

Contractor may use the data sources outlined above in Section 8.4.1, *Risk Stratification,* to identify Members for assignment to either Care Management or Care Coordination, as appropriate.

Mandatory High Priority populations include Members who meet any of the following criteria:

1. Members covered under the Commonwealth Coordinated Care Plus Waiver who are receiving private duty nursing (PDN);
2. Members transitioning from NF to the community (for a minimum of three (3) months prior to the transition and six (6) months after the transition, or longer if determined necessary by the Contractor);
3. Children receiving PDN through EPSDT;
4. Ventilator-dependent individuals;
5. Individuals in foster care or former foster youth for three (3) months after enrollment into the Medicaid program, the child welfare system or a new foster care home;
6. Individuals in foster care three (3) months prior to aging out of the child welfare system;
7. Former foster youth for the first three (3) months after aging out of the child welfare system; and,
8. For a minimum of the first three (3) months following identification as being part of one of the following populations:
    a. Substance-exposed infants;
    b. Neonatal abstinence syndrome infants (following diagnosis or identification as part of this population, whichever is later); and,
    c. Infants admitted to the neonatal ICU (NICU Level 3).

Mandatory Priority populations include Members who meet any of the following criteria:

1. Members Enrolled in Waivers
    a. Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers;
    b. Members covered under the Commonwealth Coordinated Care Plus Waiver without PDN; and
    c. Members with intellectual/developmental disabilities.
2. Members with Behavioral Health (MH/SUD), Brain Injuries, Disabilities
    a. Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
    b. Members who receive mental health and addiction treatment services, as reflected in the Cardinal Care Summary of Covered Benefits Chart, Attachment E, Parts 2A (Inpatient and Outpatient Behavioral Health Services), 2B (Mental Health Services and Residential Treatment Services), and 2C (Addiction and Recovery Treatment Services;
    c. Members with intellectual/developmental disabilities (I/DD);
    d. Members with cognitive or memory problems (e.g., dementia);
    e. Members with brain injuries; and
    f. Members with physical or sensory disabilities.
3. Members in Hospice/Nursing Facilities (NFs)
    a. Members receiving hospice benefits;

    b. NF Members (except for NF Members in the “Mandatory High Priority Population”); and
    c. Members with cognitive or memory conditions.
4. Individuals in foster care and former foster youth who are not in the “Mandatory High Priority Population”.

MCO-Determined Priority populations include Members who meet any of the following criteria:

1. Pregnant Women and Children with High Needs/Risk
    a. Members with a high-risk pregnancy, as defined by the Contractor;
    b. Children and Youth with Special Health Care Needs;
    c. Children identified as at-risk for developing developmental disabilities or delays (who should be enrolled in the early intervention program);
2. Members with Other Complex/Chronic Conditions
    a. Members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.);
    b. Members with end stage renal disease;
    c. Members with physical or sensory disabilities.
3. Members Meeting Utilization-Based Criteria
    a. Patient Utilization Management and Safety (PUMS) Program Members;
    b. Members with three (3) or more ED visits or hospitalizations related to their chronic medical and/or physical health condition in the past three (3) months;
    c. Members with one (1) or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past three (3) months;
    d. Members eighteen (18) years of age or older who have had two (2) or more falls resulting in an ED visit, hospitalization, or physician office visit within the past three (3) months;
4. Members with Behavioral Health Needs
    a. Members with behavioral health and substance use disorders;
5. Members with High Social Needs
    a. Members experiencing homelessness;
    b. Justice-involved populations, which includes individuals who have a history of incarceration, detention, probation or parole supervision; and
    c. Members who have other high social needs that pose a significant risk to their health, safety and welfare, as determined by the Contractor.
6. Other Populations Based on MCO Discretion

The Department reserves the right to conduct its own data analysis to identify Members in need of Care Management and to review the Contractor’s risk stratification results in order to validate that the Contractor’s model of care and advanced analytics system identifies Priority populations in accordance with the Department’s contractual standards. See Section 8.4.8, *Data Surveillance and Validation of Care Management Assignment*.

8.4.3 Identifying Other Members Needing Care Management

In addition to the Priority populations described above, the Contractor must identify other Members who would benefit from Care Management based on the range of information the Contractor has on the individual (including the data sources described above) and the Contractor's assessment of their need and risk. The Contractor may determine which tier of Care Management Intensity (i.e., Low, Moderate, or High) to assign the Member. Care Management level assignments may be temporary based on a Member's changing needs and progress towards stability working with treating providers and living in the community.

In future contract revisions, the Department may establish a minimum required percentage of Members that should be assigned to Care Management.

8.4.4 Care Manager Staffing Ratios

The Contractor must comply with minimum Care Manager staffing ratios to ensure that it fulfills all Care Management requirements specified in this contract. The Contractor must maintain the minimum required caseload ratios, as described in the table below, at all times. Lower staffing ratios may be utilized as clinical caseloads may warrant.

Care Management Staffing Ratios by Population		
Low Intensity	**Moderate Intensity**	**High Intensity**
1:500	1:175	1:70

Care Managers may have a "blended" caseload, comprised of Members in more than one subpopulation or different Care Management Intensity levels to meet business operational needs or provide continuity of care for Members as long as the minimum ratio thresholds are met. However, Care Managers serving Members receiving private duty nursing services through 1) the CCC Plus Waiver (LTSS level of care A) and 2) through EPSDT, must be excluded from blended caseloads. Caseloads must be adjusted according to employment status of full or part time hours per week (i.e., a 0.5 staff position would equate to 0.5 of the standard ratio). Multiple percentage split variations may occur to make up a total 100% caseload among various populations but the assignments must not exceed the total combined established ratio. If there are not enough Members receiving private duty nursing to support a full caseload, the Care Manager may work with other vent-dependent members identified in the community, hospital or NF.

As described in Section 8.8.2, *Care Management Extenders*, staffing ratios may be adjusted to account for Care Management extenders employed by (or subcontracted with) the Contractor. This will allow an FTE Care Manager to serve more than the maximum number of Members described above.

8.4.5 Care Management Contact and Format Requirements

For all Care Management intensity levels, the Contractor must provide Care Management services as frequently and expeditiously as a Member needs. The Contractor must ensure Care Managers establish a schedule of contacts to regularly monitor and address a Member's needs in a timely way on an ongoing basis. All in-person contacts should occur at the location and time of the Member's preference.

The Contractor may always deliver a contact in-person rather than by telephone call/videoconference if appropriate. The Department may waive in-person contact requirements (including for routine contacts, HRAs, or any other care management activity) in extenuating circumstances, such as a pandemic.

The Contractor must ensure that Care Managers deliver a minimum number of contacts to each Member according to their Care Management intensity level as follows:

1. Members in Low Intensity Care Management must be contacted as frequently and expeditiously as the Member's medical condition and social needs require, but at a minimum receive two (2) Care Management contacts per year. Contacts may be conducted in-person, telephonically, or via videoconference.
2. Members in Moderate Intensity Care Management must be contacted as frequently and expeditiously as the Member's medical condition and social needs require, but at a minimum receive one (1) Care Management contact per three (3) months. Contacts may be conducted in-person, telephonically, or via videoconference.
3. Members in High Intensity Care Management must be contacted as frequently and expeditiously as the Member's medical condition and social needs require, but at a minimum receive one (1) Care Management contact per month.
    a. The Member's initial contact and at least one contact in every subsequent six (6) month period must be in-person. All other contacts may be conducted via telephone or videoconference at the Contractor's discretion based on Member preference or need as appropriate.
    b. The Contractor may, in limited circumstances, use telephonic or videoconference contact modes for infants in High Intensity Care Management if an in-person visit is not feasible or appropriate; however, the Care Manager must document the reason the visit could not be conducted in person. DMAS encourages the MCO to use in-person contacts as a best practice.

The contact requirements listed above apply unless the Member expresses a preference for an alternative frequency. All contacts, including those associated with the HRA, ICT meeting, ICP completion, or other routine contacts, must occur at a place and time of the member's choosing (i.e., the Contractor may not require that the Member travel to a particular location to receive in-person contacts).

8.4.6 Restratification

The Contractor must conduct routine restratification for all of its Members at least every three (3) months to determine if there has been a change in any Member's need or risk status or whether the Member may benefit from a different level of Care Management than originally assigned. Whenever a Member clearly meets criteria for a different level of Care Management (e.g. PDN services initiated through the Waiver or EPSDT) the Contractor must re-stratify the Member within 30 calendar days. For members who were previously identified as requiring Care Management but had to be placed in "Unable to Contact", the Contractor is not required to follow "reasonable efforts" requirements as described in Section 8.5.4*, Unable to Contact for HRA*, during a quarterly restratification if the member's health status and risk has not changed.

The Contractor must use all the sources of data above, as available, and may use additional sources of data to support Member restratification. Assigned Care Managers must provide input into the restratification process.

8.4.7 Triggering Events

For the purposes of Health Risk Assessment, Individualized Care Plan, and Interdisciplinary Care Team requirements, the Department defines a Triggering Event as any occurrence that suggests a change in Member's condition or status that places the Member at a higher risk of harm or jeopardizes their health, safety and welfare. Examples of occurrences are listed but not limited to one or more of the following

1. Inpatient hospitalization or Emergency Department Visit;
2. Involuntary treatment episode;
3. Use of behavioral health crisis services;
4. Law enforcement involvement;
5. Pregnancy;
6. Transition from an NF or PRTF to the community;
7. Loss of informal supports;
8. Change in functional status ;
9. Loss of housing;
10. Child welfare, child protective services or Adult Protective Services involvement; or,
11. Foster care involvement; and
12. Critical incident, as defined in Section 16, *Critical Incident Reporting*.

In addition to the above Triggering Events, the Contractor must consider additional events that may warrant an HRA reassessment, ICP revision, or ICT meeting. For more information about HRAs after Triggering Events, see Section 8.5.3, *HRA Completion Timeframes*.

8.4.8 Data Surveillance and Validation of Care Management Assignment

The Department may perform statistical sampling and other data analysis techniques to audit the Contractor to ensure that all Members are being appropriately identified for inclusion in a Priority Population and placed in the appropriate level of Care Management, as described in Section 8.4.2, *Priority Populations*. The Department may use available data sources including claims/encounters and Member responses to the MMHS to validate that the Contractor is placing each Member in the appropriate population and level of Care Management intensity. Identification of instances of the Contractor failing to identify a Member in a Priority Population category or placing a Member in an inappropriate level of Care Management may result in the Contractor being required to conduct additional screenings or to reassign the Member to a different level of Care Management or Care Coordination. The Department also reserves the right to interview Members and conduct specialized record reviews and audits as deemed necessary based on Member and provider complaints.

8.5 Health Risk Assessments (HRA)

The Contractor must ensure that all Members in Care Management receive a Health Risk Assessment (HRA). The HRA must be completed by a qualified Care Manager, as described in Section 8.8.1, *Care Manager Qualifications*. The Contractor must use the HRA as a tool to: (1) identify Member physical and behavioral health status, needs, and risk factors along with their social, economic and housing needs, (2) assist in the development the Member's comprehensive person-centered Individualized Care Plan (ICP) (see Section 8.6, *Person-Centered Individualized Care Plan (ICP)*, and (3) assist in identifying the appropriate level of Care Management intensity for the Member. The goal of both the HRA and ICP is to develop Member-centered care strategies among the Member's interdisciplinary care team and ultimately aid in the improvement of Member health outcomes and overall social and economic independence.

8.5.1 HRA Tool Required Elements

At a minimum, the Contractor's HRA must effectively identify:

1. The Member's functional, medical, behavioral, cognitive, LTSS, wellness and preventive, and social needs (such as housing, informal supports, and employment) in addition to any other unmet needs;
2. The Member's strengths and goals;
3. The Member's need for any specialists;
4. Community resources used or available for the Member;
5. Advance directive information and documentation (as appropriate); and
6. The Member's desires related to their health care needs (as appropriate).

The Contractor's HRA must also:

1. Document that during the initial HRA, the Member was informed of Cardinal Care covered benefits and the role of the Care Manager.
2. Document the source of information for the HRA (e.g., the Member, providers, facility staff, family/caregivers) and location of completion (in-person, telephonic, or via videoconference; if in-person, the Contractor must provide the physical location).

The Contractor may, at times, use an abbreviated version of the HRA that focuses only on the changes in the Member's health status, conditions, need and risks for reassessments. All abbreviated HRA templates and a description of the circumstances under which the Contractor would use the abbreviated form must be submitted to and approved by DMAS prior to use. Information captured in an abbreviated HRA must be incorporated into or available as part of the full HRA in the Contractor's system.

8.5.1.1 HRA for Individuals Enrolled in the Commonwealth Coordinated Care Plus Waiver

For CCC Plus Waiver Members, in addition to the required elements above, the HRA must also include and account for the following elements:

1. Pertinent information from the Medicaid LTSS Screening when available, as described in Section 5.12.1, *LTSS Screening Requirements*;

2. Information to evaluate if LTSS criteria continue to be met;
3. Discussion with Member/caregiver regarding satisfaction with services received;
4. Evaluation of the environment for appropriateness, safety, and Member welfare;
5. Confirmation of the Member's needs;
6. Confirmation that the Member/caregiver understands and agrees with the care plan, the delivery of waiver services, limitations, and rights and responsibilities of everyone involved in providing care;
7. Confirmation that the waiver provider(s) is working to meet Member's care plan as written and that there is a means to communicate any and all deficiencies to the assigned Care Manager immediately; and
8. Confirmation that all appropriate documentation is available in the home (i.e., Plan of Care).

8.5.1.2 HRA for Members Receiving Private Duty Nursing Services

For Members who are receiving private duty nursing services, in addition to the required elements above, the Contractor's HRA must also include the following elements:

1. Determination that appropriate medical equipment is available;
2. Confirmation that medical needs are as described on the DMAS 108/109 and/or 62 forms;
3. Confirmation that the Private Duty Nursing provider is working to deliver on the Member's care plan as written; and
4. Confirmation that all appropriate documentation is available in the home (i.e., physicians' orders, Home Health Certification and Plan of Care (CMS-485), nursing care and medication administration documentation, etc.).

8.5.1.3 HRA for NF Members

For Members who reside in a NF, in addition to the required elements above, the Contractor's HRA must also include the following elements:

1. All pertinent information from the Minimum Data Set (MDS);
2. Information from the MDS Section Q, in addition to separate documentation of the Member's interest and desire for transition to the community and available resources and barriers to doing so;
3. The transition process including any identified health, safety or welfare needs which may result in the Member's inability or a barrier to transition to the community; and
4. Pertinent information from the LTSS screening, when available.

The Department reserves the right, providing the Contractor with at least sixty (60) calendar days advance notice, to require the Contractor to add additional elements to its HRA.

8.5.2 HRA Administration Requirements

8.5.2.1 Mode of Administration and Accommodations

1. The Contractor must conduct the HRA in-person for Members in High Intensity Care Management. The Department may waive in-person contact requirements in extenuating circumstances, such as a pandemic.

2. For most Members in Low and Moderate Intensity Care Management, the Contractor is encouraged to conduct the HRA in-person but may utilize videoconferencing or telephone if necessary and appropriate. The Contractor must ensure that any telephonic or videoconferencing mechanisms are secure, effective and appropriate based upon the Member's condition, communication abilities, and preferences.
    a. For CCC Plus Waiver and NF Members in all Care Management Intensity levels, the initial HRA and annual LOC review must be conducted in-person. Other contacts may be conducted via telephone or videoconference.
3. The Contractor must obtain the Member's consent to record audio of the HRA. The Contractor must provide the audio recording including the Member's consent to the Department upon request.
4. The Contractor's Care Managers must make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and must consider a Member's physical and cognitive abilities and level of literacy in the assessment process.
5. The Contractor must conduct HRAs in a location that meets the needs of the Member.
6. The Contractor's Care Manager must have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.
7. The Contractor's Care Managers must document efforts made to outreach and conduct HRAs for Members the Contractor has difficulty locating. Care Managers must work with providers and the Member's care team to reach the Member or work with acute and subacute hospital settings to communicate with a Member as needed.

8.5.2.2 **Data Sharing**

1. The Contractor must use appropriate documentation (e.g., MTR data, early intervention individualized family service plan, MDS, LTSS screening when current/relevant, and MMHS) to complete HRA elements in order to avoid unnecessary burden to the Member, caregiver or provider.
2. The Contractor must continuously monitor data elements that may trigger HRA reassessment (e.g. ADT information, functional status assessment, etc.), as described in Section 8.4.7, *Triggering Events*).

8.5.3 HRA Completion Timeframes

Care Managers must complete an initial Health Risk Assessment (HRA) within sixty (60) calendar days from MMHS completion and/or identification that the member needs Care Management services. The Contractor must accelerate the HRA completion timeframe, as appropriate, if necessary to effectively manage the Member's condition.

Following the initial HRA, Care Managers must complete an HRA reassessment or update an existing HRA for any individual receiving Care Management:

1. At least every twelve (12) months, and;

2. Within thirty (30) calendar days of a triggering event but not more frequently than every quarter, unless deemed necessary based on a change in the Member's condition, as defined in Section 8.4.7, *Triggering Events*.
    a. The Contractor is strongly encouraged to conduct the reassessment within ten (10) calendar days and, if the reassessment takes place beyond the ten (10)-day timeframe, must document the reason(s) why this occurred.
    b. The completion of an HRA following a triggering event resets the twelve (12) month HRA reassessment timeframe.
3. At any other time between required timeframes if it is deemed necessary based on a change in a Member's condition, need or risk.

HRA reassessment can be completed in parallel or as part of other Care Management processes such as discharge planning and ICT meetings. For foster care or former foster care, the timeframe for responding to the triggering event begins at the time the Contractor is notified that the Member's aid category has changed to a foster care aid category, (i.e., on the end of the month 834 enrollment file).

The Contractor is not required to conduct a new HRA for Members transitioning from Medicaid fee-for-service or another Contractor unless the Member has experienced a triggering event, as defined in Section 8.4.7, *Triggering Events*, or a new HRA is due. This also applies in the event that a Member is disenrolled and reenrolled with the Contractor.

8.5.4 Unable to Contact for HRA

The Contractor must place non-LTSS Members in the "Unable to Contact" (UTC) category, as described in Section 22, *Definitions*, with the exception of Commonwealth Coordinated Care Plus Waiver and NF Members, for the initial HRA if the Contractor is unsuccessful in reaching the Member following reasonable efforts to contact the Member in-person or by telephone, videoconference, or mail immediately upon completion of the MMHS. "Reasonable efforts" are defined as at least three (3) documented attempts with more than one (1) method of contact being employed over more than one day. The Contractor is encouraged to reach out to the Member's PCP and other treating providers, supports or DSS Medicaid workers to establish contact with a Member for status updates. Robocalls or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members and must not count as a valid attempt to contact or communicate with a Member.

A Commonwealth Coordinated Care Plus Waiver or NF Member must not be placed in the "Unable to Contact" category. The Contractor must ensure reasonable effort is made in contacting Commonwealth Coordinated Care Plus Waiver or NF Members. "Reasonable efforts" for contact of CCC Plus Waiver or NF Members include at least three (3) documented attempts prior to the HRA due date that may be made via phone, mail, or through home or facility visits; however, at least one (1) attempt must be a home visit. In addition, "reasonable efforts" for contacting Commonwealth Coordinated Care Plus Waiver and NF Members must include contact with existing LTSS service providers (or prior providers if not currently receiving services). If no escalation of needs or risks has been uncovered, the Contractor must conduct quarterly outreach to Commonwealth Coordinated Care Plus Waiver or NF Members unable to be contacted after the initial three (3) documented attempts described in this Section. This quarterly outreach may be via phone or mail. The Contract must monitor returned mail for invalid Member addresses to resolve the failed outreach attempt.

8.5.5 HRA When Member Refuses

The Contractor must oversee, coordinate and manage quality services for Members identified as requiring Care Management to the greatest extent possible even in the absence of a completed HRA or communication with the Member. For Members in Mandatory High Priority and Mandatory Priority Populations, if a Member refuses to participate in the HRA or it cannot be conducted for other reasons, a fully completed HRA is not required. Rather, in order to adequately manage the case and ensure appropriateness of care to the maximum extent possible, the Contractor must complete a Comprehensive Care Review (CCR). The comprehensive care review must include:

1. The Member's conditions and diagnoses, current needs and services, identified risks, concerns related to nonadherence, access to care and contradictory provider treatment plans and Contractor recommendations; and
2. The sources of information the contractor used to develop the CCR.

The CCR may be based on the following data sources, as appropriate (in addition to others identified by the Contractor):

1. Available clinical information from rendering providers or caregivers;
2. Information received from transition reports, service authorizations (SAs), and claims;
3. MDS;
4. LTSS screening; and,
5. Early intervention individualized family service plan.

The Department reserves the right to request CCRs from the Contractor.

To the maximum extent possible considering Member lack of engagement, the Contractor must develop a Comprehensive Care Plan (CCP) based on the outcome of the CCR. The Contractor must document internally in the CCP for the Member why the HRA was not completed.

The Contractor must not submit CCRs as completed HRAs or CCPs as completed ICPs to CRMS. See Section 8.11, *Administrative Transitions*.

8.6 Person-Centered Individualized Care Plan (ICP)

The Contractor must develop a person-centered, culturally competent ICP for Members engaged in Care Management. The Contractor must tailor the person-centered ICP to the Member's needs and preferences and complete it in the timeframes specified in this Contract and based, at a minimum, on the results of the Contractor's assessment of Member need, risk, and qualifying criteria for services.

The Contractor's Care Manager must:

1. Engage each Member in the ICP process. The Contractor is encouraged to conduct the ICP face-to-face but may utilize videoconferencing or telephone if necessary and appropriate. The Contractor must ensure that any telephonic or videoconference communication processes are secure and are effective and appropriate options based upon the Member's condition, communication abilities, and preferences. The Contractor must submit any ICP protocols related to telephonic/videoconference contact to the Department for approval prior to implementation;

2. Ensure that the Member receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process that includes ICT participation and person-centered ICP development;
3. Develop and maintain the ICP and make the ICP or information related to the ICP accessible to treating providers and Members as needed and upon request;
4. Revise the ICP based on triggering events, as described in Section 8.4.7, *Triggering Events*, such as hospitalizations or a decline or improvement in health or functional status;
5. Communicate any ICP revisions to the Member, ICT, and other pertinent providers;
6. Ensure information is secured for privacy and confidentiality in accordance with all applicable State and Federal requirements;
7. Obtain Member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is conducted via telephone or videoconference, if the audio is recorded, the Contractor must have the Member's consent for the audio recording. Also document all efforts when Members or their representatives refuse to sign, including a clear explanation of the reason for the Member's refusal;
8. Develop and implement the ICP no later than the end date of any existing SA. Services must be continued until the HRA has been completed and the ICP has been developed; and
9. To avoid duplication and burden on the Member, for children enrolled in the Early Intervention Program, the Contractor must coordinate the ICP with the EI Service Coordinator as part of the Multidisciplinary team and IFSP process.

8.6.1 ICP Required Elements

The Contractor must include the following elements in each Member's ICP. Other elements may also be necessary depending upon the Member's circumstances. Required elements include but are not limited to:

8.6.1.1 **Member Goals, Needs and Preferences**

1. ICP Completion date; ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measures based assessments;
2. MMHS responses;
3. Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the Member;
4. Strategies and actions to address all needs of the Member, including functional, medical, behavioral, cognitive, social, LTSS, safety, wellness and preventive needs.
5. Strategies to address social needs may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and informational supports, and personal goals (e.g., attend school, have a job);
6. Actions to address Member needs must include who is attending to the needs such as treating providers, community entities, referrals to other resources, etc.;

7. Documentation within the ICP regarding all conditions, which must be updated regularly; progress towards goal completion noting successes; rationale for extending target end goal dates; new goals; and any barriers or obstacles;
8. Documentation of the Member's carved-out services (as appropriate) (Refer to Section 5.2, Carved-Out Services);
9. Advance directive information, as described in Section 4.1.5, *Advanced Directives*, including education needs of the Member about advance directives and obtaining any advance directive documentation and filing them in the Member's file. The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and must be included in the ICP. Also included is documentation of information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives were not obtained.

8.6.1.2 Member's Providers and Other Supports

1. Identification of ICT Members, treating providers and parties responsible for providing services (e.g., name, title, contact information), including the Member's primary care provider, specialists, LTSS and social service providers;
2. Inventory of the Member's other care managers or case managers;
3. Relevant MCO contacts in addition to the Care Manager (e.g., a housing coordinator);
4. Member's informal support network and services;

8.6.1.3 Plans to Respond to Member Needs or Prevent Service Disruption

1. Plans for transition coordination and services for Members in nursing facilities who wish to move to the community;
2. Back-up and safety plans as appropriate for Commonwealth Coordinated Care Plus Waiver Members in the event that the primary caregiver is unable to provide care. If applicable, trained backup caregivers, and facility admission may be required. All Members receiving Private Duty Nursing Services must have a trained primary caregiver who accepts responsibility for providing care whenever nursing is not in the home and, if applicable, Members must have a back-up plan if personal care services cannot be rendered as planned;
3. Crisis plans for Members with behavioral health needs. For crisis plans, describe how the Contractor will assist the Member to identify and select individuals or agencies that will provide support, comprehensive crisis services or other services (including peer recovery support services) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
4. Safety plans for all Members, particularly those who face challenges living alone;
5. Plan to access needed and desired community resources and non-covered services;

8.6.1.4 Waiver, LTSS and other Specialized Services

1. Commonwealth Coordinated Care Plus Waiver, private duty nursing through EPSDT, and other covered services to be provided until the next person-centered ICP review;

2. Member's choice of services (including model of service delivery for personal care and respite – consumer-directed vs. agency-directed when appropriate for Commonwealth Coordinated Care Plus Waiver Members who are eligible for consumer-directed services);
3. Elements included in the Provider Plan of Care (DMAS-97AB) for Commonwealth Coordinated Care Plus Waiver Members receiving personal care services, the DMAS-7A for Members receiving personal care services through EPSDT and the DMAS-301 for Members receiving ADHC;
4. Elements included in the Home Health Plan of Care (CMS-485) for Members receiving private duty nursing;
5. Elements included in the DMAS 62 for Members receiving private duty nursing through EPSDT;
6. Elements included in the DMAS 99, DMAS 108 or DMAS 109 for Members receiving private duty nursing through the Commonwealth Coordinated Care Plus Waiver;
7. Elements included in the IFSP for Members receiving early intervention; and
8. Any other carved-out services.

Contractors may submit an abbreviated ICP form for Department approval, but all ICP required elements must be included in the abbreviated form.

Contractors are responsible for ensuring results from a Member's ICP and any updated ICPs are shared with other internal MCO departments as necessary for continued service authorizations and potential provider network needs.

For Members receiving HCBS, the Contractor's ICP must comply with federal requirements per 42 CFR § 441.301(c) in the CMS Home- and Community-Based Settings Final Rule; additional guidance is located at https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html.

8.6.2 ICP Completion Timeframes

Following completion of the HRA, the Care Manager must develop the Member's initial ICP prior to the first ICT meeting. The Care Manager must not wait until after the ICT meeting to complete the ICP. As appropriate, the Care Manager can develop the initial ICP during the HRA process and obtain the Member's signature at that time. The ICP is considered complete upon Member signature. Electronic signatures are acceptable within federal requirements and, with the Member's agreement, when obtained over the phone (for Members not in the Commonwealth Coordinated Care Plus Waiver or NF populations). The Contractor's Care Manager must complete the ICP according to the following timeframes:

1. For Low Intensity Care Management Members, the Contractor must ensure that ICPs are completed within sixty (60) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).

2. For Moderate Intensity Care Management Members, the Contractor must ensure that ICPs are completed within thirty (30) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).

3. For High Intensity Care Management Members, the Contractor must ensure that ICPs are completed within seven (7) calendar days of completion of the HRA (or enrollment with the Contractor, if an HRA was previously completed).

In the event the ICP Completion Timeframes cannot be met, the Contractor must document in the Member's record the reason for the delay and the expected completion date. Efforts to complete the ICP must also be documented such as education to the Member and/or family regarding role of Care Manager, coordination with treating providers, etc. Any barriers to completing the ICP in a timely manner (e.g., lack of communication with or response from another involved state agency), may be reported to DMAS for assistance.

For Members transitioning from another Contractor or Medicaid fee-for-service with an existing ICP in place, the Contractor will not be required to develop a new ICP if all elements are current and accurate. The previous ICP must be in the Member record and reviewed for accuracy prior to the ICP due date. As applicable, the Contractor must revise the ICP in accordance with requirements set forth in Section 8.6.3, *ICP Revision Completion Timeframes*.

8.6.3 ICP Revision Completion Timeframes

Following completion of the initial ICP, the Contractor's Care Manager must revise the ICP according to the timeframes set forth below:

1. The Contractor must work with the Member to revise the ICP every six (6) months following the initial ICP. The Contractor may utilize video conferencing or telephone if necessary and appropriate but is encouraged to make revisions in-person.
2. The Contractor must revise ICP for each Member within ten (10) calendar days following any triggering event, as described in Section 8.4.7, *Triggering Events*, or as expeditiously as the Member's condition requires.

The Member must agree to and sign revisions/updates to the ICP as indicated above for initial ICP.

8.7 Interdisciplinary Care Team (ICT)

The Contractor must define for each Member, in a manner that respects the needs and preferences of the Member, the individuals who make up the Member's interdisciplinary care team (ICT). The Contractor must ensure that each Member's care (including any services addressing medical, behavioral health, substance use, LTSS, early intervention, and social needs) is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to their licensure and relationship with the Member as identified in the ICP. The Contractor must encourage the Member to identify individuals that they would like to participate on their care team. The ICT must be person-centered, built on the Member's specific preferences and needs, and conducted with transparency, individualization, respect, linguistic and cultural competence, and dignity. The Care Manager must lead the ICT and ensure that ICT meetings and conference calls, when applicable, are held periodically, as described below, and ensure that ICT members are kept up-to-date and informed of the Member's care and needs, to include when they are not able to attend meetings. To avoid duplication and burden on the Member, for children enrolled in the Early Intervention Program, the Contractor must coordinate

the ICT with the EI Service Coordinator as part of the Early Intervention Multidisciplinary Team and Individualized Family Service Plan (IFSP) processes.

8.7.1 ICT Membership

The Contractor must ensure that the ICT includes the Member and/or their authorized representative(s). The Care Manager must attempt to include in the ICT all entities rendering care and services as identified in the Member's ICP and any of the following participants, at a minimum:

1. PCP;
2. Other treating providers, as applicable;
3. Behavioral health clinician, as applicable;
4. LTSS provider(s) when the Member is receiving LTSS;
5. Personal Care (PC)/PDN provider for Members receiving PC or PDN services under EPSDT;
6. Targeted case manager, if the Member is receiving targeted care management services;
7. D-SNP or other plan care coordinator, as applicable; and
8. Pharmacist, as applicable.

As appropriate and at the discretion of the Member, the ICT also may include any or all of the following participants:

1. A representative from the Medicare plan, if applicable;
2. Registered nurse;
3. Specialist clinician;
4. Other professional and support disciplines, including social workers, community health workers, and qualified peers;
5. Family members;
6. Other informal caregivers or supports;
7. Advocates; and/or
8. State agency or other case managers.

8.7.2 ICT Communication and Meeting Timeframes

The Contractor must ensure a secure means of communicating among all ICT Members. For Members at all Care Management Intensity levels, the Contractor must have a system that enables the Care Manager to provide the Member's ICT members critical and ongoing information on the Member's condition, as appropriate, and the Care Manager must use this communication system to provide this information to all ICT members.

For most Members in Low and Moderate High Intensity Care Management, the Care Manager is not required to conduct ICT meetings, but should do so if the Care Manager or an ICT member requests it and must do so at Member request.

For LTSS Members at all Care Management Intensity levels and all Members in High Intensity Care Management , the Care Manager must conduct ICT meetings. The Care Manager must conduct an initial ICT meeting within thirty (30) calendar days of completion of the ICP.

The Contractor must have a system that enables the Care Manager to securely communicate with the Member's ICT members and provide critical and ongoing information on the Member's condition, as appropriate. The Care Manager must develop a documented and agreed upon Communication Plan with the Member and the Member's ICT members, must comply with the communication requirements as described in the Communication Plan, and must inform the Member and ICT members on how to access secure communications within the Contractor's system.

The Contractor is required to conduct ICT meetings as follows:

1. **For most Members in Low and Moderate Intensity Care Management**, the Care Manager is not required to conduct ICT meetings but should do so if the Care Manager or an ICT member requests it and must do so at Member request.
2. **For Commonwealth Coordinated Care Plus Waiver and Members in NFs at all Care Management Intensity levels and all Members in High Intensity Care Management**, the Care Manager must conduct ICT meetings. The initial ICT meeting must take place within thirty (30) calendar days of completion of the ICP. Care Managers must also convene ICT meetings within thirty (30) calendar days of the following:
    a. HRA reassessments;
    b. Triggering events, as defined in Section 8.4.7, *Triggering Events*, requiring significant changes to the Member's ICP;
    c. Readmissions to acute or psychiatric hospitals or NF within thirty (30) calendar days of discharge; and
    d. Upon Member request.

For these Members who are transitioning from another Contractor or Medicaid fee-for-service for whom there is documented evidence of an ICT meeting, the Contractor will not be required to facilitate a new ICT meeting.

8.7.3 ICT Meeting Attendance

The Care Manager must attend all ICT meetings. The Care Manager must provide reasonable and sufficient notice in advance of an ICT meeting to the Member and other required attendees in order to maximize participation for planned ICT meetings. The Contractor must ensure that input is requested for inclusion in the ICT discussion from ICT Members who are unable to attend the ICT in-person or via telephone or videoconference.

The Care Manager must include the Member or his/her authorized representative in ICT meetings unless a Member refuses or is unable to participate. Alternate forms of soliciting input from the Member are not acceptable unless there is clear documentation of the Member's refusal to participate with the stated reason.

If the Care Manager makes best efforts to have all required and encouraged ICT Members attend but is unable to do so, the Care Manager should proceed with ICT meetings and provide a summary of the meeting to all ICT Members that were unable to attend within thirty (30) calendar days of the meeting as described in Section 8.7.4, *ICT Meeting Documentation Requirements*.

8.7.4 ICT Meeting Documentation Requirements

Following each ICT meeting and in accordance with the Communication Plan, the Contractor must ensure that there is documented evidence in the Member record accessible to all ICT Members within thirty (30) calendar days of the meeting summarizing the ICT meeting with the following information:

1. The names, titles, and roles of each ICT participant in attendance for each meeting;
2. The names, titles, and roles of invitees that were not in attendance;
3. Solicited input from required participants who were unable to participate in the ICT meeting and information provided through alternate means;
4. Information discussed, outcomes of the ICT meeting and any additional information obtained through alternate means;
5. When applicable, the Member's active refusal to participate in the ICT;
6. Review and discussion of the initial ICP, and any updates to it, developed by the Care Manager with the Member; and
7. Identification of any next steps such as referrals or follow-up appointments or any information necessary for the purpose of Care Coordination or administration of benefits.

In accordance with the Communication Plan, the Care Manager must send a summary of the meeting to ICT members who are unable to attend the meeting and must ensure the summary is available electronically to members and providers.

8.8 Care Manager Staffing

8.8.1 Care Manager Qualifications

The Contractor's Care Management staff listed below must have the following qualifications to deliver Care Management services.

Care Management Staffing Qualifications

	Care Manager Position	Required Credentials*	Required Experience
1	Care Managers serving Members in: • Low or Moderate Intensity Care Management • High Intensity Care Management except for populations listed in rows 2 and 3 below	Bachelor's degree in a health or human services field, LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	One year of experience working directly with individuals who meet the Cardinal Care Priority Population criteria.
2	Care Managers serving Members in High Intensity Care	RN	One year of experience working directly with Members who meet the conditions listed in this row.

	Care Manager Position	Required Credentials*	Required Experience
	Management with the conditions listed below: • Members receiving private duty nursing services; • Life-sustaining Ventilator-dependent Members; • Vulnerable infant Members, including those diagnosed with neonatal abstinence syndrome, classified as substance-exposed, or admitted to the NICU Level 3.		
3	Care Managers serving Members in High Intensity Care Management who are in Foster Care	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	One year of experience working directly with individuals involved in the foster care/Child Protective Services system and/or former foster youth.
4	ARTS Care Manager	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW, CSAC, CSAC-Assistant	One year of experience working directly with individuals with SUD.
5	Care Manager Supervisor	LMHP or RN	Two years of experience working directly with individuals who meet the Cardinal Care Priority Population criteria.

*Credentials that require licensure or certification must be current/active in Virginia. RN/LPNs must be licensed in Virginia or hold an RN/LPN license with multi-state privilege recognized by Virginia.

8.8.2 Care Management Extenders

The Contractor is encouraged to utilize staff Care Management "extenders" who are not required to meet the minimum qualifications of a Care Manager but are qualified to complete select non-clinical, Care Management activities such as appointment scheduling, coordinating social services, and completing specific non-clinical paperwork/documentation, problem solving in response to complaints and concerns as well as leveraging any specialized expertise and experience in building trusted, authentic relationships with Members. Care Management Extenders must work under the supervision of the Care Manager. Care Management extenders may include Virginia Board of Certification-certified Community Health Workers, DBHDS-certified Peer Support Specialists, and non-specialized

administrative staff employed by or under contract with the Contractor. Extenders may not render clinical assessments or deliver clinical care to Members, and the Contractor must ensure the extenders receive adequate oversight and supervision from qualified Care Managers.

In order to account for staffing efficiencies generated by employing extenders, the Contractor will have the opportunity to reduce Care Manager staffing levels based on the number of employed extenders. For each FTE-equivalent extender employed by (or subcontracted with) the Contractor, the maximum number of Members for the Care Manager staffing ratios described in Section 8.4.4, *Care Manager Staffing Ratios,* will be increased by 20% for a corresponding FTE Care Manager. For example, if a Contractor employs two FTE extenders, two corresponding FTE Care Managers will be permitted serve 20% more Members. The Contractor will be permitted to apply extender staffing ratio "credits" on a blended basis.

8.8.3 Care Manager Supervisor

All Care Managers must have oversight by a Care Manager Supervisor. One Care Manager Supervisor must not oversee more than fifteen (15) Care Managers. Care Manager Supervisors must meet the qualifications described in the Table above. All supervisors must have access to the Contractor's Medical Director for review of cases. Care Manager Supervisors must have experience working in health care delivery systems and must have demonstrated ability to communicate with Members who have complex medical or social needs and who may have communication barriers.

8.8.4 Care Manager Training

The Contractor must ensure all Care Managers and Care Manager Supervisors serving all Cardinal Care Members have access to and complete training appropriate to the sub-population being served as it relates to their duties and responsibilities. Curriculum must include:

1. Educational information about Members' various medical/behavioral health needs and common comorbidities, environmental risk factors (e.g. tobacco smoke, e-cigarette aerosols), and training in specialized areas (e.g., motivational interviewing, dementia, substance use disorders);
2. The Cardinal Care program and services described in the Cardinal Care Covered Services Chart;
3. Person-centered practices including needs assessment and care planning, addressing LTSS and other needs;
4. Understanding and addressing social and other unmet health-related social needs, including identifying, utilizing, and helping the Member navigate available social supports and resources at the Member's local level;
5. Understanding and addressing ACEs, trauma, and trauma-informed care;
6. Cultural and Linguistic Competency, including LTSS needs, considerations for tribal populations, non-white populations, and forms of bias that may affect Members;
7. Skills to support community integration (e.g. independent living skills, diversion from congregate care settings, detention, institutional settings or correctional facilities, supportive housing/tenancy support programs, employment supports and resources);
8. Health promotion techniques (e.g., self-management, self-help recovery, tobacco use intervention, motivational interviewing);

9. Transitional Care Management best practices;
10. Preparing Members for and assisting them during emergencies and natural disasters;
11. Infection control and prevention practices, including frequent handwashing and proper use of personal protective equipment and training Members on proper practices, particularly for Members receiving care in the home or community settings, or as Members transition across care settings;
12. General understanding of telehealth applications in order to assist Members in using the tools;
13. Understanding and navigating the Medicare program for coordination purposes, including preparation for Medicare eligibility and enrollment and other programs that may serve dually eligible Members, such as Dual Special Needs Programs (D-SNP) and PACE;
14. Involuntary psychiatric admissions related to emergency custody orders and temporary detention orders; including when to initiate the process with the Community Services Boards.
15. Providing assistance to Members in crisis;
16. Adult Protective Services (APS) and Child Protective Services (CPS) reporting processes; and
17. Understanding needs of the justice-involved population, which includes individuals who have a history of incarceration, detention, probation or parole supervision.

For more information on Provider training requirements, see Section 7.4.5, *Provider Training, Technical Assistance, and Education*.

The Department reserves the right to request and review Care Manager training materials as necessary. Contractors are encouraged to allow staff to participate in external training opportunities available through the Department or other state agencies.

8.8.5 Care Manager Assignment

The Contractor must assign Care Managers based on an assessment of the Member's needs and the qualifications of the Care Manager. The Contractor must include a description of its process for assigning Members to Care Managers, which must take into consideration the Care Manager's experience working with populations with physical disabilities, developmental disabilities, serious mental illness, traumatic brain injury, the elderly, or other populations with unique needs in its Care Management Staffing Plan, described below.

Non-LTSS Members who have been determined to be "unable to contact" may be assigned to a Care Manager that does not meet the specified qualification above. Once the Member has been contacted, they must be reassigned to a Care Manager that meets the minimum qualifications above within one (1) week. See Section 8.5.4, *Unable to Contact for HRA*.

The Contractor must assign Members assigned to High intensity Care Management a Care Manager on or before the Member's MCO enrollment effective date with the Contractor. The Contractor must send a notice to the Member within fourteen (14) calendar days following MCO enrollment with the Contractor providing the name and contact information for their assigned Care Manager. For Members who are assigned to Low or Moderate intensity Care Management, the Contractor must send a notice to the Member within fourteen (14) calendar days following enrollment of the Member into Care Management, providing the name and contact information for their assigned Care Manager. Upon request by the Department, the Contractor must provide the name and contact number of the Care

Manager assigned to a particular Member. The Contractor must keep changes to Care Manager assignments at a minimum and must coordinate a transition to a new Care Manager with prompt notification to the Member of the new Care Manager. The Contractor must conduct outreach by telephone or videoconference within fourteen (14) calendar days to inform the Member of the new Care Manager assignment and contact information. If unable to contact the Member via telephone or videoconference, the Contractor must mail this information to the Member.

8.8.6 Care Management Staffing Plan

The Contractor must submit to the Department for approval prior to implementation, upon revision, or upon request, a Care Management Staffing Plan. This must include a description of staff positions that will be involved in Care Management operations for the Cardinal Care program, including but not limited to, Care Manager Supervisors, Care Managers, Care Management support staff and extenders, and administrative staff support. The Contractor must also identify the role/function(s) of each Care Management staff role as well as the required educational requirements, clinical licensure standards, certification, and relevant experience with Care Management standards and/or activities. The staffing plan must also include all training each role is required to complete during onboarding and ongoing employment as a health plan Care Manager. The Department reserves the right to train the Contractor's Care Management staff in relation to the Cardinal Care program requirements and expectations. The Department will inform the Contractor of any mandatory training as learning needs are identified.

8.9 Ongoing Care Management

8.9.1 General Requirements

The Contractor must ensure that each Member who is actively engaged in Care Management receives services according to their ICP. The Contractor must ensure that Care Management includes:

8.9.1.1 **Access to the Care Manager**

1. Meeting face-to-face requirements as outlined in this Contract;
2. Accommodating any Member request or need for face-to-face visits;
3. Ensuring that Members have ongoing access (e.g., telephone number, email address) to their Care Manager. The Member must have all current and accurate contact information for their assigned Care Manager at all times. Should the Care Manager not be available for an extended period of time, the Contractor must identify back-up coverage from the Contractor's staff;
4. Notifying Members if there is a change in their assigned Care Manager and ensuring continuity of care during the transition process to a new Care Manager, if applicable; and,
5. Ensuring that the Member's Care Manager maintains regular contact with other care managers/case managers assigned to the Member.

8.9.1.2 **Coordination of Member Services and Providers Across the Continuum**

1. Engaging Members in Care Management activities;
2. Coordinating and providing assessment, referral, information, and assistance in obtaining and maintaining the following types of Medicaid services, including those covered by either the Contractor or FFS:

a. Physical Health;
b. Behavioral Health;
c. I/DD;
d. LTSS;
e. TBI;
f. Pharmacy;
g. Vision;
h. Dental; and
i. Peer Supports/Recovery Services.

3. Supporting Members to ensure they receive all medically necessary services as expeditiously as the Member's condition requires, including scheduling appointments and coordinating referrals. In particular, Care Managers must support Members as expeditiously as required following a triggering event, as defined in Section 8.4.7, *Triggering Events*, and when Members face challenges finding in-network providers;

4. Referring Members to and coordinating social services provided by community and social providers, including disability benefits, food and income supports, housing, transportation, employment services, education, child welfare services, domestic violence services, legal services, and services for justice-involved populations;

    a. If a Member is identified as experiencing homelessness or at-risk of imminent homelessness, the Contractor must support facilitating and coordinating emergency housing placements.

5. Coordinating Medicare services for Members dually eligible for Medicare and Medicaid, by assisting with referrals and access to Medicare-covered services as requested by the Member when the need is identified. These services should be included in the ICP;
6. For Members with disabilities, providing effective communication with health care providers and participate in assistance with decision making with respect to treatment options;
7. Coordination with early intervention providers. Care Managers must provide this coordination for children who "age-out" of the early intervention program and need to continue receiving services and ensure that services are transitioned to non-early intervention providers (PT, OT, speech, etc.);
8. Connecting Members to services that promote community living and help avoid premature or avoidable NF or other residential placements or inpatient hospitalizations (medical or psychiatric);
9. Working with nursing facilities and community-based LTSS providers to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the LTSS benefit;

10. Communicating and consulting with other providers and the Member and the Member's supports, including family, informal, and formal caregivers, as appropriate; and

11. Facilitating timely communication across the care team, including case conferencing.

8.9.1.3 **Monitoring and Supporting Member Health**

1. Providing enhanced monitoring of functional and health status. The Contractor must design programs to proactively provide the support needed to improve or maintain current health status and avoid functional decline;
2. Ensuring that Members have scheduled annual physical exams, or well-child visits based on the appropriate age-related frequency;
3. Ensuring that Members have a postpartum visit with a provider within fifty-six (56) calendar days of delivery to assess for signs of postpartum depression, as applicable;
4. Conducting the HRA at least every twelve (12) months, or as otherwise required, according to the requirements in Section 8.5, *Health Risk Assessments*;
5. Conducting continuous monitoring of progress toward goals identified in the ICP through in-person contacts with the Member and the Member's supports, including family, informal, and formal caregivers and routine care team reviews. Contacts may be conducted in-person, by videoconference, or telephonically. See Section 8.4.5 *Care Management Contact and Format Requirements*;
6. Conducting medication management, including regular medication reconciliation (conducted by appropriate ICT Member) and support of medication adherence;
7. Supporting the Member's adherence to prescribed treatment regimens and wellness activities;
8. Following up on referrals and setting up appointments, as appropriate;
9. Making available twenty-four (24) hours a day, seven (7) days a week Member support for referrals and consultations, including determining Members' service needs, discussing service options and providing appropriate triage and referral, as appropriate. See Section 2.12.2, *Clinical Triage Line Requirements*;
10. Connecting the Member to evidence-based patient education programs;
11. Arranging transportation to medical appointments, as needed;
12. Developing behavioral health crisis and safety plans as appropriate for Members with behavioral health needs. The plan must describe how the Contractor and the Care Manager will assist the Member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer recovery support services) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
13. Developing safety plans for Members with chronic medical conditions;
14. Conducting transitional Care Management as described in Section 8.10, *Transitional Care Management*; and
15. Ensuring that Care Managers support assigned Members through administrative transitions, as described in Section 8.11, *Administrative Transitions*, and proactively make best efforts to ensure that Members do not lose their Medicaid eligibility at renewal periods unnecessarily due to administrative reasons.

8.9.2 Local Care Management Requirements

The Contractor must ensure that Care Management is locally and regionally based (and not limited only to outreach by telephone or videoconference). Care Managers assigned to conduct face-to-face Care Management activities must be located in each of the contracted regions to the extent possible. All Care

Managers, including those providing centralized telephonic/videoconference Care Management and those located throughout the regions must be aware of region-specific community resources. The Contractor may accomplish this through innovative partnerships with community-based organizations that perform local Care Management functions. See Section 8.9.3, *Care Management Partnerships*, Including with Community-Based Organizations.

8.9.3 Care Management Partnerships, Including with Community-Based Organizations

When requested by the Department, the Contractor must participate in collaborative planning with the Department and its community partners. Partnering organizations may include, but are not limited to, Centers for Independent Living (CILs), CSBs, AAAs, adult day health care centers (ADCCs), health systems, Early Intervention Local Lead Agencies and nursing facilities.

Contractors may form innovative partnerships with Community-Based Organizations (CBOs) that perform Care Management or Care Management Extender functions and offer support services to Cardinal Care Members, such as options counseling and facilitating transitions from an institution to the community.

The Contractor must ensure that CBO Care Management staff and supervisors meet all contractual standards and Federal conflict of interest requirements, particularly in the area of functional eligibility assessments. Administrative firewalls should exist to ensure that staff within the contracted CBOs who perform direct care services, such as personal care, are not the same staff who provide Care Management services.

The Contractor must ensure that documentation of all CBO Care Management activities are available within the Contractor's systems and that required reporting can be provided (HRA, ICP data, etc.) to DMAS as required. The Contractor must also maintain accurate records of CBO Care Manager assignments, both current and historical.

CMS and the Department do not consider case management to be a direct care service and therefore, case managers are not prohibited from performing Care Coordination and Care Management functions. Additional guidance is available from CMS at https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-training-series/index.html#conflict.

8.9.4 Referral Requirements

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

1. Establish referral mechanisms to link Members with providers and programs not covered through Cardinal Care or Medicaid;
2. Establish relationships with key state partners and community-based partnerships;
3. Maintain a current list of providers, agencies, and programs and provide that list to Members who have needs for those programs;
4. Refer Members to the Department for carved-out and excluded services pursuant to Section 5.2, *Carved-Out Services*; and
5. Refer Members to the Department who are transitioning to residential treatment.

In accordance with 42 CFR§ 457.1201, the Contractor must guarantee that it will not avoid costs for services covered in this Contract by referring enrollees to publicly supported health care resources.

8.10 Transitional Care Management

The Contractor must oversee care transitions for Members who are moving from one clinical setting to another to prevent unplanned or unnecessary readmissions, ED visits, or adverse outcomes consistent with 42 C.F.R. § 438.208(b)(2)(i).

The Contractor may have one (1) or more dedicated Regional Transition Care Managers in each region to be available to Care Managers, at a Care Manager's discretion, to assist Members with care transitions. Care transitions include: (1) transitioning Members between NFs, hospitals and other acute care settings, inpatient rehabilitation, or other institutional settings, (2) transitioning Members from any of these settings into the community, and (3) assisting individuals who desire to remain in their community setting. In instances when a Care Manager elects to bring a Regional Transition Care Managers onto the care team, the Regional Transition Care Manager must work in tandem with the Member, the Member's Care Manager and all ICT Members to ensure safe and effective transitions between clinical settings and from nursing facilities to the community. See Section 8.10.3, *Transition from NF to the Community*. The Contractor and the Care Manager must ensure that the Regional Transition Care Manager does not duplicate the efforts and activities of the Member's Care Manager. Care Managers must not fully delegate Care Management responsibility to a Regional Transition Care Manager but rather may leverage their expertise to assist with various Transitional Care Management functions in coordination with the lead assigned Care Manager.

The Regional Transition Care Manager must not have a caseload other than individuals in transition and must meet the qualifications of a Care Manager as described in Section 8.8.1, *Care Manager Qualifications*.

8.10.1 Regional Transition Care Manager Responsibilities

The Regional Transition Care Manager, when engaged by the Care Manager, must work in tandem with the Member, the Member's Care Manager and all ICT Members to ensure safe and effective transitions between levels of care. The Regional Transition Care Manager must:

1. Participate in discharge planning for Members transitioning from acute institutional settings to lower levels of care, including involuntary psychiatric admissions, Long-Stay Hospitals, Nursing Facilities, and the community. Single, non-recurrent (within 30 calendar days) medical stays of two nights or less do not require the participation of the Regional Transition Care Manager unless indicated by the Member's needs and circumstances;
2. Coordinate with the assigned Care Manager in discharge planning activities to ensure a safe transition that meets the Member's needs and preferences, including assisting with scheduling of discharge/aftercare appointments and identifying non-clinical supports and the role they serve in the Member's treatment and aftercare plans;
3. Coordinate with the Contractor's Utilization Management staff, as indicated, regarding discharge planning;

4. Coordinate with NF staff, the Member's assigned Care Manager, and the Member when it is identified that the Member wishes to transition from NF care to the community;
5. Use HRA information and work with NF staff (including obtaining MDS Section Q data), hospital staff, community care providers, screening teams, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This includes utilizing local contact agencies in order to facilitate transitions and linking with other community resources that provide support (including housing and employment options) to individuals and their families/caregivers, such as CILs, CSBs, and local AAAs;
6. Provide support to the Care Manager to maintain Members in the community in lieu of transitioning to institutional settings, as needed; and
7. For dual-eligible Members enrolled in a D-SNP, work with the D-SNP Care Coordinator upon approval of the Member, to coordinate the above activities.

8.10.2 Care Manager Responsibilities in Coordination with the Regional Transition Care Manager

Collaboration between the Regional Transition Care Manager and the Care Manager is vital for ensuring smooth transitions to and from hospitals, nursing facilities, other institutions, and the community. The Member's Care Manager must work with the Regional Transition Care Manager to:

1. Support transitions across the continuum of care and ensure Member's needs and preferences are met, including:
    a. Ensuring that admissions and lengths of stay are appropriate to the Member's needs;
    b. Ensuring services are provided in the least restrictive environment;
    c. Upon notification of a hospital or NF admission or discharge, ensuring that communication of the hospital or NF admission or discharge is conveyed to the PCP and community-based providers within 24 hours;
    d. Ensuring that there is timely and adequate discharge planning and medication reconciliation;
    e. Working to reduce the need for hospital transfers and emergency room use;
    f. Communicating with providers of waiver services when an admission has occurred and sharing the tentative discharge date once available; and
    g. Documenting all efforts related to these activities, including the Member's active participation in discharge planning.
2. Ensure completion of the HRA and ICP following discharge in accordance with required timeframes, as described in Section 8.5.3, *HRA Completion Timeframes* and Section 8.6.2, *ICP Revision Completion Timeframes*;
3. Work with facility staff and the Transition Care Manager to make ICP revisions; ICP revisions must include descriptions of detailed Care Management interventions and strategies employed to provide seamless transitions and avoid delays in services and supports;
4. Ensure the ICT meeting is scheduled and held as required and includes a discussion of discharge planning, coordination, and reassessment, as needed;
5. Ensure that the appropriate behavioral health providers provide a discharge plan to ICT Members following any behavioral health admissions;

6. Ensure that Members who require medication monitoring will have access to such services within fourteen (14) calendar days of discharge from a behavioral health inpatient setting or as medically advised;
7. For dual-eligible Members enrolled in a D-SNP, coordinate with the D-SNP Care Coordinator upon the approval of the Member;
8. Provide outreach to providers of Medicare services regarding the role of the Care Manager related to transitions of care and the model of care;
9. Provide education to Members, authorized representatives, family/caregivers, and providers regarding the importance of notifying the Care Manager of any inpatient admissions to ensure the Care Manager can help effectuate successful transitions; and
10. Comply with continuity of care provisions described in Section 8.11, *Administrative Transitions*, to the extent applicable.

8.10.3 Transition from NF to the Community

The Contractor's Regional Transition Care Managers must, if engaged to assist with transitional Care Management by the Care Manager, provide transition support to Members who have the desire to and can safely transition from NFs to the community (and maintain or improve their health status). Care Managers should work closely with LTSS Care Managers to facilitate the transition.

The scope of transition services that the Contractor must provide includes assessing not only medical/health needs but also assessing the Member's social determinants of health (e.g., housing, transportation, social interactions, etc.). The Contractor must develop an inclusive and realistic transition plan for the Member and assist in addressing all components of the transition plan (e.g., assisting with finding housing, setting up non-medical transportation, helping the individual integrate into the community through clubs, volunteering/work, and faith organizations). The Contractor must provide consistent follow-up during the first year after discharge and must make adjustments to the transition plan to assure acclimation and integration into the community as needed by the Member.

NF transitional Care Management must include, but is not limited to:

1. The development of a transition plan;
2. The provision of information about services that may be needed, in accordance with the timeframes specified in this Contract, prior to the discharge date, during and after transition;
3. The coordination of community-based services with the Care Manager. This includes the identification of needed CCC Plus Waiver-covered Transition Services if the Member will be enrolled in the CCC Plus Waiver ; and
4. Linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation.

The Contractor and Care Manager must determine the appropriate staffing mix between the Care Manager and the Regional Transition Care Manager to support NF Transitional Care Management.

The Contractor is encouraged to utilize Transitional Care Management resources in acute discharge planning efforts and in the Virginia Emergency Department Care Coordination Program to support overall Care Management resources. See Section 5.7.6, *Virginia Emergency Department Care*

Coordination Program. This particularly applies to Members in Moderate to High Intensity Care Management.

8.11 Administrative Transitions

The Contractor must work closely with the Department and other Department contractors toward the goal of ensuring continuity of care for Members whose enrollment changes between the Contractor's plan and fee-for-service or another Contractor. These enrollment changes are referred to as "administrative transitions".

The Contractor must develop and implement strategic processes that support collaborative efforts among contractors for smooth care transitions and that prevent a Member from having interrupted or discontinued services throughout an administrative transition until the transition is complete. In accordance with 42 CFR § 438.62, the Contractor must:

1. Comply with requests for historical utilization data when the Member is enrolled in a new MCO;
2. Ensure the Member retains access to services consistent with the access they previously had and is permitted to retain their current provider during the continuity of care period (see below) if that provider is not in the network;
3. Refer the Member to appropriate providers of services that are in the network;
4. Ensure the Member's new providers are able to obtain copies of the Member's medical records; and
5. Educate providers regarding any potential periods of disenrollment and billing options for services rendered during the transition between Managed Care and FFS. Discontinuation of life-saving services should be prevented and Member abandonment by contracted providers during an administrative transition must not be tolerated.

In addition to the above requirements, the Contractor must also ensure compliance with the provisions of Va. Code §§ 38.2-3407.10 and 38.2-4319 when a provider is terminated from the Contractor's provider network.

8.11.1 Continuity of Care Upon Enrollment

The Contractor must ensure continuity of care for all Members who undergo an administrative transition and enroll with the Contractor.

To ensure continuity of care upon enrollment for newly enrolled Members who have undergone an administrative transition, the Contractor must:

1. Conduct all activities described in Section 8.4.1, *Risk Stratification*, to determine if a Member is in a Priority Population or otherwise may benefit from Care Management and, if so, the appropriate Care Management intensity.
2. Observe a "continuity of care period" for the first thirty (30) calendar days of a Member's enrollment, unless otherwise specified in this Contract. The Contractor must extend the continuity of care period pending the Member's provider(s) contracting with the Contractor (if applicable) or the Member's safe and effective transition to a contracted provider. The Department has sole discretion to extend the continuity of care period time frame.

a. For Members receiving High Intensity Care Management, the continuity of care period must be for the first sixty (60) calendar days of a Member's enrollment.
b. For pregnant individuals, the continuity of care period must be for the first sixty (60) calendar days postpartum.

3. Allow Members to continue seeing their out-of-network providers with reimbursement provided at the Medicaid FFS rate for the duration of the continuity of care period.
4. Not change a Member's existing provider before the end of the continuity of care period, except in the following circumstances:
    a. The Member requests a change;
    b. The provider chooses to discontinue providing services to a Member as currently allowed by Medicaid;
    c. The Contractor or the Department identify provider performance issues that affect a Member's health or welfare; or,
    d. The provider is excluded under State or Federal exclusion requirements.
5. Make reasonable efforts to contact out-of-network providers who are providing services to Members, and provide them with information on becoming credentialed, in-network providers.
    a. If the provider does not join the network, or the Member does not select a new in-network provider, the Contractor must facilitate a seamless transition to a participating provider (with the exception of NF residents) See Section 8.11.4, *Members in NFs*.
6. Honor SAs issued by the Department or its contractors for the duration of the SA or the duration of the continuity of care period, whichever comes first.
    a. The Contractor must create SAs including but not limited to Continuity of Care authorizations for services or authorizations in place on the date of enrollment specific to the Contractor.
    b. If the authorization ends before the Contractor completes a new HRA and ICP (if required), and the provider has requested a continuation of services, the Contractor must extend the continuity of care period until the new HRA and ICP are completed.
    c. If the Contractor proposes modifications to the Member's SA, the Contractor must provide written notification to the Member and provider with the opportunity for the Member to appeal the proposed modifications.
    d. The Department will provide the Contractor with SA data through the Medical Transition Report. The Contractor must interrogate the MTR file to create and honor SAs, as applicable. The remainder of the MTR data should be utilized for Member stratification purposes.
7. Permit Members to continue to receive medications/refills authorized by the Department (including the Department's Drug Utilization Review (DUR) Board) or another Department Contractor during the continuity of care period. Transitional refills must be provided for a minimum of thirty (30) days but may be provided for up to the duration of the prior service authorization up to a maximum of twelve (12) months, at the Contractor's discretion, which covers a minimum of thirty (30) days. This would not preclude the Contractor from working with the Member and their treatment team to resolve polypharmacy concerns. Additionally, a Member that is, at the time of enrollment receiving a prescription drug that is not on the

Contractor's formulary or PDL must be permitted to continue to receive that drug if medically necessary.

8. Provide coverage at the Medicaid FFS rate for any previously scheduled medical appointments, surgeries, durable medical equipment, prosthetics, orthotics or other supplies determined to be medically necessary by the Department and/or the previous Contractor.

The Contractor is not required, as a result of an administrative transition, to readminister the MMHS to Members who had the MMHS completed within the previous twelve (12) months.

The Contractor is not required to conduct a new HRA for Members undergoing an administrative transition unless the Member has experienced a triggering event or a new HRA is due according to the requirements, as defined in Section 8.5.3, *HRA Completion Timeframes*. This also applies in the event that a Member is disenrolled and reenrolled with the Contractor.

For Members who are hospitalized at the time of MCO enrollment, see Section 3.8, *Enrollment Process for Individuals Hospitalized at Enrollment*. Forr requirements related to financial responsibility, refer to Section 12.2.1, *Hospital Payments*.

Members in a NF at the time of Cardinal Care program enrollment may remain in that NF as long as they continue to meet the Department's level of care criteria for NF care, unless they or their authorized representatives prefer to move to a different NF or return to the community. The only reasons for which the Contractor may require a change in NF is if:

1. The Member requests a change;
2. The provider is excluded under State or Federal exclusion requirements; or,
3. Due to one or more deficiencies that constitute immediate jeopardy to resident health or safety, per direction from the Department, the Virginia Department of Health (VDH) – Office of Licensure and Certification (OLC), or Adult Protective Services (APS). Such reasons are described in the Department's Nursing Home Manual, Chapter IX, 42 CFR § 488.410, 12VAC30-20-251, and http://www.vdh.virginia.gov/OLC/LongTermCare/survey.htm.

8.11.2 Continuity of Care Upon Disenrollment

The Department, or its designee, must assume responsibility for all covered services authorized by the Member's previous MCO within the Department's 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).

If the authorized service is an inpatient stay, the financial responsibility must be allocated per Section 3.8, *Enrollment Process for Individuals Hospitalized at Enrollment*.

To facilitate seamless transitions, upon disenrollment of the Member, the Contractor must send SA, HRA, and ICP, information using the method, frequency, and format specified by the Department in the CRMS Technical Manual.

Following the transition, the Department, or its designee, or the Member's receiving health plan must assume responsibility for all covered services authorized by the Contractor during the continuity of care period.

In addition, the Contractor must make best efforts to develop a Transition Plan for Members engaged in all levels of Care Management who are transferring to another Contractor or FFS. The Contractor is required to conduct a warm handoff to the Member's new health plan or the Department, including, whenever possible, identifying the Member's new Care Manager and helping the Member to connect with the new Care Manager. Electronic transfer of Transition Plan information is permitted through secure means. The Transition Plan should include the following elements:

1. Summary of known diagnoses, status of ongoing treatment, and plan for treatment going forward;
2. Date of Medicaid eligibility renewal;
3. List of Member's providers;
4. Physical and behavioral health treatment records;
5. List of medications previously and currently prescribed, including dosage and contraindications (as applicable);
6. Care management records;
7. List of scheduled appointments;
8. Summary of ICT composition;
9. List of key family/caregiver contacts; and,
10. Other materials, as appropriate.

8.11.3 Transition Plans for Member's Receiving Life-Saving Services

Members receiving PDN who become disenrolled from the Contractor are at high-risk of hospitalization or in some cases death. For Members receiving PDN services, the Contractor must use its advanced analytics to set up an alert system to facilitate proactive transition planning. The alert system must include prompts to the Member's Care Manager regarding the Member's pending eligibility renewal date and must also notify the Care Manager in any instance where the 834 enrollment file reflects the Member's enrollment is ending with the Contractor. To mitigate risks to the Member's health, safety, and welfare, the Contractor must:

1. Require the Care Manager to make every effort to assist the Member in responding timely to eligibility renewal requirements to mitigate a lapse in eligibility, which could result in disruption to life-saving services.
2. Ensure the Member has a written plan in place, including a plan to respond to emergencies;
3. For Contractor to Contractor transitions, coordinate the exchange of information to the extent possible to ensure there is no lapse is service.
4. For Members who lose eligibility or move to fee-for-service, the Contractor must notify the treating provider within one (1) business day to inform them of continuity of care provisions available through fee-for-service. Discontinuation of life-saving services and Member abandonment by contracted providers should not be tolerated.

8.11.4 Members In NFs

If it is determined that a NF is not able to safely meet the needs of a Member (e.g., due to dangerous behaviors) or because the Member no longer meets the NF level of care requirement, the Contractor must continue to pay the facility until the Member is transitioned to a safe and alternate placement.

If an individual residing in a continuing care retirement facility becomes eligible for Cardinal Care and subsequently qualifies for NF level of care, the Contractor must make every reasonable effort to contract with the NF provider at rates equitable to other contracted NF, or reimburse the NF at the fee-for-service rate for this Member. The continuing care NF must accept the agreed upon reimbursement as payment in full for the Member. If the provider refuses to contract with the Contractor or accept the FFS rate, only then may the Contractor require the Member to move to an in-network facility.

Where a Member who resides in an out-of-network NF is hospitalized, the Contractor must allow the Member to return to the out-of-network NF upon discharge from the hospital when all of the following criteria are met:

1. Returning to the NF meets the Member's preferences and level of care needs; and,
2. There is a bed available at the Member's prior NF; and,
3. The NF will accept the Member at fee-for-service rates (or a negotiated rate between the Contractor and the facility. The negotiated rate must be in accordance with the required payment terms for NFs as described in this Contract).

In the event of an NF closure, or as necessary to protect the health and safety of residents, the Contractor must arrange for the safe and orderly transfer of all Members and their personal effects to another facility. In addition to any notices provided by the facility, the Contractor must provide timely written notice inclusive of the required elements in 42 CFR § 483.73(c)) and work cooperatively with the Department for Aging and Rehabilitation, including the local Departments of Social Services, the Long-term Care Ombudsman, and other state agencies in arranging the safe relocation of residents. The Contractor's Care Manager must coordinate the relocation plan and act as a resource manager to other agencies and as a central point of contact for Member relocations.

8.11.5 Coordination with Contracted Behavioral Health Service Agencies

The Contractor must coordinate behavioral health, ARTS, and MHS benefits with the DMAS Service Authorization Contractor when appropriate. See Section 5.5, *Behavioral Health Services*. Care Managers must be trained and knowledgeable about all Medicaid covered behavioral health and MHS services, including psychiatric residential treatment and therapeutic group home services that are carved-out of this Contract and covered through FFS, to ensure that Members have access to the full continuum of care.

8.11.6 Data Sharing and Reporting

The Contractor must have systems and operational processes in place for sharing data to and from the Department and other Contractors, including but not limited to Member's claims and SAs, reviewing the data for Member risks/needs and utilizing the data to support the transition process.

At minimum, the Contractor's data sharing and reporting processes must:

1. Ensure that there is no interruption of covered services for Members;
2. Accept the transfer of all medical records and Care Management data, as directed by the Department; and,

3. Transfer SA, HRA, ICP, and other needed data to the Department or other Contractors, as appropriate and support all requirements set forth in the CRMS Technical Manual to support Members who transition. Refer to Section 11.9.2, *Care Management Solution (CRMS),* for more information.
4. Follow the model of care reporting requirements described in the Cardinal Care Technical Manual.

8.12 Care Coordination and Care Management for Specific Subpopulations

8.12.1 Foster Care Management

8.12.1.1 General Requirements

The Contractor must provide specialized Care Management to all children and youth in foster care and former foster youth according to the following requirements. See Section 8.4.2, *Priority Populations* above for more information:

1. Members in foster care and former foster youth must be assigned to High Intensity Care Management for a minimum of three (3) months following enrollment in Medicaid, entry into the child welfare system or a new home;
2. Members aging out of foster care must be assigned to High Intensity Care Management for three (3) months after aging out of the child welfare system; and,
3. Outside of these three (3) month periods, Members in the groups above must receive either Low, Moderate or High Intensity Care Management.

The Contractor must document on a case by case basis the reason(s) for assigning a Member in foster care or who is a former foster youth to a specific Care Management intensity tier (i.e., Low, Moderate, or High). The Contractor must also document the reason(s) for re-assigning a member to a different Care Management tier upon restratification or following a triggering event.

In addition to receiving Low, Moderate or High Intensity Care Management, the Contractor must:

1. Support the efforts of the LDSS social worker and/or the foster care parents during initial outreach to ensure that Members in foster care receive both a PCP and a dental visit within thirty (30) days of enrollment with the Contractor, unless their social worker attests that they have recently seen a provider within three (3) months prior to enrollment;
2. Ensure in the event that the Member has seen an out-of-network PCP and/or a dentist prior to enrollment, that the Member is assigned to an in-network PCP and/or Smiles for Children dentist for future ongoing care;
3. Provide prompt medication management/reconciliation upon enrollment on the basis of foster care status or if a Member is known to have entered the foster care system while already enrolled in Medicaid; and,
4. Ensure that Members in Treatment Foster Care Case Management or Residential Treatment services consisting of Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) have access to transportation and pharmacy services related to the delivery of these carved-out services, as necessary.

8.12.1.2 Foster Care Transition Planning

The Contractor must develop and maintain transition of care policies and procedures for children in foster care who are transitioning out the child welfare system. The policies and procedures must include provisions for convening a comprehensive treatment team meeting prior to Member leaving the child welfare system to discuss the services and supports the Member's needs post-separation. If the services are not covered by Medicaid, the Contractor must inform the Member, or their authorized representative, of available community programs that may be able to meet their needs and make the necessary referrals, as needed. If the Member has an ICP, the Contractor must include transition needs in the updated ICP.

The Contractor must establish a process to notify youth in foster care who are approaching age seventeen (17) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor must ensure Care Management continues during this transition period.

The Contractor must start transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system or immediately upon notification that an enrollee has achieved permanency status. The Contractor must assist the Member with all aspects of the eligibility determination process and coordinate with the local Department of Social Services to ensure transition to Aid Category 70, former Foster Care children and youth in Fostering Futures.

The Contractor must provide youth aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions) and providing resources to assist with transitioning to adulthood and managing their own medical decisions.

8.12.1.3 Compliance with Other Federal and State Requirements

The Contractor must work collaboratively with the Department and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan, the provision of health care services as outlined in the VDSS Five Year State Plan for Child and Family Services, and the VDSS Child and Family Services Manuals for children in foster care. The Contractor must comply with the following rules:

1. Care Coordination and Care Management
    a. The Contractor must work with DSS in all areas of Care Management and Care Coordination;
    b. For decisions regarding the foster care child's medical care, the Contractor must 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 Contractor must work directly with the adoptive parent;
    c. For decisions regarding the medical care of former foster care or Fostering Futures Members (AC 070), the Contractor must work directly with the former foster care Members;
2. Covered Services

a. The Contractor must provide coverage for all contractual covered services until the Department disenrolls the child from the Contractor's plan. This includes circumstances where a child moves out of the Contractor's service area;
b. Coverage must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area;

3. Enrollment and Plan Selection
   a. Foster care children are not restricted to their health plan selection following the initial three (3) month enrollment period;
   b. The DSS 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 through the Enrollment Broker at any time that the child is placed in an area not serviced by the MCO where the child is enrolled; and,
   c. The former foster care or Fostering Futures Members (AC 070) must be responsible for all changes regarding their MCO enrollment; and,
4. Other
   a. The Contractor must participate in child welfare stakeholder collaboration work groups as requested by the Department. See Section 1.3.2, *Child Welfare Stakeholder Collaboration*.

8.12.1.4 Foster Care/Adoption Assistance Reporting Requirements

The Contractor must report monthly to the Department any barriers identified in contacting and/or providing care to foster care children. The Department will use the Barrier Report to assist the Contractor in resolving the barriers reported. Refer to the Cardinal Care Technical Manual for Barrier Report specifications.

The Contractor agrees to adhere to all additional reporting requirements related to the foster care and adoption assistance population, as outlined in the Cardinal Care Technical Manual.

8.12.2 Care Management for High-Risk Pregnant Individuals and Infants

In addition to ensuring that high-risk pregnant individuals and infants receive Care Management services appropriate to their Priority Population status. See Section 8.4.2, *Priority Populations*) and Care Management Intensity level as described throughout Section 8, *Model of Care*, the Contractor must comply with the following enhanced requirements.

8.12.2.1 High-Risk Pregnancy Requirements

The Contractor must have written policies and procedures that outline how the Contractor differentiates pregnant individuals according to risk status. The methods applied to assess the risk of a pregnant Member must be evidence-based and developed in accordance with guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). At a minimum, the process must consider:

1. The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.;
2. Previous pregnancy complications and adverse birth outcomes;

3. History of or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use);
4. History of, or a current positive screen for, depression, anxiety and/or other behavioral health concerns; and
5. The Member's personal safety (e.g., housing situation, violence).

The Contractor must provide Care Management services for its high-risk pregnant individuals and infants per Section 8.4, *Care Management*. Care management services must be coordinated with Contractor-reimbursed high-risk prenatal and infant targeted case management services.

Within three (3) business 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.). The Contractor must have methods in place to monitor Members who are deemed by the Contractor as being "high-risk maternity." The Contractor must also continue to monitor, as deemed appropriate, the risk status of pregnant Members not originally considered "high-risk maternity" for potential enrollment in the Contractor's high-risk maternity programs.

8.12.2.2 Substance-Exposed Infants (SEIs) and Neonatal Abstinence Syndrome (NAS) Infants

The Contractor must also have methods in place to monitor infants who are deemed by the Contractor as being "high-risk". At a minimum, high-risk infants include all newborns/infants admitted to the NICU (Nursery Level 3/NICU) for neonatal intensive care and Substance-Exposed Infants (SEIs) and Neonatal Abstinence Syndrome (NAS) Infants.

To best support SEIs/NAS infants, the Contractor must develop specialized Care Management interventions to address the medical and psychosocial needs of the infant and the infant's mother along with creating a plan of safe care for the SEI/NAS infant. These interventions must be delivered with the objective of ensuring that the SEI/NAS infant is receiving care in conjunction with the substance use recovery Care Management provided for his or her mother.

The Contractor must provide Care Management services to each family parenting an identified SEI/NAS infant. SEIs/NAS infants must be identified through both their own health status and their biological mother's risk factors for drug use including their prenatal substance use history. These Care Management services must include parental psychosocial education on the potential developmental needs of SEIs/NAS infants, trauma-informed services for both the parents of SEIs/NAS infants and the SEI/NAS infant, as developmentally appropriate, a plan of safe care developed for the SEI/NAS infant with a licensed behavioral health professional and the SEI's/NAS infant's care giver and substance use treatment Care Management services for the biological parents of SEIs, as applicable. Adoptive parents parenting an SEI/NAS infant who qualifies for Medicaid through adoption assistance must also have the option of receiving these Care Management services, as clinically appropriate and requested. See Section 8.4.2, *Priority Populations*.

8.12.2.3 Service Plans for High-Risk Pregnant Women and Infants

For all high-risk pregnant women and infants, and the Contractor must develop service plans that include individualized descriptions of what services and resources are needed and how to access those services and resources. See Section 8.6, *Person-Centered Individualized Care Plan*.

Refer to Section 5.13, *Maternal and Infant Health Services,* for general coverage requirements for Maternal and Infant Care Programs.

8.12.3 Care Management for Members Receiving HCBS

For members with special health care needs or those who need LTSS, in accordance with 42 CFR § 438.208(c), the Contractor must:

1. Develop processes for identifying and assessing the needs of individuals who need LTSS or who have special health care needs.
2. Produce treatment/service plans (known in this contract as individualized care plans or ICPs) for individuals who require LTSS. Care plans must be:

    a. Developed by an individual qualified to coordinate LTSS service requirements with Member participation, and in consultation with any providers caring for the Member;
    b. Developed by a person trained in person-centered planning using a person-centered process and care plan as defined in 42 CFR § 441.301(c);
    c. Approved by the Contractor in a timely manner;
    d. In accordance with any applicable State quality assurance and utilization review standards; and
    e. Reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

The Contractor must fully comply with federal requirements around person-centered planning at 42 CFR § 441.301(c)(1) and (2) and CMS guidance documents. .

8.12.4 ARTS Care Management

In addition to ensuring that individuals with SUD receive the minimum levels of Care Management available to other Members, the Contractor, consistent with Federal and State confidentiality requirements, must implement structured Care Management plans for achieving seamless transitions of care for individuals with SUD. These plans will address overall care coordination for the ARTS benefit, transitions between all ASAM Levels of Care, transitions between ARTS service providers, transitions between delivery systems (i.e., moving from FFS to Managed Care), collaboration between behavioral health and physical health systems, and collaboration between the health plans and the Department Fee-for-Service contractor. The Contractor must emphasize Care Management for any Member with SUD transitioning from emergency departments, residential or inpatient stays as well as correctional settings. The Contractor must make every effort to provide outreach and Care Management to Members who are at higher risk for a fatal overdose including those discharged from an inpatient setting

including correctional settings within seven (7) calendar days of notice of discharge. At minimum, this outreach must include ensuring access to naloxone prescriptions through working with the Member and their providers and information on how to get prescriptions filled by in-network pharmacies. The plan of care post-discharge will be developed by the provider and can be updated by the Contractor.

The Contractor must use data from multiple sources (including utilization data, health risk assessments, state agency aid categories, demographic information, Emergency Department Care Coordination Reports and Health Department epidemiology reports) to identify Members with complex health needs, including Members who need help navigating the health system to receive appropriate delivery of care and services. When clinically indicated, the Contractor will assign each Member to an ARTS Care Manager to provide Care Management support throughout the course of substance use disorder treatment, ensuring that all relevant information is shared with the treating providers through care transitions.

The Contractor must develop Care Management structures to manage pregnant and postpartum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

The Contractor must provide ongoing education to providers regarding the requirement to engage in discharge planning for all Members, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care. The Contractor must conduct chart reviews to ensure compliance and identify opportunities to improve quality of care and ensure alignment with identified Department quality priorities. See Section 10, *Quality Improvement*. The Contractor must facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.

In order to minimize barriers to care, the Contractor must ensure that its network includes behavioral health professionals performing addiction and recovery treatment service assessments, treatment and recovery services via telehealth (where available). Services provided via telehealth must be consistent with State regulations. ARTS Care Managers must be knowledgeable about the telehealth delivery system in Virginia and must refer Members in rural and other hard to access areas to these systems in order to receive an assessment and needed services for treatment and recovery. It is expected that there will be some Members who will not be able to access these assessments or needed services through telehealth or an office visit due to transportation, psychosocial, or health issues, thus the Contractor must contract with a subset of providers for an assessment in the Member's home in order to accommodate the needs of these Members.

The ARTS Care Manager must coordinate information with the Member's assigned Care Manager to ensure integration of all care and comprehensive care planning.

8.12.5 Formal Referral and Assistance Process for Members Experiencing Homelessness

The Contractor must develop formal referral and assistance processes and procedures in its Care Management policies and processes and case management programs that identify Members experiencing homelessness. The Contractor must provide members with information and referrals to the homeless crisis response system and provide individualized assistance as the member's situation

and condition warrants. Communities maintain homeless crisis response systems and provide listings of the local homeless point of entry, which is the starting point for anyone who is homeless and in need of shelter and services. The Contractor must work collaboratively with any identified housing providers to ensure non-Medicaid resources are leveraged to support the Member. The Contractor must work to ensure access to needed medical services and that continuity of care is supported.

8.13 Coordination with the Member's Medicare or Other MCO Plan

Dual-eligible Members enrolled in Cardinal Care program may receive their Medicare benefits from the Contractor's companion D-SNP, Medicare FFS, or through another Medicare Advantage (MA) Plan. The Contractor must encourage its Members to also enroll in their companion D-SNP for the Medicare portion of their benefits, in order to provide consistency and maximize the Contractor's ability to coordinate services for the Member. The Contractor must respect the Member's choice of Medicare benefit service delivery and not unduly pressure the Member into aligning their Medicaid and Medicare benefits with the Contractor.

The Contractor must work with the Department to align, whenever possible, enrollment of dual-eligible Members in the same plan for both Medicare and Medicaid services.

The Contractor is responsible for coordinating care and services for Members who do not participate in the Contractor's companion D-SNP. The Contractor is responsible for coordinating the care needed for dual-eligible Members and is responsible for coordination of benefits and crossover claims, as described in Section 13.4.2, *Payment Coordination with Medicare*.

In accordance with 42 CFR § 438.208(b)(2)(ii), the Contractor must implement procedures to coordinate services the Contractor furnishes the Member with the services the Member receives from any other MCO, PIHP, or PAHP. When a dual-eligible Member is enrolled either with the Contractor's D-SNP or MA plan for his/her Medicare benefits, or with a D-SNP or MA plan, or another MCO not affiliated with the Contractor, the Contractor must be responsible for coordinating all benefits covered under this contract and the Member's Medicare plan, other health plan or payor. In this effort the Contractor must at a minimum:

1. Provide the Member's Medicare plan, other health plan or payor with contact information of the person and division responsible for coordination of the Member's Medicaid benefits;
2. Provide the Member's Medicare plan, other health plan or payor with contact information of the person or division responsible for coordination of cost sharing between Medicare or the Member's primary MCO and Medicaid;
3. Request a representative from the Member's Medicare plan or primary MCO carrier to participate in all needs assessments and person-centered planning;
4. Provide the Medicare plan or primary MCO carrier with the results of all needs assessments and person-centered planning;
5. At a minimum, provide the Medicare plan or Member's primary MCO with timely (within 48 hours of becoming aware, of hospital, emergency department and NF admissions and discharges and within 72 hours of the diagnoses of, or significant change in the treatment of, a chronic illness) inpatient hospital, emergency department and NF admissions and discharges and the

diagnosis of, or significant change in the treatment of, a chronic illness in order to facilitate the coordination of benefits and cost sharing between the Medicare and Medicaid plan;

6. Coordinate with the Medicare plan or Member's primary MCO regarding discharge planning from an inpatient setting, including hospital and NF;
7. Request a representative from the Member's Medicare plan or primary MCO to participate in all ICT meetings;
8. Receive, process and utilize in a timely manner (within 72 hours at a maximum or sooner if circumstances necessitate a faster response) information, including Member-specific health data from the Member's Medicare plan or the Member's primary MCO, regarding the effective coordination of benefits and cost sharing;
9. At the request of a Medicare plan or the Member's primary MCO, the Contractor must participate in training of the Medicare or Member's primary MCO plan's staff regarding coordination of benefits and cost sharing between Medicare and Medicaid;
10. Coordinate with a Member's Medicare or primary MCO plan to ensure timely access to medically necessary covered benefits needed by a Member enrolled in the Cardinal Care Plus program;
11. Submit to a Member's Medicare or primary MCO plan, as applicable and appropriate, referrals for Care Coordination, Care Management and/or disease management; and,
12. Receive and process from a Member's Medicare or primary MCO plan a referral for transition from a NF to the community, and coordinate with the Member's Medicare or primary MCO plan to facilitate timely transition, as appropriate, including coordination of services covered by the Contractor and services covered by the Medicare or Member's primary MCO plan.

The Contractor must utilize both Medicare and Medicaid health care data and data from the Member's primary MCO to coordinate all aspects of the Member's health care, including but not limited to: Medicare A, B, and D; data from the Member's primary MCO; historical data; Medicaid historical data; data from the DMAS Service Authorization Contractor; discharge planning; disease management; chronic conditions; and Care Management.

The Contractor must train staff working on services provided under this Contract, including Care Managers and other related staff, on available Medicare benefits and coordination of Medicare and Medicaid benefits. See Section 8.8.4, *Care Manager Training* and Section 7.4.5, *Provider Training*, Technical Assistance and Education for more information. Training must also include procedures for coordinating with the Member's primary Medicare MCO as applicable. The Contractor must also be required to train staff on topics as requested by the Department and within a timeframe designated by the Department. The Contractor must:

1. Train network providers on available D-SNP and Cardinal Care Plus program benefits and services as requested by provider and/or provider associations;
2. Establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for Members, that Care Managers are notified/engaged as appropriate;
3. Maintain daily reports for audit to determine appropriate and timely engagement in discharge planning;
4. Coordinate with a Member's D-SNP or MA Plan or other primary MCO regarding services that may be needed by the Member; however, the D-SNP or MA Plan or primary MCO carrier must

remain responsible for ensuring access to all benefits covered by the Member's primary payer, including nursing facilities and home health, and must not supplant such medically necessary covered services with services available only through the Cardinal Care Plus program;

5. Provide to D-SNPs and MA plans and any other MCO carrier with whom the Member has coverage, training on any Contractor's NF diversion or transition programs including the referral process;
6. Accept and process from a Member's D-SNP, MA plan, health plan or payor a referral for HCBS, including making referrals as appropriate for LTSS screening services, in order to delay or prevent NF placement; and,
7. Develop, for review and approval by the Department, policies, and procedures and training for the Contractor's staff, including Care Managers, regarding coordination with a Member's Medicare Plan or primary MCO plan. The Department expects all items described in this Section to be reflected in the resulting documents.

8.14 Electronic Care Coordination System

The Contractor must utilize an electronic Care Coordination/management system that maximizes the opportunity to share and integrate data and information among the Contractor, its multiple service areas, helplines, providers, Members, and Care Managers quickly and efficiently. The system must allow staff (e.g., customer service, nurse helpline, medical management) who may be contacted by a Member regarding Care Management to have immediate access to the most recent case-specific information within the Contractor's electronic system. The data contained within the electronic system may include the following: administrative data, call center notes, helpline notes, provider service notes, a Member's Care Management notes, and any recent inpatient or emergency department utilization. The system must also have the capability to share or access relevant information (i.e., ICP, utilization reports, care treatment plans, etc.) with the Member, Member's provider(s), and Care Managers. The Contractor must also send and receive relevant data with subcontractors (i.e., to/from the Contractor's Care Management or other systems) to facilitate effective Care Management and transitions of care.

The Contractor must provide utilization management, health risk assessment, individualized care plan and Care Coordination data to the CRMS as described in the Cardinal Care and CRMS Technical Manuals. The Contractor must work collaboratively with the Department to continue to refine CRMS data exchange processes to facilitate efficiencies and enhance care coordination and continuity of care efforts.

8.15 Disease Management Programs

The Contractor must have Disease Management programs, available to all Members enrolled in Cardinal Care that, at a minimum, focuses on identifying and improving the health status of Members diagnosed with the following focus conditions:

1. Respiratory Conditions such as Asthma & Chronic Obstructive Pulmonary Disease (COPD) (pediatrics and adults);
2. Heart disease, including Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF);
3. Diabetes (pediatrics and adults); and
4. Cancer.

8.16 Health Homes

The Contractor may establish health homes for Members with complex health conditions. Health homes should leverage existing community systems that serve individuals with complex health and social needs. Examples may include, but are not limited to, health homes for individuals with dementia utilizing Area Agencies on Aging, Rural Health Clinics, Adult Day Health Care Centers, or other community providers.

8.17 Social Determinants of Health

The Contractor must develop programs, establish partnerships, and provide care coordination efforts that identify, address and track Member needs across each of the five (5) key Social Determinants of Health (SDOH) areas identified by the federal Office of Disease Prevention and Health Promotion's, Healthy People 2020, listed below, including each of the Economic Stability subsections listed below:

1. Economic Stability (access to employment, food security, housing);
2. Education;
3. Social and Community Context;
4. Health and Health Care; and
5. Neighborhood and Built Environment.

The Department encourages the Contractor to focus SDOH programs and partnerships on addressing needs of the following populations:

1. Transitions of care – Members transitioning from the hospital to the community, from the NF or PRTF to the community, and from incarceration or detention to the community;
2. High-risk populations – Members who are considered high emergency department (ED) utilizers and children with asthma;
3. Substance Use/Opioid Use Disorders – Members with SUD and/or OUD especially pregnant individuals with SUD and/or OUD and those transitioning from an institutional stay (i.e. inpatient hospitalization, emergency department, residential facility, detention, incarceration); and
4. Individuals who are potentially unemployed or underemployed requiring referrals to employment, training, education assistance and other related support services, including to Virginia Career Works.

As described in Section 8.4.2, *Priority Populations*, Members with high social needs are part of the MCO-Determined Priority Population and should be considered for Care Management at an intensity level at the Contractor's discretion based on a Member's needs and risks. Additionally, as described in Section 8.4.1*, Risk Stratificatio*n, referrals from social service agencies are a data source the Contractor must use, when available, in its risk stratification/scoring methodology.

8.18 Care Management Collaborative

The Contractor must participate in Care Management Collaborative meetings with the Department in-person, unless otherwise permitted by the Department. The Department's representatives will meet with the Contractor's nursing/medical Care Management and behavioral health Care Management leadership to review cases and scenarios that offer integrated care opportunities and to clarify the

expectations around Care Management. The Department will advise the Contractor of any required documentation in preparation and advance of each meeting. The clinical work group meetings will be held on a frequency as determined by the Department.

9. GRIEVANCES AND APPEALS

In accordance with 42 CFR §§ 438.402(a) and 438.228(a), the Contractor must have a system in place to respond to grievances, internal appeals, reconsiderations, and complaints received from Members and Providers. Additionally, the Contractor must ensure that Members and providers are sent written notice of any adverse benefit determination or adverse action that informs Members and providers of their rights to appeal through the Contractor as well as their rights to access the Department's State Fair Hearing and provider appeal systems, in accordance with 42 CFR §438.408, after they have exhausted their appeals with the Contractor. This process must ensure that appropriate decisions are made as promptly as possible. The Member internal appeals process must include provisions for expedited appeals for Members within seventy-two (72) hours from receipt of the appeal request. The Contractor must develop policies and procedures regarding the grievance and internal appeal processes. Such policies and procedures must be submitted to the Department in accordance with the requirements in the Cardinal Care Technical Manual. The Contractor must notify Providers and Members of their rights to grievances and appeals with the Contractor. The Contractor must ensure that all network providers are informed, at the time they enter into a contract, about all Member grievance, appeal, and fair hearing procedures, timeframes, and associated Member rights as specified in 42 CFR §438.400 through 42 CFR §438.424 and described within this Section of this Contract. As described in the Cardinal Care Technical Manual, the Contractor must provide the Department with monthly reports indicating the number of grievances and internal appeal requests received, as well as the detailed analysis and disposition.

The Contractor must use the Department's Appeals Information Management System (AIMS) to monitor appeal requests filed with the Department, respond to inquiries about whether internal appeals or reconsiderations have been exhausted, file appeal summaries and case summaries with the Department, and confirm hearings and informal conferences.

Written materials for Members must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs or those who are not English language proficient. Members must be informed that information is available in alternate formats (including translation/interpretation) and how to access those formats.

In accordance with 42 CFR §§ 438.406(a) and 438.228(a), the Contractor must provide appeals, grievance forms, and/or written procedures to Members or providers who wish to register written appeals or grievances. Additionally, the Contractor must provide reasonable assistance to Members 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.

In accordance with 42 CFR §§ 438.406(a) and 438.228(a), the Contractor must ensure that neither the individual nor a subordinate of any such individual who makes decisions on grievances or appeals was

involved in any previous level of review or decision-making. Pursuant to 42 CFR §§ 438.406(b) and 438.228(a), in any case where the reason for the grievance or appeal involves clinical issues or is related to denials of expedited resolution of an appeal, the Contractor must ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the Member's condition or disease.

Pursuant to 42 CFR §§ 438.406(b) and 438.228(a), the Contractor must ensure that decision makers on Member grievances and appeals consider all comments, documents, records, and other information submitted by the Member or the Member's authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The Contractor agrees to be fully compliant with all state and federal laws, regulations, and policies governing the Member and Provider grievances and appeals processes, as applicable, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited Member appeal requests. The Contractor will be financially liable for all judgments, penalties, costs, and fees related to an appeal in which the Contractor has failed to comply fully with said requirements.

The Contractor and its subcontractors, as appropriate, must include the minimum elements identified on the Department templates for 1) adverse benefit determinations; 2) internal appeal decisions; and 3) coverage decision letters. The templates are located in the Cardinal Care Technical Manual. The Department will review and approve the form and content of the Contractor's adverse benefit determination, internal appeal decision, and coverage decision letter templates prior to implementation. The minimum elements for adverse benefit determinations are found in Section 9.4, *Notice of Adverse Benefit Determination*; the minimum elements for internal appeal decisions are found in Section 9.6, *Contractor Internal Appeals*, and the minimum elements for coverage decisions are found in Section 9.5, *Coverage Decision Letters for Dual-Eligible Members*.

9.1 Grievances

The Department's Appeals Division does not handle grievances. In accordance with 42 CFR §438.402(c), a Member may file a grievance and a provider or interested stakeholder may file a complaint with the Contractor. In accordance with 42 CFR §438.408, the Contractor must properly respond to all grievances and complaints. In accordance with 42 CFR §438.400 et seq. and as directed by the Department, the Contractor must have a system in place for addressing Member grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. As part of that process, the Contractor must have written policies and procedures that describe the grievance process and how it operates, and the process must comply with federal requirements and NCQA standards. The Contractor must also have a system in place to address Provider and other complaints and must have written policies and procedures that describe the complaint process. These written directives must describe how the Contractor intends to receive, track, review, and report all Member inquiries and grievances and other complaints. The Contractor must make any changes to its grievance and complaints procedures that the Department requires. The Contractor must submit the procedures and any changes to the procedures to the Department as required by the Cardinal Care Technical Manual. The Contractor must maintain written records of all Member grievance and

complaint activities and notify the Department of all internal grievances as required by the Cardinal Care Technical Manual.

The Contractor's grievance process must allow a Member, an attorney, or a Member's authorized representative (provider, family member, etc.) acting on behalf of the Member, in accordance with 42 CFR §§438.402(c) and 438.408, to file a grievance at any time, either orally or in writing as required by 42 CFR §438.402(c)(3). With the exception of an attorney, an authorized representative must have the Member's written consent to file a grievance. In accordance with 42 CFR §§ 438.406(a) and 438.228(a), the Contractor must acknowledge receipt of each grievance. Grievances received orally can be acknowledged orally, though the resolution must be provided in writing.

The Contractor must resolve a grievance and provide notice as expeditiously as the Member's health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the Contractor receives the grievance in a format and language that meets, at a minimum, the standards described in 42 CFR §438.10. In accordance with 42 CFR §§ 438.56(d), 438.56(e), and 438.228, if the Department requires a Member to seek redress through Contractor's grievance system before the Department makes a decision on the Member's request for disenrollment, the Contractor is required to complete review of the grievance in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Contract refers the request to the Department.

The written grievance response must include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures that provide the basis for the decision; and a clear explanation of any further rights available to the Member or provider under the Contractor's grievance process.

9.2 Appeals Requirements

The Contractor must maintain written records of all Member and Provider appeal activities at all levels and report them in the manner and format reflected in the Cardinal Care Technical Manual. The Contractor is required to respond promptly to any requests made by the Department pertaining to appeals. The Department may require the Contractor to provide a response within twenty-four (24) hours.

The Contractor must attend and explain the Contractor's decisions at all Department appeal hearings or conferences, whether in-person or by telephone, as deemed necessary by the Department's Appeals Division. The representative chosen by the Contractor must be able to explain the facts and authority to support the Contractor's position in the appeal. If the appeal stems from a clinical denial, a medical professional in a specialty with experience treating the member's condition must be present to explain the facts and authority that support the action. Contractor travel and telephone expenses in relation to appeal activities must be borne by the Contractor. Failure to attend and explain the Contractor's actions at all appeal hearings and/or conferences will result in the application of liquidated remedies as set forth in this Contract.

The Contractor does not have the right to appeal or seek judicial review of the Department's decisions from Department State Fair Hearings or Provider informal or formal appeals. The Contractor does not

have the right to object or fail to implement any settlement DMAS enters with a Member or provider. Furthermore, the Contractor is bound by the terms of a settlement agreement that is entered into by the Department and a Member or provider to resolve the adverse benefit determination or adverse action that is appealed for a state fair hearing.

9.3 Member Appeals

Pursuant to 42 CFR § 438.402, as a prerequisite to filing an appeal to the Department, any Member, Member's attorney, or Member's authorized representative (provider, family member, etc.) acting on behalf of the Member, in accordance with 42 CFR §§ 438.402, 438.406(b), and 438.408, wishing to appeal an adverse benefit determination must first file an internal appeal, either orally or in writing, with the Contractor within sixty (60) calendar days from the date on the notice of adverse benefit determination. The Contractor must have procedures in place to handle standard and expedited internal appeals.

A Member may request continuation of services during the Contractor's internal appeal and the Department's State Fair Hearing. A determination on continuation of services must be made in accordance with 42 CFR § 438.420 and the regulations governing the Managed Care program. If the determination is made to continue benefits, the Contractor must continue the Member's benefits so long as all the requirements of 42 CFR § 438.420(b) are met. In accordance with 42 CFR §§ 438.420(d) and 431.230(b), if the final resolution of the appeal upholds the Contractor's action and services to the Member were continued while the internal appeal or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services from the Member, in accordance with the Department's policies on recovery.

9.3.1 Direct Appeals to the Department

In accordance with 42 CFR § 438.56(f)(2), Members who are dissatisfied with the Department's determination on the Member's for cause request to dis-enroll from one (1) health plan and enroll in another have the right to appeal the Department's decision through the State Fair Hearing process without first having to seek an internal appeal decision from the Contractor. Also, Members have the right to appeal the Department's decision to move them to a different Contractor directly to the Department without first having to seek an internal appeal decision from the Contractor.

9.4 Notice of Adverse Benefit Determination

In accordance with 42 CFR §§ 438.210(c) and 438.404, the Contractor must provide a timely written Notice of Adverse Benefit Determination to the requesting provider and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The written Notice of Adverse Benefit Determination must meet the requirements of 42 CFR § 438.404. The Notice of Adverse Benefit Determination template provided by the Department must be used by the Contractor. Pursuant to 42 CFR § 438.404(c) and 42 CFR § 431.211, for termination, suspension, or reduction of previously authorized Medicaid covered services, such notice must be provided at least ten (10) calendar days in advance (plus five [5] calendar days for mailing, for a total of fifteen [15] calendar days) of the date of its action. In accordance with 42 CFR §§ 438.404(c), 431.213, 431.231(d), 483.12(a), and Section 1919(e)(7) of the Social Security Act, notice may

be provided no later than the date of action for the exceptions noted in 42 CFR § 431.213. For denial of payment, such notice must be provided at the time of action. For standard service authorization decisions that deny or limit services, the notice is required as expeditiously as the Member's condition requires and within the timeframes referenced in Section 6.1.1, *Standard Authorization Decisions*. For cases in which a Provider indicates or the Contractor determines that following the standard authorization timeframe could seriously jeopardize the Member's life, physical or 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., as discussed in Section 6.1.2, *Expedited Authorization Decisions*. In accordance with 42 CFR §§ 438.404(c) and 438.210(d), the Contractor may extend the notice the 14-calendar day Notice of Adverse Benefit Determination timeframe for standard authorization decisions pursuant to Section 6.1.1, *Standard Authorization Decisions*.

At a minimum, the notice must meet the requirements of 42 CFR §§ 438.404 and 438.402, and Code of Virginia § 32.1-137.13 and explain:

1. The action the Contractor has taken or intends to take;
2. The reasons (specific to the Member and request) for the action, including the right of the Member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
3. The citation to the law or policy supporting such action;
4. A list of titles and qualifications, including specialties, of individuals participating in the authorization review;
5. The Member's or the Member's representative's right to file an internal appeal with the Contractor, including information on exhausting the Contractor's appeal processes and an explanation that the Member and/or representative has a right to file an appeal with the Department for a State Fair Hearing only after the Contractor's internal appeal process has been exhausted;
6. The procedures for exercising the Member's rights to appeal;
7. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
8. If applicable, the Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to repay the costs of these services;
9. The right to be represented by an attorney or other individual; and
10. The written notice must be translated (upon request) for individuals who speak prevalent languages. Additionally, written notices must include language explaining that oral interpretation is available for all languages and how to access it.

9.5 Coverage Decision Letters for Dual-Eligible Members

In accordance with 42 CFR §438.210, the Contractor must provide a Coverage Decision Letter to the requesting provider and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For dually eligible members who are also enrolled in a D-SNP with exclusively aligned enrollment, the Coverage Decision Letter must meet the provisions set forth in 42 CFR §§422.629 through 422.634.

Contractors offering Fully Integrated Dual-Eligible Special Needs Plans (FIDE SNPs) or Highly Integrated Dual-Eligible Special Needs Plans (HIDE SNPs) with exclusively aligned enrollment at either the contract or Plan Benefit Package (PBP) level ("applicable integrated plans") must complete and issue a Coverage Decision Letter to Members, when, as a result of an integrated organization determination under 42 CFR §422.631, they reduce, stop, suspend, or deny, in whole, or in part, a request for a service/ item (including a Medicare Part B drug) or a request for a payment of a service or item (including a Medicare Part B drug) the Member has already received.

The Coverage Decision Letter must be used in place of the Adverse Benefit Determination or the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS-10003). Applicable integrated plans should not send this letter when the request for a service or item is fully covered by the D-SNP or affiliated MCO, either under the Medicare or Medicaid benefit. Additionally, this letter must not be used for Medicare Part D denials. Applicable Integrated Plans will continue to use form CMS-10146, Notice of Denial of Medicare Prescription Drug Coverage, for Part D denials.

At a minimum, and in accordance with 42 CFR §422.631(d)(1), the Coverage Decision Letter must explain:

1. The applicable integrated plan's determination;
2. The date the determination was made;
3. The date the determination will take effect;
4. The reasons for the determination;
5. The enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf;
6. Procedures for exercising enrollee's rights to an integrated reconsideration;
7. Circumstances under which expedited resolution is available and how to request it; and
8. If applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

The Coverage Decision Letter template is located at the link provided in Section 9, *Grievances and Appeals*.

9.5.1 Coverage Decision Letter Timing of Notice

In accordance with 42 CFR § 422.631(2), the Contractor must mail the coverage decision letter within the following timeframes:

1. The applicable integrated plan must send a notice of its integrated organization determination at least ten (10) calendar days before the date of action (that is, before the date on which a

termination, suspension, or reduction becomes effective) (plus five [5] calendar days for mailing, for a total of fifteen [15] calendar days) of the date of its action, in cases where a previously approved service is being reduced, suspended, or terminated, except in circumstances where an exception is permitted under 42 CFR §§ 431.213 and 431.214;

2. For other integrated organization determinations that are not expedited integrated organization determinations, the applicable integrated plan must send a notice of its integrated organization determination as expeditiously as the enrollee's health condition requires, but no later than fourteen (14) calendar days from when it receives the request for the integrated organization determination;
3. The applicable integrated plan may extend the timeframe for a standard or expedited integrated organization determination by up to fourteen (14) calendar days if:
    a. The enrollee or provider requests the extension; or
    b. The applicable integrated plan can show that:
        i. The extension is in the enrollee's interest; and
        ii. There is need for additional information and there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.

9.6 Contractor Internal Appeals

Internal appeals must be filed with the Contractor. The filing of an internal appeal and exhaustion of the Contractor's internal appeal process is a prerequisite to filing an appeal to the Department.

The Contractor's appeals process must include the following requirements:

1. Acknowledge receipt of each appeal, in accordance with 42 CFR §§ 438.406(a) and 438.228(a);
2. Allow for an appeal by the Member, Member's attorney, or Member's authorized representative;
3. Provide the Member a reasonable opportunity to present evidence and allegations of fact or law in-person, in accordance with 42 CFR §438.406(b), as well as in writing. Pursuant to 42 CFR §§438.406(b) and 438.408, the Contractor must inform the Member of the limited time available for this, especially in the case of expedited resolution;
4. Pursuant to 42 CFR §§438.406(b) and 438.408, provide the Member and his or her representative the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor or at the direction of the Contractor in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for standard (thirty (30) calendar days) and expedited (seventy-two (72) hours) internal appeals; and
5. In accordance with 42 CFR §438.406(b), consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.

The Contractor must respond in writing to standard internal appeals as expeditiously as the Member's health condition requires and must not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal. In accordance with 42 CFR §438.408(c)(1), 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 that there is a need for additional information and that a delay in rendering the decision is in the Member's interest.

In accordance with 42 CFR §438.408(c)(2), if the Contractor extends the timeframe for an appeal not at the request of the Member, the Contractor must make reasonable efforts to give the Member prompt oral notice of the delay. In addition, the Contractor must resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. For any internal appeals decisions not rendered within thirty (30) calendar days where the Member has not requested an extension, the Contractor must make reasonable efforts to provide oral notice and must within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision.

The Contractor must establish and maintain an expedited review process for internal appeals when the Contractor determines (with respect to a request from the Member) or the Provider indicates (when making the request on the Member's behalf or supporting the Member's request) 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. Pursuant to 42 CFR §438.402(b), the Contractor is prohibited from requiring a Member, or Provider acting on behalf of the Member, follow an oral request for an expedited appeal with a written, signed appeal. In accordance with 42 CFR §438.410(b), the Contractor must ensure that punitive action is neither taken against a Provider that requests an expedited resolution or 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 decided according to the timeframe for standard resolution of internal appeals, and the Member must be given prompt oral notice of the denial. Within two (2) calendar days of the oral notice of denial, the Member must be sent written notice of the reason for the decision to deny the request for an expedited appeal and informed of the right to file a grievance if the Member disagrees with that decision.

The Contractor must provide written notice and make reasonable efforts to provide oral notice of the resolution of an expedited internal appeal within seventy-two (72) hours from the initial receipt of the appeal. For standard internal appeals, the Contractor must issue its internal appeal decision as expeditiously as the Member's health condition requires and must not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal request in a format that meets, at a minimum, the standards described in 42 CFR §438.10. In accordance with 42 CFR §438.408, the Contractor may extend the timeframe for expedited or standard appeals 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 that there is a need for additional documentation and that a delay in rendering the decision is in the Member's interest. For any extension not requested by the Member, the Contractor must make reasonable efforts to give the Member prompt oral notice of the delay; written notice within two (2) calendar days to the Member of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. The Contractor must resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

In accordance with 42 CFR §§ 438.408 and 438.10, all Contractor determination on internal appeals must be in writing and include, but not be limited to, the following information:

1. The decision reached by the Contractor, including a specific discussion of the reason for any adverse benefit determination (specific to the member and the request), including citations to the policies, procedures, and/or authority that support the decision;
2. The date the Member's appeal request was received;
3. The date of the decision (which must match the date it is mailed/transmitted); and
4. For appeals not resolved wholly in favor of the Member:
    a. The right to request an appeal of the Contractor's final denial through the Department's State Fair Hearing process. The final denial letter must clearly identify that the Contractor's internal appeal process has been exhausted, and include the timeframe for filing an appeal to the Department, the submission methods and related address and phone numbers to file an appeal, and list pertinent statutes/regulations governing the appeal process;
    b. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
    c. The right to request to receive benefits while the State Fair Hearing is pending and how to make the request, explaining that, in accordance with 42 CFR §438.420(d), the Member may be held liable for the cost of those services if the State hearing decision upholds the Contractor to the extent that services were furnished (continued) solely because of the requirements of this Section;
    d. A list of titles and qualifications, including specialties, of individuals participating in the appeal review;
    e. The right to be represented by an attorney or other individual; and
    f. Information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging and Rehabilitative Services.

9.6.1 Contractor Adverse Internal Appeal Decisions

Members have the right to appeal the Contractor's internal appeal decision upholding its adverse benefit determinations to the Department by requesting a State Fair Hearing. However, pursuant to 42 CFR §438.402(c)(1)(i)(A), the Contractor's internal appeal process must be exhausted or deemed exhausted due to the Contractor's failure to adhere to the notice and timing requirements prior to a Member filing an appeal with the Department's Appeals Division. The final appeal decision issued by the Contractor must state that the internal appeals process has been exhausted and provide State Fair Hearing or Appeal information to the Department. Denials of benefits that are offered by the Contractor that are not included under the State Plan and not included in the capitation rate calculation are not appealable to a State Fair Hearing.

9.7 State Fair Hearing Process

The Department's Member appeals, called "State Fair Hearings," are conducted in accordance with 42 CFR §431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include reductions in service, suspensions,

terminations, and denials. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" in 42 CFR §447.45(b) is not an adverse benefit determination. Furthermore, the Contractor's denial of payment for Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed.

Standard appeals may be requested orally or in writing to the Department by the Member or the Member's authorized representative, in accordance with 42 CFR §§438.402(c) and 438.408. Expedited appeals may be filed by telephone or in writing. The appeal may be filed at any time after the Contractor's internal appeal process is exhausted, but must be requested no later than one hundred and twenty (120) calendar days from the date of the Contractor's internal appeal decision.

Within one (1) business day of a request by the Department, the Contractor must provide a copy of the Member's internal appeal decision to the Department's Appeals Division through AIMS; or, if there has been no internal appeal decision, notify the Appeals Division in writing that the Member has not exhausted the Contractor's appeal process.

Upon receipt of notification by the Department of an appeal, the Contractor must prepare and submit an appeal summary describing the rationale for maintaining the denial to the Department's Appeals Division, the Department's Managed Care contract monitor, the Member, and if applicable, the Member's authorized representative, involved in the appeal in accordance with required time frames. The appeals summary must be provided to the Department's Appeals Division and Managed Care contract monitor by uploading the document to AIMS. The summary must be completed in accordance with 12 VAC 30-110-70, which describes notification requirements and provides a guideline for information necessary to include in both the notice and the summary. 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. However, the appeal summary is not an opportunity for the Contractor to supplement the original denial with additional justification. The appeal summary must explain the denial as given in the adverse benefit determination. If the member has submitted additional documentation, however, the appeal summary must also demonstrate that it was considered and explain why those documents do not meet the requirements for approval.

For standard appeals, the Department's Appeals Division requests that the Contractor submit the appeal summary to the Department within twenty-one (21) calendar days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all standard appeals, 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, and, if applicable, the Member's authorized representative, on the date submitted to the Department Appeals Division. For expedited appeals that meet the criteria set forth in 42 CFR §438.410, the appeal summary must be uploaded to AIMS and faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) hours after the Department informs the Contractor of the expedited appeal. Failure to submit appeal summaries within the required timeframe or with the required content will result in compliance enforcement actions as described in this Contract.

The Department's Member appeals are conducted as *de novo* hearings, which means that the Department's appeal decision is based on the totality of the documents submitted during the appeal,

even if the documents were not available for review during the initial request. Therefore, the Department will forward all documents to the Contractor that are received during the Department's appeal. The Contractor must review these documents. If the documents can result in a full approval, the Contractor must issue a new notice of action to the appellant and send a copy to the Department's Appeals Division. The Department's Appeals Division will then determine if the appeal is resolved. If the documents cannot result in a full approval, the Hearing Officer may request that the Contractor submit a written response addressing the new evidence submitted by the Member during the appeal process. The written response by the Contractor must be sent to the Department's Appeals Division and the appellant, explaining the Contractor's position on why the documents do not meet the criteria for approval.

If the Contractor's internal appeal decision was based in whole or part, upon a medical determination, including but not limited to medical necessity or appropriateness or level of care, the Contractor must provide sufficiently qualified medical personnel to attend the State Fair Hearing.

Appeals to the Department that do not qualify as expedited must be resolved or a decision must be issued by the Department within ninety (90) calendar days from the date the Member filed the internal appeal with the Contractor, not including the number of days the Member took to subsequently file for a State Fair Hearing. In accordance with 42 CFR § 431.244(f)(4) and 12 VAC 30-110-30 relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays, the timeline for resolution or issuance of a decision in State Fair Hearing appeals may be extended for delays not caused by the Department.

Appeals to the Department that qualify as expedited appeals must be resolved within seventy-two (72) hours or as expeditiously as the Member's condition requires, as required under 42 CFR §438.408(a) and 42 CFR §438.408(b).

In accordance with 42 CFR §438.424, if the appeal decision reverses a decision to deny, limit, or delay services where such services were not furnished while the appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision. In accordance with 42 CFR §§438.420(d) and 431.230(b), if the appeal decision reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Contractor must pay for those services.

If the appeal decision remands the case back to the Contractor, the Contractor must follow the remand instructions, after which it must promptly issue a written notice to the Member in accordance with the requirements described throughout this Contract. Refer to Sections 9.4, *Notice of Adverse Benefit Determination*, Section 4.3, *Member Materials*, and Section 9, *Grievances and Appeals*.

The Department's final administrative appeal decision may be appealed through the court system by the Member. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, the Department and/or its counsel at the Office of the Attorney General (OAG) may have a need to confer with the Contractor to gain further information about the appealed action. The Contractor must respond to inquiries from the Department or the OAG within one (1) business day or sooner, if the situation warrants a quicker response. Furthermore, the Contractor is

responsible for complying with the court's final order, which could possibly include a remand for a new hearing. The Contractor is responsible for payment of attorney fees when ordered by Department Appeals or the court. Refer to Section 21.2.4, *Attorney Fees*, for additional information regarding attorney's fees.

9.8 Provider Appeals

The first level of a provider appeal is a reconsideration with the Contractor. For services that have been rendered, providers have the right to appeal adverse actions. In accordance with 42 CFR §438.414 and 42 CFR §438.10(g), the Contractor must inform providers and subcontractors, at the time of entering into a contract, of any state-determined provider's appeal rights to challenge the failure to cover a service. The Provider must exhaust the Contractor's reconsideration process prior to filing an appeal with the Department's Appeals Division, except in the case of an appeal of a payment suspension notice. Provider payment suspension notices are appealed directly to the Department with no internal appeal to the MCO.

9.8.1 Reconsiderations

The Contractor must have a reconsideration process in place and available to Providers who wish to challenge adverse actions made by the Contractor. This process must assure that appropriate decisions are made as promptly as possible. The Contractor must submit its reconsideration process to the Department for review and approval as required by the Cardinal Care Technical Manual.

If a Provider has rendered services to a Member enrolled with the Contractor in a Medicaid program and has either been denied authorization or reimbursement for the services or has received reduced authorization or reimbursement, that Provider can request a reconsideration of the denied or reduced authorization or reimbursement. Before appealing to the Department, Providers must first exhaust the Contractor's reconsideration process. Providers in the Contractor's network may not appeal the Contractor's enrollment or terminations decisions to the Department.

The Contractor's reconsideration process must include the following requirements:

1. Provide a reasonable amount of time for a Provider to submit a reconsideration request;
2. Acknowledge receipt of each reconsideration request;
3. Ensure that the individuals who make decisions on reconsiderations were not involved in any previous level of review or decision making;
4. Require that a reconsideration request must be submitted in writing;
5. Provide the Provider a reasonable opportunity to present evidence and allegations of fact or law. The Contractor must inform the Provider of the limited time available for this; and
6. Allow the Provider the opportunity, before and during the reconsideration process, to examine the Provider's case file, including any medical records and any other documents and records considered during the reconsideration process.

All Contractor reconsideration decisions must be in writing and must include, but not be limited to, the following information:

1. The decision reached by the Contractor, including a specific discussion of the reason for any adverse action, including citations to the policies, procedures, and/or authority that support the decision;
2. The date the Provider's appeal request was received;
3. The date of the decision; and
4. For appeals not resolved wholly in favor of the Provider, the right to request an appeal to the Department of the Contractor's reconsideration decision through the Department informal appeals process. The final decision must clearly identify that the Contractor's reconsideration process has been exhausted and include the timeframe for filing an appeal to the Department, the submission methods and related address and facsimile number to file an appeal, and list pertinent statutes/regulations governing the appeal process, and the right to be represented by an attorney.

9.8.2 Provider Appeals to the Department

Provider appeals to the Department will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 et seq. and 12 VAC 30-20-500 et seq. There are two (2) levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is before an Informal Appeals Agent (IAA) employed by the Department. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and a Formal Appeals Representative employed by the Department helps present the Department's position.

The Provider must submit all Provider appeals to the Department's Appeals Division in writing and within thirty (30) calendar days of the Contractor's adverse reconsideration decision. The Contractor's reconsideration decision must include a statement that the Provider has exhausted its reconsideration rights with the Contractor and that the next level of appeal is with the Department. The reconsideration decision must include the standard appeal rights to the Department, including the time period and address to file the appeal.

The Department's normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time, Monday through Friday. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the Department's Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the Department's Appeals Division (including uploaded to AIMS) after 5:00 p.m. on the deadline date will be untimely. If the last day specified for the filing of the document or the performance of any act falls on a day on which DMAS is officially closed for the full or partial day, the deadline for such filing shall be extended to the next day on which DMAS is open.

Upon receipt of notice that the Department has received an appeal from a Provider involving services provided or being provided to the Contractor's Member, the Contractor must verify that the Provider has exhausted the Contractor's reconsideration process. Further the Contractor must verify, based upon the Contractor's records, that the appeal to the Department meets the Department's timeliness requirements (i.e., within thirty (30) calendar days of the Contractor's last date of denial). The Contractor must notify the Department's Appeals Division via AIMS within one (1) business day 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.

The Contractor must attend and defend the Contractor's reconsideration decisions at all appeal hearings or conferences, whether informal or formal, or whether in-person, by telephone, or as deemed necessary by the Department's Appeals Division. If the Contractor's reconsideration decision was based in whole or part, upon a medical determination, including but not limited to medical necessity or appropriateness or level of care, the Contractor must provide sufficiently qualified medical personnel to attend the appeal-related conference(s) and hearing(s). All appeal activities, including but not limited to travel, telephone expenses, copying expenses, staff time, and document retrieval and storage, must be borne by the Contractor. Failure to attend or defend the Contractor's reconsideration decisions at all appeal hearings or conferences will 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, as well as any other compliance enforcement actions specified in this Contract.

9.8.3 Informal Appeals

Providers appealing a Contractor's reconsideration decision must file a written notice of informal appeal with the Department's Appeals Division within thirty (30) calendar days of the Provider's receipt of the Contractor's reconsideration decision. The Provider's notice of informal appeal must identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within thirty (30) calendar days of receipt of the Contractor's reconsideration decision will result in an administrative dismissal of the appeal.

The Contractor must file a written case summary with the Department's Appeals Division via AIMS within thirty (30) calendar days of the filing of the Provider's notice of informal appeal. For each adjustment, patient, and service date or other disputed matter identified by the Provider in its notice of informal appeal, the case summary must explain the factual basis upon which the Contractor relied in making its reconsideration decision and identify any authority or documentation upon which the Contractor relied in making its reconsideration decision.

The Department's IAA must conduct the conference within ninety (90) calendar days from the filing of the Provider's notice of informal appeal. If the Contractor, the Provider, and the IAA agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the IAA must specify the time within which the Provider may file written submissions, not to exceed ninety (90) calendar 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 IAA. Only written submissions filed within the time specified by the IAA will be considered.

The conference may be recorded at the discretion of the IAA and solely for the convenience of the IAA. Because the conference is not an adversarial or evidentiary proceeding, no other recordings or transcriptions will be permitted. Any recordings made for the convenience of the IAA will not be released to the Department, the Contractor, or the Provider.

Upon completion of the conference, the IAA must specify the time within which the Provider may file additional documentation or information, if any, not to exceed thirty (30) calendar days. Only documentation or information filed within the time specified by the IAA must be considered.

The informal appeal decision must be issued within one hundred eighty (180) calendar days of receipt of the notice of informal appeal. In accordance with 12 VAC 30-20-560, providers have the right to appeal the Department's informal appeal decision as a formal appeal.

9.8.4 Formal Appeals

Any Provider appealing a Department informal appeal decision must file a written notice of formal appeal with the Department's Appeals Division within thirty (30) calendar days of the Provider's receipt of the Department informal appeal decision. The notice of formal appeal must 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) calendar days of receipt of the informal appeal decision will result in dismissal of the appeal.

At the formal level, the Contractor assists the Department's staff counsel (Formal Appeal Representative) 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 Contractor must supply the necessary expertise to defend its actions and must assist the Formal Appeals Representative in the preparation of all hearing matters leading to the Final Agency Decision.

The Department's Formal Appeal Representative and the Provider must file with the Department's Appeals Division all documentary evidence on which the Department or the Provider relies within twenty-one (21) calendar days of the filing of the notice of formal appeal. Simultaneous with filing, the filing party must transmit a copy to the other party and to the hearing officer. Only documents filed within twenty-one (21) calendar days of the filing of the notice of formal appeal will be considered. The Department and the Provider must file any objections to the admissibility of documentary evidence within seven (7) calendar days of the filing of the documentary evidence. Only objections filed within seven (7) calendar days of the filing of the documentary evidence will be considered. The hearing officer must rule on any objections within seven (7) calendar days of the filing of the objections.

The hearing officer must conduct the hearing within forty-five (45) calendar 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 will 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 comply with the due date for the submission of the recommended decision.

Within thirty (30) calendar days of the completion of the hearing, the Department and the Provider must file their opening briefs with the Department's Appeals Division. Any reply brief from the Department or the Provider must be filed within ten (10) calendar 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 must transmit a copy to the other party and to the hearing officer.

Formal hearings will be transcribed by a court reporter retained by the Department. The hearing officer must submit a recommended decision to the Department's Director with a copy to the Provider within one hundred twenty (120) calendar days of the filing of the formal appeal notice. If the hearing officer does not submit a recommended decision within one hundred twenty (120) calendar days, then the Department will 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 Department's Director must notify the Department and the Provider in writing that any written exceptions to the hearing officer's recommended decision must be filed with the Department's Appeals Division within fourteen (14) calendar days of receipt of the Department Director's letter. Only exceptions filed within fourteen (14) calendar days of receipt of Department Director's letter will be considered. The Department's Director must issue the Final Agency Decision within sixty (60) calendar days of receipt of the hearing officer's recommended decision.

9.8.5 Court Review

The Provider may appeal the Department's Final Agency Decision 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 legal issues only. No new evidence is considered. During the court appeal process, the Department and/or its counsel at the Office of the Attorney General (OAG) may have a need to confer with the Contractor to gain further information about the appealed action. However, the Contractor is not a party to the appeal because the issue being contested is the Department's Final Agency Decision. The Contractor must respond to inquiries from the Department or the OAG within one (1) business day or sooner if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

9.9 Evaluation of Grievances and Appeals

The Contractor must, at a minimum, track trends in grievances, internal appeals, and reconsiderations. The Contractor's internal appeals, reconsiderations, and grievances system must be consistent with Federal and State regulations and the most current NCQA standards. The grievances, internal appeals, and reconsiderations process evaluation must include the following:

1. Procedures for registering and responding to grievances in a timely fashion;
2. Documentation of the substance of the grievance or appeal and the actions taken;
3. Procedures to ensure the resolution of the grievance;
4. Aggregation and analysis of these data and use of the data for quality improvement; and
5. 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.

9.10 Grievance and Appeal Reporting

The Contractor must submit a report to the Department of all the previous month's Provider and Member grievances and appeals as reflected in the Cardinal Care Technical Manual. The Contractor may submit this information using alternative reports from its existing Member Services system if the system meets the Department's criteria.

9.11 Recordkeeping and Document Preservation

Recordkeeping and document preservation are important to ensure the integrity of the appeals process, to assist in identifying and responding to trends, and to meet federal and state legal requirements.

In accordance with 42 CFR §438.416, for a minimum of ten (10) years the Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing quality improvement strategy. The record must be accurately maintained in a manner accessible to the Department and must be made available upon request to CMS. The record of each grievance or appeal must contain, at a minimum, all the following information:

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

The Contractor is responsible for the preservation and production of documents associated with any Appeal. The Contractor will be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, FOIA request, or any litigation involving the Contractor or the Department, including but not limited to, external appeals. These responsibilities and obligations extend to any of the Contractor's subcontractors.

Upon receipt of a subpoena for Medicaid data, the Contractor or its subcontractor must notify the Department at FOIA@dmas.virginia.gov within one (1) business day. The Department may confer with the Contractor to determine the appropriate response.

10. QUALITY IMPROVEMENT

The Department is responsible for evaluating the quality of care provided to eligible enrollees in the contracted MCOs. The Department partners with MCOs and follows state, federal and departmental policies to ensure that Medicaid Members, both those receiving physical and mental health services, receive high quality cost-effective care, driven by innovation. The care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness.

The Contractor must cooperate with the Department's quality improvement (QI) requirements to the extent described herein and must, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor must 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, as well as NCQA Accreditation requirements as outlined in Section 2.3, *National Committee for Quality Assurance (NCQA) Accreditation*.

The Department developed a Medicaid Comprehensive Quality Strategy in accordance with 42 CFR §438.340. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients. The Contractor's QI initiatives must be designed to help achieve the goals outlined in the Virginia Medicaid Quality Strategy.

10.1 Quality and Domains of Care

As defined by Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Guided by this definition, the Contractor must deliver quality care that enables its Members to remain healthy, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

1. Quality of physical health care, including primary and specialty care;
2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;
3. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, long-term services and supports, and Managed Care providers and services;
4. Continuity and coordination of care across all care and services settings, and for smooth transitions in care and maximum care continuum; and
5. Enrollee experience and access to high quality, coordinated, and culturally competent clinical care and services.

10.2 Continuous Quality Improvement Principles and Expectations

The Contractor must apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

1. Most current state endorsed health care quality improvement methodology and techniques;
2. Align with the most current Virginia Medicaid Quality Strategy;
3. Quantitative and qualitative data collection and data-driven decision making;
4. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
5. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities;
6. Issues identified by the Contractor, and the Agency; and
7. Ensure that the quality management and improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health, LTSS, and care coordination.

10.3 MCO Quality Assessment and Performance Improvement (QAPI)

Pursuant to 42 CFR §438.330, the Contractor must implement and establish an ongoing comprehensive QAPI program for the services it furnishes to its enrollees that includes the elements identified in 42 CFR § 438.330(b). The QAPI program also supports the application of the principles of Continuous Quality Improvement (CQI) noted previously. The Contractor must use the results of the QAPI activities to improve the quality of services and Member's health with appropriate input from providers and Members. The QAPI must include collection and submission of performance measurement data, including any required by the Department or CMS as specified:

1. The Contractor should clearly define its quality improvement structure.
2. Address all aspects of health care, including specific reference to behavioral health care with respect to monitoring and improvement efforts, and integration with physical health care.
3. Address involvement of a behavioral health care clinician(s) with respect to the QI program.
4. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems;
5. Include organization-wide policies and procedures that document processes through which the Contractor ensure clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes must include, but not be limited to, Appeals and Grievances and Utilization Management;
6. Be fully compliant with and contribute to the Virginia Medicaid Quality Strategy and the annual Department's Quality Work Plan;
7. Identify and analyze objectives for servicing diverse Memberships to include but not limited to analyzing significant health care disparities gaps; and,
8. Have a Quality Improvement Committee that oversee quality functions as outlined in the contract; and
9. Evaluate the QAPI annually and update as appropriate.

In accordance with 42 CFR § 438.330(b), 441.302, and 441.730(a), the QAPI must also include written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QAPI, inappropriate or substandard services are furnished, or the provider fails to provide the required services. These written remedial/corrective action procedures include:

1. Specification of the types of problems requiring remedial/corrective action;
2. Specification of the person(s) or body responsible for making the final determination regarding the quality problems;
3. Specific actions to be taken;
4. Provisions of feedback to appropriate medical or behavioral health providers and staff;
5. The schedule and accountability for implementing corrective actions;
6. The approach to modifying the corrective action if improvements do not occur; and
7. Procedures for terminating the affiliation with physical or behavioral health providers.

The Contractor must take appropriate action to address service delivery, including continuity and coordination of care, access to care, utilization of services, health education, and emergency services; patient safety; provider; and other QAPI issues identified.

The Contractor must make all information about its QAPI available to providers and Members. The Contractor must include in all its provider contracts, a requirement securing cooperation with the QAPI.

10.3.1 Annual Evaluation of the QAPI Program

Consistent with 42 CFR §438.330, the comprehensive QAPI must include all of the following (at a minimum) including a mechanism to detect underutilization and overutilization of services; to assess the quality and appropriateness of care furnished to enrollees with special health care needs; to assess the quality and appropriateness of care furnished to enrollees using long-term services and support, including assessment of care between care settings and comparison of services and supports received with those set forth in the enrollee's treatment/service plan as applicable; and to participate in efforts by the State to prevent, detect, and remediate critical incidents, in accordance with 42 CFR § 438.330(b), 441.302, and 441.730(a). The Standards for Quality Management and Improvement also should be consistent with the most recent version of the NCQA's Standards and Guidelines for the Accreditation of Health Plans. In accordance with 42 CFR §438.330(e)(2) and 42 CFR §438.310(c)(2), the Contractor must conduct an annual written evaluation of the QAPI program that includes the following information:

1. The evaluation of the QAPI must address quality studies and other activities completed; and ongoing QI activities that address quality and safety of clinical care and quality of services;
2. Trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and
3. An analysis and evaluation of the overall effectiveness of the QAPI program to include its progress toward influencing network wide safe clinical practices.

The Contractor must provide its Quality Improvement Plan (QIP) consistent with the requirements in the Cardinal Care Technical Manual. Health Plans new to Virginia Medicaid must provide their QIP at least sixty (60) days before the first Membership file is provided to the MCO. The new MCO must submit a plan that adheres to NCQA's "QI 1 Element A, Standards for Quality Improvement Program's Structure and Operations." The new health plan must provide the Department with an update to its QIP at least once every twelve (12) months for possible review by both the Department and the EQRO.

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 Contractor must also notify the Department in writing within ten (10) days of any change to the Contractor's accreditation level. As required per 42 CFR §438.332, the accreditation status (including if applicable, the name of the accrediting entity, accreditation program, and accreditation level) of each MCO will be posted to the Department's Cardinal Care Managed Care website.

10.4 Quality Infrastructure

The Contractor must structure its QI program for Managed Care separately from any of its existing Medicaid, Medicare, or commercial lines of business. The Contractor must maintain a well-defined QI organizational and program structure that supports the application of the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system. The QI program

must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure must comply with all applicable provisions of 42 CFR §438, including Subparts A through E, and must meet the quality management (QM) and improvement criteria described in the most current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements.

10.5 MCO Coordination of QI Activity

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken must be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels. QI activities must be coordinated with other performance monitoring activities, including the monitoring of Members' grievances and appeals and must reflect the most current requirements of NCQA.

10.5.1 System Requirements

The Contractor's quality information system or core systems must support all quality related activities as described in this Contract. The system must accurately track and report all the QI performance measures at the frequency and timeframe required by the Department. The system must be flexible with creating and customizing performance measures to support the full scope of QI initiatives performed under this Contract.

10.5.2 MCO Quality Committee and Meeting Requirements

The Contractor must have a Quality Committee with established parameters for the role, structure, and the function of the committee. The Committee must include a designated senior executive who is responsible for program implementation, the Contractor's Quality Director, Chief Medical Officer and plan providers.

This Committee must analyze and evaluate the result of the quality activities, recommend policy decisions, ensure that providers are involved in the Quality program, institute needed action, and ensure that appropriate follow-up occurs.

The Quality Committee must review the approved written Quality Assessment and Performance Program (QAPI) work plan and associated work prior to submission to the Department.

The QAPI Committee must be accountable to the Contractor's Governing Body. The Governing Body of the organization is a designated committee of the senior management of the Contractor. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

1. Oversight of Quality Program- There is documentation that the Governing Body has approved the overall Quality Program and the annual QAPI work plan.
2. Quality Program Progress Reports-The Governing Body receives written reports at least quarterly from the Quality Committee describing actions taken, progress in meeting quality objectives, and improvements made.
3. Program Modification- Upon receipt of regular written reports from the Quality Program delineating actions taken and improvements made, the Governing Body takes action when

appropriate and directs that the operational quality program be modified on an ongoing basis to accommodate review findings and issues of concerns within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality monitoring and improvement.

The QAPI Committee must meet on a regular basis (no less than quarterly) with specified frequency to oversee quality activities. This frequency is sufficient to demonstrate that the structure/committee is following-up with specified frequency to oversee quality activities.

The QAPI Committee must keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting must be available on-file after the completion of the following committee meeting in which the minutes are approved and must be available for review upon request and during the Operational System Review completed by the EQRO.

10.6 HEDIS® and CAHPS Quality Measures and Reporting

10.6.1 HEDIS® Quality Measures and Reporting

In alignment with the most current NCQA Accreditation Standards, the Contractor's HEDIS® measure reporting must be done through a certified vendor/auditor. The Contractor must have an internal reporting data quality review and compliance process to ensure performance measure data is complete, accurate and timely. All measures must be calculated without rotation per NCQA technical specifications and the Cardinal Care Technical Manual.

In conducting HEDIS® calculations, the Contractor must use the hybrid methodology unless HEDIS® technical specifications only require the use of administrative data. Failure to use hybrid methodology may result in corrective action. 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 2020 must be reported to the Department by July 31, 2020). 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 required for reporting.

With respect to the HEDIS® measures listed in the Cardinal Care Technical Manual, 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 is required to consent to publication via NCQA's Quality Compass of all Medicaid HEDIS® measures for the Virginia Medicaid product. The Department will require all measures to be reported based on populations in accordance with the Managed Care Organization Data Request document provided by the EQRO. In addition, the Contractor must, at a minimum, consider the Medicaid HEDIS® performance measures listed within the Cardinal Care Technical Manual.

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 the measures listed in the Cardinal Care Technical Manual. For other quality measures, the Contractor must review the most current Department Quality Strategy for quality measure performance targets to ensure that the Contractor attains or exceeds stated performance targets and timelines.

10.6.2 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The Contractor must enter into agreement with a vendor that is certified by NCQA to perform annual CAHPS surveys. The Contractor's vendor must perform the CAHPS Adult Version Medicaid survey, CAHPS Child Version, and Children with Chronic Conditions Medicaid survey using the most current CAHPS version specified by NCQA. Survey results must be reported on the Managed Care program separately for each required CAHPS surveys listed above, and composite scores should also be reported. Performance on CAHPS surveys may also be publicized as described above.

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. Survey results must be submitted to the Department, NCQA, and Agency for Healthcare Research and Quality (AHRQ) for inclusion in the National CAHPS Benchmarking Database if the option is available through AHRQ. CAHPS Surveys are due annually by July 31 of each calendar year.

10.7 Other Department Priority Quality Measures and Reporting

In addition to HEDIS® measures, the Department has identified clinical quality, access, and utilization measures using nationally recognized measure sets to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the Managed Care delivery system in the most current version of the Department's Quality Strategy. The Department maintains the right to add or remove measures and/or other quality reporting during the contract cycle period at the Department's discretion. Additionally, when selecting measures for the specific needs of the populations, the Department will take into consideration the availability and reliability of the data for the Managed Care Program Contract that are used to calculate the measure. All performance measures will be located within the Cardinal Care Technical Manual or as specified by the Department via the Department's EQRO.

10.7.1 Behavioral Health Services Outcome Measures

The behavioral health outcome measures will help to assess the standards of care and adherence to best practices within behavioral health. The goals are to increase the overall health of the population, improve the care for Members and to gain efficiencies in health care delivery leading to reduced care costs. See the Cardinal Care Technical Manual for more information.

The Contractor must require behavioral health providers to collect clinical outcomes data as determined by the Contractor and approved by the Department. The Contractor's behavioral health provider contracts must require the provider to make available behavioral health clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes.

The Contractor must use outcome measures based on best practices within behavioral health care. As directed by the Department, the Contractor must collaborate with DBHDS, other state agencies, CSBs/BHAs and behavioral health providers to develop outcome measures that are specific to each covered behavioral health service.

10.7.2 EPSDT Quality Improvement Activities

The Contractor must incorporate EPSDT requirements such as lead testing and developmental screenings, according to AAP and Bright Futures, in its quality assurance activities. The Contractor must implement interventions and/or strategies to meet the following criteria:

1. Childhood Immunization rates;
2. Well-child rates in all age groups;
3. Lead testing rates;
4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year; and
5. Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).

The Contractor must follow a long-term improvement plan relating to improving EPSDT indicators that will not exceed five (5) years.

10.7.3 Maternity Reporting

The Contractor must submit its maternity program policies and procedures and a plan to support positive birth outcomes to the Department in accordance with the requirements outlined in the Cardinal Care Technical Manual. This report must also include accomplishments, challenges, and partnerships during the previous contract year as well as copies of educational, training, and informational materials that the Contractor provided to OBGYNs.

The Contractor must submit reporting related to maternity services, including measures demonstrating services for both its high-risk and non-high-risk prenatal and postpartum members to the Department in accordance with the requirements outlined in the Cardinal Care Technical Manual.

10.8 Quality Rating System (QRS)

As required by CMS pursuant to 42 CFR §438.334, the Department will publish a quality rating system (QRS). The Department will publish the Consumer Decision Support Tool, comprised of performance measurement data collected from the Contractor. This data will include performance measures identified by the Department and a methodology approved by CMS and stakeholders. This tool will be prominently published annually and posted on the Department's website. The consumer decision support tool will be available by May of each year.

10.9 Oversight, Compliance, Review, and Publication

The Department will implement a performance measure reporting compliance program. Its results will impact the Contractor's score and rating in the Cardinal Care Managed Care Quality Incentive program and overall Annual Contract Evaluation and Compliance program. The Contractor must contribute to data quality assurance processes, including responding in a timely manner to data quality inadequacies

identified by the Department and rectifying those inadequacies, as directed by the Department. Failure to comply with the quality requirements in this Section may be cause for the Department to impose remedies or sanctions as outlined in Section 17, *Oversight*.

10.10 Department Quality Collaborative

The Contractor must actively participate in the Department Quality Collaborative, including attendance at all meetings by the QI Director and the Contractor's Chief Medical Officer or Medical Director or designee if approved by the Department in advance of the meeting. The Contractor must also actively participate in all other workgroups that are led by the Department, including any quality management workgroups or activities that are designed to support QI activities and provide a forum for discussing relevant issues. These workgroups will be attended by representatives of the Department, the Department's contractors, and other entities, as appropriate. The Contractor will identify qualified representatives, including the QI Director and senior physicians such as medical directors or associate medical directors and clinicians who are actively working on quality activities, to participate in these workgroups.

Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup. The Contractor must also serve as a liaison to, and maintain regular communication with, the Department or its designated QI representatives. Responsibilities must include, but are not limited to, promptly responding to requests for information and/or promptly sharing data relevant to all QI activities. These QI activities may include ongoing health plan quality monitoring, sharing quality data and best practices through the Quality Collaborative, coordinating performance improvement projects, and participating in a quality workgroup for survey planning and Cardinal Care Managed Care Health Plan Rating System development.

10.11 EQRO Quality Activities

In accordance with 42 CFR §438.350, the Contractor must undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this Contract. 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 must also submit requested information from the Department or EQRO for all federally mandated and optional EQRO tasks according to 42 CFR §438.358, including but not limited to 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 (1) week prior to the requested due date unless otherwise agreed to by the Department.

1. The Contractor must take all steps necessary to support the External Quality Review Organization (EQRO) contracted by the Department, in accordance with 42 CFR §438.358 or corresponding section in the Medicaid Managed Care final rule. EQR activities must include, but are not limited to:

2. Annual validation of performance measures reported to the Department, as directed by the Department, or calculated by the Department;
3. Annual validation of quality improvement projects required by the Department;
4. At least once every three (3) years, review of compliance with standards mandated by 42 CFR Part 438, or corresponding section in the Medicaid Managed Care final rule, and at the direction of the Department, regarding access, care coordination, structure and operations, scope and quality of care and services furnished to Members, and other standards;
    a. 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.
5. Annual validation of the Contractor's provider network adequacy;
6. Any other optional EQRO activities the Department may contract with the EQRO to conduct including validation of encounter data, administration or validation of consumer or provider surveys of quality of care, calculation of performance measures in addition to those reported by health plans, conduct PIPs in addition to those mandated to be conducted by health plans, focus studies, and assistance with the health plan quality rating system development required by CMS; and,
7. The Contractor must take all steps necessary to support the EQRO in conducting EQR activities including, but not limited to:
    a. Designating a qualified individual to serve as project director for each EQR activity who must, at a minimum:
        i. Oversee and be accountable for compliance with all aspects of the EQR activity;
        ii. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO or the Department in a timely manner;
        iii. Serve as the liaison to the EQRO and the Department and answer questions or coordinate responses to questions from the EQRO or the Department in a timely manner; and
        iv. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR activity and as requested by the EQRO or the Department.
    b. Maintaining data and other documentation necessary for completion of EQR activities specified above. The Contractor must maintain such documentation for a minimum of ten (10) years;
    c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or the Department;
    d. Participating in health plan-specific and cross-health plan meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and the Department;
    e. Implementing actions, as directed by Department, to address recommendations for QI made by the EQRO, and sharing outcomes and results of such activities with the EQRO or the Department in subsequent years; and

f. Participating in any other activities deemed necessary by the EQRO and approved by Department.

10.11.1 Performance Improvement Project (PIP) Validation

In accordance with 42 CFR §438.330, the Contractor must conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO pursuant to 42 CFR §438.358. The Department will select the topics, and each PIP must include implementation of interventions to achieve improvement in the access to care, timeliness and quality of care, consistent with 42 CFR §430.330.

The Contractor must perform a least one (1) clinical and one (1) non-clinical PIP in a format specified by the Department. The Department will require at a minimum, the two (2) previously mentioned PIPs to address specific topic areas and use specific performance measures with input from the Cardinal Care Managed Care Quality Collaborative.

In accordance with 42 CFR §438.330, the Contractor must identify benchmarks and set measurable achievable performance goals for each of its PIPs, which will be submitted to the Department for review and approval. The Contractor must implement PIPs in a culturally competent manner, to achieve their objectives using the Plan Do Study Act (PDSA) improvement model defined by the Institute for Health Care Improvement. Pursuant to 42 CFR §438.330, the Contractor must identify and implement intervention and improvement strategies for achieving the performance goals set for each PIP and promote sustained improvements.

Prior to discontinuing a PIP, the Contractor must identify a new PIP and submit a new PIP project plan to the Department for approval. The new PIP focus areas will be mandated by the Department after gathering recommendations from the Quality Collaborative. The Contractor must receive the Department's approval to discontinue the previous PIP and perform the new PIP.

The measures for each contract period will be communicated by the Department to the Contractor at a time and in a format as determined by the Department, consistent with 42 CFR §438.330. The due date for PIPs and validation must be in accordance with the process and methodology agreed upon by the Department and its EQRO agent. All PIP requirements will be located within the Cardinal Care Technical Manual.

The Contractor must conduct additional PIPs, special projects, focus studies, and research outside of the two (2) mandatory PIPs if mandated by the Department.

10.11.2 Performance Measure Validation (PMV)

To meet a CMS EQR mandated activity for validating performance measures in accordance with 42 CFR §438.358(b)(ii), the EQRO will validate a select group of the Contractor's HEDIS® or other identified quality measure scores on an annual basis. The measures for each contract period 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."

The timing of this requirement will be in alignment with the NCQA's most current timeline for 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.

11. INFORMATION SYSTEM MANAGEMENT

In accordance with 42 CFR §438.242, the Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The Contractor must implement and maintain a publicly accessible standards-based Application Programming Interface (API) as described in 42 CFR 431.70, which must include all the provider directory information specified in 42 CFR 438.10(h)(1) and (2). The Contractor must comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of Section 1903(r)(1)(F) of the Act. The Contractor's management information systems must be capable of furnishing the Department with timely, accurate, and complete information. The information system must be able to:

1. Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;
2. Accept and process provider claims as set forth in this Contract;
3. Generate and submit encounter data using the HIPAA Compliant Transactions and Code Sets and file formats following the Department's EDI requirements;
4. Track provider network composition and access as set forth in this Contract;
5. Track grievances and appeals as set forth in this Contract;
6. Perform data quality improvement activities and data validation, as set forth in this Contract;
7. Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract, including service authorizations and care coordination data;
8. Maintain formulary data;
9. Generate financial management reports and transaction data for any off systems payments including, but not limited to:
    a. MLR reports, BOI data
    b. Lump sum payments to providers
    c. Incentive payments to providers
    d. Cost recovery transactions (e.g., third party liability explanation of benefits, fraud/waste investigations, and/or legal actions).

The Contractor must provide raw data, including data from subcontractors, upon request to the Department. The data must be compliant with industry standards (e.g., National Information Exchange Model) and State companion guides. The Contractor must submit all required data in the timeframe and required format(s).

DMAS receives and validates claim data submitted by the MCOs through the Encounter Processing Solution (EPS) system. Based on encounter validation, DMAS will pass or fail encounter submissions by

the Contractor. EPS edits will seek to validate that the Contractor's claim data submissions demonstrate compliance with federal provider enrollment requirements, in accordance with 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, as described in section 7.3.2, *Provider Enrollment into Medicaid*. The Contractor's encounter claim data submission will not pass validation for any claims the Contractor has paid from billing, rendering, ordering, referring, or prescribing network providers who are not enrolled in PRSS, or out-of-network providers who are not registered as non-par providers in PRSS, except for providers participating within an MCO's D-SNP network that only provide Medicare services.

In accordance with 42 CFR §438.242(b), the Contractor must screen all data received from providers for completeness, logic and consistency. All data submissions are required to be certified. Data certification forms must be signed by the MCO'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 MCO. The Contractor must 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 must report this data to the Department with the required certification.

The Contractor must disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor must 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 must engage with testing in order to ensure continuity of existing data exchanges.

The following requirements must apply to all submissions. For each data submission, the Contractor must:

1. Collect and maintain one hundred percent (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 must 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;
3. Use standard formats, include required data elements, and meet other submission requirements as detailed in its 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.

The Contractor must comply with the Department's requirements, policies, and standards in the design and maintenance of its systems in order to successfully meet the requirements of this Contract. The

Contractor's systems must interface with the Department's VaMMIS/MES system, the Department's Virtual Gateway, and other Department IT architecture. The Contractor's systems must be able to support any future IT architecture or program changes. Solutions must be compliant with COV Information Technology Resource Management (ITRM) policies, standards, and guidelines, and may be updated from time to time. A complete list is located on the VITA ITRM Policies, Standards, and Guidelines website. The Contractor's systems must also be compliant with CMS MARS-E requirements.

The Contractor must:

1. Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and the Department and any other entity deemed appropriate by the Department. Such files must be transmitted to the Department through secure FTP, HTS, or a similar secure data exchange as determined by the Department;
2. Develop and maintain Member and provider portals that are accurate, up-to-date, and designed in a user-friendly way that enables Members and providers to quickly and easily locate all relevant information. The Contractor must establish appropriate links on the Contractor's websites that direct users back to the Department's website;
3. Provide secure email access (Transport Layer Security (TLS) encryption between the Department and the Contractor for correspondence containing sensitive private health information (PHI) or personal identifiable information (PII).
4. Cooperate with the Department in its efforts to verify the accuracy of all Contractor data submissions to the Department; and
5. Actively participate in any Department Systems workgroups, as directed by the Department.

All expenses incurred in establishing a secure connectivity between the Contractor and the Department, any software licenses required, and any training necessary must be the responsibility of the Contractor.

11.1 Medicaid Enterprise System

The Contractor's interface with VAMMIS/MES must include, but will not be limited to, receiving Medicaid participant enrollment information in HIPAA standard EDI X12 834 format; the submission of encounter data in the HIPAA standard X12, 837I, 837P, and the NCPDP D.0 formats; and receiving monthly capitation payments in the HIPAA standard X12 820 format. All of the Contractor's staff must have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor must supply all hardware, software, communication and other equipment necessary to meet the requirements of this Contract.

It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of this Contract. The Contractor will be granted access to the Department's EDI portal used for submission and receiving of X12 standard data files and other non-X12 data files. This access will be through the secured EDI portal maintained by the Department.

The Contractor will be granted access to VAMMIS through the web portal with an ACF2 secure sign on. This will enable the Contractor to view eligibility and pertinent VAMMIS data as deemed necessary by the Department. The Contractor's Help Desk employees supporting this Contract must have access to the internet.

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 CFR § 164.312. If the Contractor stores or maintains PHI in encrypted form, the Contractor must, promptly at the Department's request, provide the Department with the software keys to unlock such information.

11.3 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 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.

11.4 Test Data Transmission

The Contractor will 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 must pass the testing phase for all encounter claim type submissions within twelve (12) calendar weeks from the effective date of the Department's change.

The Contractor must submit the test encounters to the Department's Fiscal Agent electronically according to the specifications of the HIPAA Implementation Guide, The Department's Companion Guide, and the Cardinal Care Technical Manual.

An MCO (or subcontractor) can lose production privileges due to high volume of compliance errors and/or critical errors (as determined by the Department). Both the Department and its Fiscal Agent can remove production privileges. When an MCO (or subcontractor) loses its production privileges, then the MCO (or subcontractor) must actively test with the Department and its Fiscal Agent. Production privileges are expected to be regained within thirty (30) days.

11.5 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 Contract 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 and 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.

11.6 Collected Data Available to the Department and CMS

In accordance with 42 CFR §438.242(b), the Contractor must make all collected data available to the Department and to CMS upon request. The Contractor must make all systems and system information available to authorized Department staff and other agency staff to evaluate the quality and effectiveness of the Contractor's data and Systems. The Contractor will collect and provide to the Department all data required under 42 CFR §438.66 and 42 CFR §438.8 to improve the performance of the Managed Care program. The Contractor is prohibited from sharing or publishing Department data and information without prior written consent from the Department.

11.7 Data Security and Confidentiality of Records

The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member names.

The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the privacy and security of protected health information in accordance with 45 CFR §164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 CFR Part 164, subpart C, and the HIPAA Security Rule.

The Department requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document the Contractor's compliance with the most stringent requirements listed below:

1. Section 1902 (a)(7) of the Social Security Act (SSA);
2. 45 CFR Parts 160, and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; Final, January 25, 2013
3. COV ITRM Policy SEC5519 (latest version);
4. COV ITRM Standard SEC501 (latest version);
5. CMS MARS-E (latest version);
6. VITA security standards, which may be found on the VITA website, including:
    a. COV SEC 520(latest version) IT Risk Management Standard;
    b. COV SEC 525 Hosted Environment Information Security Standard (latest version);
    c. COV SEC 501 (latest version) IT Information Security Standard;
    d. COV SEC 514 (latest version) Removal of Commonwealth Data from Electronic Media; Standard; and
7. DMAS policies specifically identified.

The Contractor shall ensure the Risk Management and Security plan for the information system:

1. Is consistent with the organization's enterprise architecture;
2. Explicitly defines the authorization boundary for the system;
3. Describes the operational context of the information system in terms of missions and business processes;
4. Provides the security categorization of the information system including supporting rationale;
5. Describes the operational environment for the information system and relationships with or connections to other information systems;
6. Provides an overview of the security requirements for the system;
7. Identifies any relevant overlays, if applicable;
8. Describes the security controls in place or planned for meeting those requirements including a rationale for the tailoring and supplementation decisions; and
9. Is reviewed and approved by the authorizing official or designated representative prior to plan implementation.

The Risk Management and Security Plan document must be delivered to the Department 30 days before implementation. The Plan will also be made available to appropriate State and Federal agencies as deemed necessary by DMAS. The contractor shall review Risk Management and Security Plan on an annual basis or more frequently if required to address an environmental change. The Plan shall be made available to the Department with every change or at the minimum on an annual basis.

11.7.1 Personal Data

The Contractor must inform each of its employees of the laws and regulations related to confidentiality if the employee has any involvement with personal data or other confidential information (whether with regard to design, development, operation, or maintenance). The Contractor must ensure that access to personal data records is commensurate with user role.

The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor must not use any such data or any material derived from the data for any purpose, and, where so instructed by the Department, will destroy such data or material.

For any PHI received regarding an eligible beneficiary referred to the Contractor by the Department who does not enroll in Contractor's plan, the Contractor must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable State and Federal privacy and security laws including HIPAA and its related implementing regulations, at 45 CFR Parts 160, 162, and 164, as may be amended from time to time.

11.7.2 Research Data

The Contractor must seek and obtain prior written authorization from the Department for the use of any data pertaining to this Contract for research or any other purpose not directly related to the Contractor's performance under this Contract.

11.7.3 Information Sharing

During the course of an Member's enrollment or upon transfer or termination of enrollment, and subject to all applicable Federal and State laws, the Contractor must arrange for the transfer, at no cost to the Department or the Member, of medical information regarding such Member to any subsequent provider of medical services to such Member, as may be requested by the Member or such provider or directed by the Department, the Member, regulatory agencies of Virginia, or the United States Government. With respect to Members who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the state agency with custody of the Member, a copy of said Member's Medical Records in a timely manner.

11.8 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 must 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 (1) 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 must sign an agreement with the Contractor that complies with HIPAA. The Contractor must 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) agrees in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor under this Contract.

11.8.1 Certification of Internal Controls

The Contractor must have clearly delineated processes and procedures for the internal control of sensitive data and processes, which are any data and processes of which the compromising of confidentiality, integrity, and/or availability could have a material adverse effect on Commonwealth of Virginia interests, the conduct of agency programs, or to the privacy of which individuals are entitled, when such sensitive data or processes are related to the goods and/or services provided pursuant to this agreement.

In accordance with VITA SEC 520 IT Risk Management Standards, the Contractor must maintain updated System Security Plans (SSPs), Risk Registers, Risk Assessments, Plan of Action and Milestones (POAMs) and Audits, internal PEN Tests, Scan Reports, Cyber Insurance certificates, and Incident Response Plans to the Department annually or upon material change.

The Contractor must provide evidence of compliance and ongoing internal controls for sensitive data and processes through a standard reporting methodology. The evidence of compliance must be included in a report describing the effectiveness of the Contractor's internal controls that is compliant with the most current Virginia sec VITA IT and Security controls, federal requirements reflected in the CMS

MARS-E, American Institute of Certified Public Accountant (AICPA) Statement on Standards for Attestation Engagements (SSAE) No 18, Reporting on Controls at a Service Organization, Service Organizations Controls (SOC 2®), Processing Integrity, Confidentiality, or Privacy (AICPA, Attestation Standards, AT-C section 105, Concepts Common to All Attestation Engagements, and AT-C section 205). Where controls overlap the Contractor must apply the most restrictive control set. The (SOC 2®), Type 2 audit reports must be provided to the Department annually, no later than thirty (30) days after the report is issued with a documented gap analysis of the controls tested.

11.9 Enrollment Processing

The Department, or its duly authorized representative, will 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 file," will 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 must be extended by one (1) business day for each day the enrollment report is delayed. The MCO Enrollment reports will provide the Contractor with ongoing information about its Members and Enrollees and will be used as the basis for the monthly capitation payments.

The Contractor must 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.

11.9.1 Enrollment File (834)

An 834 enrollment file will be sent to the Contractor weekly on the sixth (6^{th}) and thirteenth (13^{th}) of each month (known as weekly files), monthly on the nineteenth (19^{th}) (known as mid-month), and on the last day of the month. The weekly 834 files will contain any changes of Member information, and enrollment adds and terminations (drops) for Managed Care enrollments. The monthly 834 file will contain information about the Contractor's Cardinal Care Membership, including audit, add and termination records for full eligibility/enrollment for current and future enrollment dates. The 834 includes all related Level of Care (LOC) benefit information, including retro changes, based upon the transaction date.

11.9.2 Care Management Solution (CRMS)

The Contractor must adhere to data exchange requirements as described in the CRMS and Cardinal Care Technical Manuals, as revised. The CRMS system is designed to support the continuity of care of Medicaid members and will facilitate data exchanges when a member transitions between the fee-for-service and Managed Care programs and for plan-to-plan transfers.

11.10 Capitation Payment File

The Contractor must accept the Department's electronic transfer of funds to receive capitation payments using the EDI X12 820 standard. The 820 Capitation Payment file will list all of the Members for whom the Contractor is being reimbursed. The 820 is processed on the last Friday of the calendar

month and is available to the Contractor on the following Monday. The file includes individual Member month detail with current and retroactive capitation payment adjustments.

11.11 Data Timeliness Requirements

The Contractor must meet all data requirements as defined by the Department and in compliance with 42 CFR §§438.604, 438.606, 438.818, 438.116, 438.8 and 438.206-207, and all data must be transmitted in a HIPAA-compliant manner. Requirements will be described in, but will not be limited to: electronic data interchange (EDI) companion guides, EDI implementation guides, Cardinal Care Technical Manual, Cardinal Care reporting requirements, or other documents that refer to this Section of the Contract. All deadlines and schedules for data submissions must 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 Members 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 must have sixty (60) days from the date of the document's modification to comply. For newly required data, the Contractor must have sixty (60) calendar days to implement the exchange of each data set as specified by the Department. The Contractor must 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 must 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, including paid amount and allowed amount;
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 must be defined in supporting documentation at the time requested. The Contractor must 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; and
4. Medical record data.

11.12 Data Quality Requirements

11.12.1 Data Reconciliation and Potential Audit Requirements

The Department may request a sample extract of previously submitted data from the Contractor to be compared with data received by the Department. At the discretion of the Department, the Contractor must 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 must provide Department-specified Member records in order to permit the Department to conduct data validation assessments.

The Department, or its designee, will 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.

The Department may require the Contractor or its subcontractor to replace any data that is not compliant with the Department specifications set forth in the Cardinal Care Technical Manual and submitted to the Department with compliant data at no cost to the Department. Any actual cost incurred by the Department to reprocess replacement data must be passed through in its entirety to the Contractor; "actual costs" include, without limitations, the costs charged to the Department by a third party and the costs associated with Department staff involved in the reprocessing the data.

11.12.2 Data Inventory and Data Quality Strategic Plan Requirement

At least twice yearly, or as otherwise requested by the Department, the Contractor must 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 the Department, if that source is required by the Department.

Should the Contractor possess a new data source with data on the Members, the Contractor must inform the Department sixty (60) calendar days prior to that data source's acquisition or creation.

The Contractor must provide the Department with an Annual Data Quality Strategic Plan in accordance with the requirements of the Cardinal Care Technical Manual 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 noncompliant data; and

4. The compliance actions and data quality standards expected of service providers, billing providers, subcontractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

11.13 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 must submit paid and denied encounter data for all services. The Contractor must submit complete, accurate, and timely encounters for all adjudicated services for all members for all services regardless of contracted payment type and or payment status. The Contractor must submit encounters according to the Medicaid Enterprise System (MES) Encounters Processing Solution (EPS) Cardinal Care Technical Manual, as well as the Companion Guide.

The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:

1. Expected utilizations;
2. Actual visits to expected visits;
3. Service date lag time benchmarks;
4. Expected EDI fail amounts;
5. Average paid amount per service, by billing code;
6. Average encounter volume; and
7. Accuracy and frequency of encounter coding.

The Contractor must also:

1. 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 subcapitated sources. Encounters submitted outside of a Member's eligibility span dates will be rejected.
2. Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) calendar days of the Contractor's adjudication date and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements must be detailed in its supporting documentation.
3. Provide notification to the Department within two (2) business days of identification of any unanticipated changes that may have an impact on the substance or process of data exchanges between the parties, and must engage with testing before submitting files into EPS production.
4. Maintain staff with the necessary technical expertise to support all EDI and encounter reporting requirements. The Contractor must have expertise for each transaction type supported by the Department;
5. Participate in site visits and other reviews and assessments by the Department, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of encounter data. The Department may request a sample extract of claims data from the Contractor that must be compared to encounter data received by the Department. Upon request by the Department, or its designee and with timeframes given in the request, the Contractor must provide Department

specified member records in order to permit the Department to conduct data validation assessments;

6. 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 5.16.10, Drug Rebates.
7. The Contractor must regularly reconcile financial reporting for enrollment and expense data, claim data, encounter data including rejections, and enrollment. The Contractor must be able to produce reports and documentation that demonstrate regular reconciliation is occurring.
8. Payment cycle data must be submitted and certified according to the Cardinal Care Encounter Technical Manual. Payment cycle data must be submitted and certified according to the EDI Procedure Manual.
9. The Contractor's systems must generate and transmit encounter data files according to the Department's requirements and any additional specifications as required by the Department.

The Contractor is responsible for oversight and submission of all its subcontracted encounter data. Subcontracted encounter data must comply with all Department specifications and requirements. Subcontracted encounter data have the same requirements as those for Contractor encounter data. The Contractor must evaluate the completeness and quality of subcontractor encounter data on a periodic basis and document these evaluation procedures and the results in the annual Data Quality Strategic Plan that is submitted to the Department.

In accordance with 42 CFR§ 438.602(e), the Contractor must 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, under the penalty of perjury. The Contractor must cooperate with the Department designated auditor(s) to ensure the audit is completed within the timeframe specified by the Department. In accordance with 42 CFR §457.1201, the Contractor must attest to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

The Contractor must fully cooperate with all Department efforts to monitor the Contractor's or subcontractors' compliance with the requirements of encounter data submission. Pursuant to 42 CFR §§438.242(c)(1)-(4) and 438.818, the Contractor must comply with all requests related to encounter data monitoring efforts in a timely manner.

If the Department or the Contractor determines at any time that the Contractor's (including subcontractor) encounter data is not complete and accurate, the Contractor must:

1. Notify the Department, prior to encounter data submission and within two (2) business days of discovery, that the data is not complete or accurate, and provide an action plan and timeline for resolution and approval;
2. Submit for Department approval a Corrective Action Plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level. The timeframe for submission must be established by the Department, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that the Contractor is not in compliance with the encounter data requirements;

3. Implement the Department-approved Corrective Action Plan within the Department's approved timeframes. Implementation completion must not exceed thirty (30) calendar days from the date that the Contractor submits the Corrective Action Plan to the Department for approval; and
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, must determine whether the Contractor is financially liable for such validation review.

11.14 Electronic Visit Verification (EVV) System

The Contractor must require agency-directed providers that bill for personal care and respite care services to use an EVV system that will electronically verify and collect data that meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). The Department will work with the Contractor to effectively operationalize these requirements. At a minimum, the EVV must capture in real time the following data elements for agency-directed personal care and respite services.

1. Type of service performed;
2. The Member receiving the service;
3. Date of service;
4. Time the service begins and ends;
5. The location of service delivery at the beginning and the end of the service; and
6. Employee providing the service.

The Contractor must ensure that the provider's EVV systems must:

1. Securely transmit all EVV raw data elements to the Contractor.
2. Limit authority to modify changes and modifications to service entries. In the event the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the attendant's hours. For agency-directed providers, this may be a supervisor or the agency owner or designee who has authority to make independent verifications.
3. Support real time access to Members (if Member authentication is used) and providers.
4. Be compliant with the requirements of the ADA (as amended, 42 USC § 12101 et seq.) and HIPAA (P.L. 104-191).
5. Retain EVV data for at least six (6) years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception is resolved. Policies regarding retention of records must apply even if the provider discontinues operation.

The Contractor's claim processing system must have edits in place that prevent claims for services that are not electronically verified and documented using an EVV system.

The Contractor must submit EVV encounter data to the Department in a format as defined by the Department. For technical assistance on submission of EVV encounters, refer to the Encounter Processing System (EPS) Medicaid Enterprise System (MES) Companion Guide for 837 Professional

Health Care and Transportation Encounter Transactions, available at this link. The Companion Guide will be revised to accommodate the home health services providers' submission of the EVV required fields.

11.15 All-Payers Claim Database

The Contractor must 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 must ensure submission of paid 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.

11.16 Record Retention

The Contractor and its Network Providers must make medical records for each Member available to the Department, the contracted External Quality Review Organization (EQRO), and other Department designees upon request.

The Contractor and any applicable subcontractors must retain, as applicable, enrollee grievance and appeal records in accordance with 42 CFR §438.416, base data in 42 CFR §438.5(c), MLR reports in 42 CFR §438.8(k), and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years. Refer to Section 21.2.2, *Access to and Retention of Records,* for additional information.

11.17 Recovery of Costs

The Department may require the Contractor or its subcontractor to replace any data that is not compliant with the Department specifications set forth in the Cardinal Care Technical Manual and submitted to the Department with compliant data at no cost to the Department. Any actual cost incurred by the Department to reprocess replacement data must be passed through in its entirety to the Contractor; "actual costs" include, without limitations, the costs charged to the Department by a third party and the costs associated with Department staff involved in the reprocessing the data.

12. PROVIDER PAYMENT

12.1 General Provider Payment Processes

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor must pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 CFR §§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. The Contractor must ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment. Timely processing of claims is defined in 42 CFR §447.45 as:

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

The Contractor's timely filing requirements for all providers (in and out-of-network) must not be less than three (3) months and not more than twelve (12) months from the date of service. If the Member has other coverage, the timeframe for submission would begin on the date of payment from the primary payer. Where the service is covered by Medicare, the timeframe begins on the date of adjudication of the Medicare claim. The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor must make every effort to assure at least sixty percent (60%) of claims received from providers are submitted electronically.

In the absence of an agreement between the Contractor and the provider, the Contractor must pay out-of-network providers, including out-of-state providers, at the prevailing Department rate in existence on the date of service. This reimbursement must be considered payment in full to the provider or facility. Additionally, claims for emergency services must be paid in accordance with the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171), Section 6085. Reference the CMS SMD #06-010. The Contractor must ensure that Members are not billed for any amounts billed by the out-of-network provider and not paid by the Contractor. Refer to Section 13.3, *Protecting Member from Liability for Payment*.

In accordance with Section 1932(b)(2)(D) of the Social Security Act, State Medicaid Director Letter 06-010, and 42 CFR §424.101 and 42 CFR §405.400, respectively, the Contractor must reimburse out-of-network providers, and providers of emergent or urgent care, the Medicaid FFS payment level for that service.

In accordance with 42 CFR §447.15, the Contractor and all of its subcontractors must accept, as payment in full, the amounts paid by the Department.

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) that is:

1. Furnished under the health 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;
2. 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);
3. Furnished by an individual or entity that the Contractor is investigating (or has been informed that the Department is investigating) relating to the Department's determination that a credible

allegation of fraud exists, unless the Department determines there is good cause, in accordance with federal law, not to suspend such payments; and

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

In accordance with 42 CFR §457.1201, the Contractor must guarantee that it will not avoid costs for services covered in this Contract by referring enrollees to publicly supported health care resources.

In accordance with 42 CFR § 441.18 and § 438.208, Contractor must ensure that it does not make duplicative payments to public agencies or private entities under the State plan and other program authorities for Care Management or Case Management services the Member is receiving.

The Contractor must notify the Department forty-five (45) days in advance of any proposal to modify claims operations and processing that includes 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) must be borne by the Contractor.

In accordance with 42 CFR §438.6, the Department will ensure that no payment is made to a network provider, other than by the Contractor, for services covered under this Contract except those required by Title XIX of the Act or direct payments for graduate medical education approved under the State Plan.

The Department does not and will not make any passthrough payments, as defined at 42 CFR §438.6(a).

In accordance with 42 CFR §438.602(b), 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, the Contractor must not pay claims to any network providers who are not enrolled in PRSS or out-of-network providers who are not registered in PRSS, other than for providers participating within an MCO's D-SNP network that only provide Medicare services. See section 7.3.2 *Provider Enrollment into Medicaid.*

12.1.1 Provider Preventable Conditions and Services (Never Events)

The Contractor must comply with 42 CFR §438.3(g) requirements mandating provider identification of provider preventable conditions (PPC) 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 must be based on the Provider Preventable Conditions policy defined in 42 CFR §447.26. 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 as specified in the Cardinal Care Technical Manual.

No reduction in payment for a provider preventable condition should 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. Reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider preventable conditions would otherwise result in an increase in payment; and

2. The Department can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.

Under 42 CFR §§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:

1. Is identified in the State Plan;
2. 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;
3. Has a negative consequence for the beneficiary;
4. Is auditable; and
5. 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.

Non-payment of provider preventable conditions must not prevent access to services for Medicaid beneficiaries.

Payments for Hospital Acquired Conditions (HACs) must be adjusted in the following manner: For Diagnosis Related Grouping (DRG) cases, the DRG payable must exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days must be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days must 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, must be reduced to forty-two (42) covered days.

12.1.2 Payment Suspension

Pursuant to 42 CFR §455.23 and 438.608(a)(7), the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. When the Department makes a credible allegation of fraud determination, the Department will issue a Notice of Payment Suspension to the Contractor. The Contractor must suspend payment as soon as possible, but no later than one (1) business day or in accordance with the timeframes communicated by the Department in the notice. As set forth below, the Department will handle issuing payment suspension notices to providers.

If the Contractor believes there is good cause, as defined in 42 CFR §455.23, to not suspend payments or to suspend payment only in part to such a provider, 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 (Final Determination). Upon notification from the Department of the Final Determination to suspend payments, the Contractor must suspend payments immediately in accordance with the timeframes communicated by the Department in the Final Determination.

The Contractor must confirm in writing to the Department the implementation date of the payment suspension and the service claim types suspended, if directed by the Department to suspend payments only in part. Confirmations must be submitted to the Department within one (1) business day of (i) receipt of the Notice of Payment Suspension from the Department, or (ii) receipt of the Final Determination if the Contractor submitted a good cause exemption form. Confirmations must be directed to: providerenrollment@dmas.virginia.gov. Upon receipt of confirmation from the Contractor, the Department will issue a Notice of Payment Suspension to the provider.

DMAS will notify the Contractor upon the termination of any provider payment suspension. The Contractor must list any payment suspension as directed by DMAS.

12.1.3 Payment of New Provider Applicants

In accordance with Va. Code § 38.2-3407.10:1, the Contractor must establish reasonable protocols and procedures for reimbursing new provider applicants, within thirty (30) calendar days of being credentialed by the carrier, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. At a minimum, the protocols and procedures must:

1. Apply only if the new provider applicant's credentialing application is approved by the Contractor;
2. Permit reimbursement to a new provider applicant for services rendered from the date the new provider applicant's completed credentialing application is received for consideration by the Contractor;
3. Apply only if a contractual relationship exists between the Contractor and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
4. Require that any reimbursement be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan.

12.1.4 Payment for Disenrolled Members

The Contractor is not liable for the payment of services covered under this Contract rendered to a Member outside of the dates of enrollment with the Contractor except for:

1. Specially manufactured DME that was authorized/ordered by the Contractor; and/or,
2. The full hospital DRG payment, from admission to discharge, if the Member is hospitalized and enrolled with the Contractor on admission.

In certain instances, a Member may be excluded from participation effective with retroactive dates of coverage. Providers may submit claims to the Department for services rendered during this retroactive period. Payment by the Department for services rendered during this retroactive period is contingent upon the Members meeting eligibility and coverage criteria requirements.

12.1.5 Payment to Excluded Providers

The Contractor must not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act.

12.1.6 Increased Payments to Ensure Access

The Contractor must provide a uniform percentage increase to the base provider payments made to the following providers and services:

1. Private acute care hospitals for actual inpatient and outpatient hospital services provided to Medicaid Managed Care enrollees. For purposes of the uniform percentage increase, private acute care hospitals exclude public hospitals, free-standing psychiatric and rehabilitation hospitals, children's hospitals, long-stay hospitals, long-term acute care hospitals, and critical access hospitals. The Department will establish the uniform percentage increases based on an analysis of the fee-for-service (FFS) upper payment limit (UPL) with adjustments for consideration of managed care reimbursement.
2. Non-state-owned acute care hospitals for actual inpatient and outpatient hospital services provided to Managed Care Members. The non-state government owned acute care hospitals are Chesapeake Regional Medical Center and Lake Taylor Hospital. The Department will establish the uniform percentage increase based on the UPL gap. The UPL gap is based on 95% of the FFS ACR analysis for the UPL.
3. State-owned nursing homes for actual nursing home services provided to Managed Care Members. The state government owned nursing facilities are those owned by Type One hospitals (Virginia Commonwealth University's Community Memorial Hospital [The Hundley Center], and the Children's Hospital of Richmond). The Department will establish the uniform percentage increase based on the UPL gap. The UPL gap is based on 100% of the FFS ACR analysis for the UPL.
4. Physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth for actual physician services provided to Managed Care Members. The Department will establish the uniform percentage increase based on the UPL gap which is updated every three years. The UPL gap is based on the FFS ACR analysis for the UPL.
5. Physicians affiliated with state university teaching hospitals (University of Virginia Health Center and Virginia Commonwealth University Health System) for actual physician services provided to Managed Care Members. The Department will establish the uniform percentage increase based on the UPL gap which is updated every three years. The UPL gap is based on the FFS ACR analysis for the UPL.
6. Physicians employed by or contracted with Chesapeake Regional Medical Center (CRMC), Virginia's only non-state government owned general acute care hospital. The uniform percentage is determined by the state based on the FFS ACR analysis which compares the ACR to the existing Medicaid payments.
7. Physicians employed by or contracted with Children's Hospital of the Kings Daughters (CHKD) through Children's Specialty Group (CSG) for actual physician services provided to Managed Care Members. The uniform percentage increase is determined quarterly by dividing $11,050,000 by the total payments made by Cardinal Care plans to CSG in the previous quarter but no more than a uniform percentage increase consistent with the State Plan ACR as a percentage of Medicare for the same physician practice.
8. Physicians employed by or contracted with a private acute care type 2 hospital system with at least one level 2 trauma center as of January 2022 with at least 290 beds in cost report period

2020 located in the Eastern Health Planning Region. The uniform percentage is determined quarterly such that total annual directed payments to physicians that are a component of the qualifying private health system will be less than the ACR.

9. Physicians employed by or contracted with a private acute care type 2 hospital system with at least one level 2 trauma center as of January 2022 located in Lord Fairfax Health District and Northwest Health Planning Region. The uniform percentage is determined quarterly such that total annual directed payments to physicians that are a component of the qualifying private health system will be less than the ACR.

The uniform percentage increases are subject to approval by CMS. These payments are intended to improve access to and the quality of services.

Following the end of each quarter, the Department will calculate the amounts the Contractor must pay each provider based on encounters reported in the immediate prior quarter. Funding for these payments will be included in quarterly supplemental capitation payments. The Contractor must make payments to providers within seven (7) days of receipt of the supplemental capitation payments. The Department will provide the Contractor instructions for making these payments. The Contractor must collect and provide to the Department such information as is required to support the administration and distribution of the uniform percentage increases.

12.1.7 Value-Based Payments (VBP)

Value-based Payments (VBP) includes a broad set of payment strategies intended to improve health care 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. All incentive arrangements described in this contract comply with 42 CFR §438.6(b) and 42 CFR §438.6(c)".

The Contractor must maintain a VBP strategy that follows the Alternate Payment Model (APM) framework in the White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on models in categories three (3) and four (4). The Contractor will assure annual improvement in the level of VBP penetration until such time that the contract has a minimum of twenty five percent (25%) of its relevant spending for medical services governed under VBP arrangements. The Department will take this figure from the Contractors' annual HCP-LAN APM Data Collection Submissions referenced below. The Department may revisit VBP penetration targets, including potential targets for the adoption of more advanced VBP (i.e. HCP-LAN categories 3-4), in future years.

12.1.7.1 **Contractor VBP Plan**

The Contractor's policies and procedures must have a VBP Plan for the adoption, evolution, and growth of APMs in its network. Each VBP Plan, as specified below, must cover the current status of the Contractor's VBP efforts and strategies to enhance or further those efforts over the two (2) subsequent contract years. The Contractor must update its VBP Plan annually. The Contractor's VBP Plan must, at a minimum, include:

1. Current State Review

a. A detailed description of all APMs the Contractor is currently using within its Medicaid provider network, by provider type and the HCP-LAN APM framework category/sub-category into which the APM best fits (e.g., 2a, 3b, or 4a); and
b. For the APMs identified above, the percentage of the Contractor's total Medicaid medical expenses expected to be paid under each type of APM model in the current contract year. The numerator and denominator should include all Medicaid related medical spending, including primary and acute, behavioral health, and 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 quality 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. Effectiveness of the Contractor's APM strategies for services and populations under Managed Care, including how the APMs effect Member outcomes, experience, and associated medical spending; and
    b. Relationship to the Contractor's commercial and/or Medicare Advantage VBP strategy and discussion of how these VBP strategies align with VBP efforts under the Managed Care program.

The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals:

1. Improved birth outcomes;
2. Appropriate, efficient utilization of high cost, high intensity clinical settings; and
3. Improving MCO performance on Department Clinical Efficiency Performance Measures, including potentially preventable and/or avoidable ED visits, hospital admissions, and hospital readmission.

The Contractor must submit the Contractor VBP Plan in accordance with the requirements of the Cardinal Care Technical Manual.

12.1.7.2 **Department Approval of VBP For Certain Services**

The Contractor must have prior approval from the Department before implementing an alternative payment arrangement or value-based payment that revises the payment method for MHS, LTSS, ARTS, and Early Intervention Services such that the payment rate could be less than the current Medicaid FFS rate, such as a shared risk arrangement. The Contractor does not require Department approval to implement arrangements that pay at least the current Medicaid FFS rate and are mutually agreed upon by the provider and the Contractor.

12.1.7.3 **VBP Status Report**

The Contractor must maintain a VBP Status Report which includes additional details on its Medicaid VBP initiatives. At a minimum, the Contractor must include the following information for each VBP initiative:

1. VBP Category (and applicable subcategory, using the HCP-LAN model);

2. Short Description (including listing of associated performance measures);
3. Goal(s) and measurable results;
4. Description of targeted providers and number of providers eligible and participating;
5. Description of targeted Members, number of participating members whose services are covered by VBP initiative;
6. Total Medicaid payments to providers for services covered under VBP initiative; and
7. Total potential payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative.

The Contractor must submit its VBP Status Report and HCP-LAN Data Collection Submission (see below) to the Department in accordance with the requirements in the Cardinal Care Technical Manual. The Department will provide a template for Contractors to use in completing this submission.

12.1.7.4 **Contractor HCP-LAN APM Data Collection Submission**

The Department will use measurement methodologies developed by HCP-LAN to evaluate the adoption, evolution, and growth of VBP arrangements in a Contractor's Medicaid provider network. Annually, the Contractor must complete the Medicaid APM data collection tool for the twelve (12) months of the prior calendar year (e.g. April 2023 submission will cover CY 2022). Contractor submissions should include numerators and denominators that account for all relevant spending for medical services, including primary and acute, behavioral health, and drug spending. The HCP-LAN APM Data Collection Submission and VBP Status Report is due on April 1 of each contract year. The Department will provide a template for Contractors to use in completing this submission.

12.1.7.5 **Nursing Facility Value-Based Payment Incentive Initiative**

In an effort to support appropriate staffing and the provision of high-quality care to Medicaid members in nursing facilities (NF) across the Commonwealth, in 2021, the Virginia General Assembly directed the Department to develop a unified, value-based purchasing (VBP) program for NFs under Medicaid to begin by July 1, 2022. By connecting significant financial incentives to the achievement of better care and care outcomes for members, this program will enhance the quality of care furnished to NF residents.

Eligible NFs participating in the NF VBP program will receive performance-based payments tied to their attainment and improvement on designated performance measures (PM). The Department will evaluate NF performance against program measures and participating NFs will receive VBP payments from a single Contractor. The Department will direct Contractors to make performance payments to assigned NFs, as well as specify the size and timing of such payments under the NF VBP Program.

Additional details concerning the NF VBP program, including performance measures and thresholds, payment timing, eligible facilities, and other information regarding the methodology are available in the Nursing Facility Value-Based Purchasing Methodology, available on the Department's website at this link.

12.1.7.6 **NF VBP Payment Timing and Contractor Responsibility**

The Contractor must make payments as directed on a schedule determined by the Department to specified NFs. The Department will provide the Contractor with a list of NFs to which it is responsible for

making NF VBP payments, the specified amounts to be paid out to each attributed NF, and the time by which the Contractor must make these specified payments to the identified facilities. The payments must be made in the exact amount and in the timing dictated by the Department. The Contractor is also responsible for keeping contact and banking information updated for attributed NFs each year of the program.

The Contractor will receive two lump sums in February/March (performance payment one) and May/June (performance payment two) throughout the state fiscal year from the Department for the Contractor to pay NFs. Should the Contractor be unable to successfully a complete a specified payment to a NF within 30 days of receipt of the designated funds from the Department, the Contractor must immediately take the following actions:

1. Provide a written statement to the Department describing why the payment could not be completed as directed within thirty (30) days of receipt of the designated funds from the Department;
2. Resolve the issue; and
3. Notify the Department and all parties involved of when the payment in question is made to the correct NF.

Any Contractor that provides a written statement to the Department describing why the payment could not be completed as directed within thirty (30) days of receipt of the designated funds will be granted an additional thirty (30) days (a "30-day correction period") from the date of the written statement to make payment to the correct NF, and forty-five (45) days from the date of the written statement to provide attestation of completed payments. If the Contractor does not complete payments as directed within the 30-day correction period, or the Department does not receive attestation of completed payments within forty-five (45) days from the date of the written statement, the compliance action will begin on the forty-sixth (46^{th}) day after the date of the written statement.

As part of the compliance action, the Contractor will be notified of the Department's intent to initiate compliance action and will be assessed a $5,000 penalty for each day that payments are not made as directed by the Department or the Contractor has not provided attestation to the Department of completed payments, starting the forty-sixth (46^{th}) day after receipt of the lump sum. The Department reserves the right to waive the $5,000 penalty per day based on the written statement from the Contractor describing why the payment cannot be completed. Waiver of the $5,000 penalty per day is subject to review by the Office of the Attorney General. The Department may audit the Contractor to ensure payments are made as directed each program year, which may include desk or onsite audits of the Contractor to ensure payments are completed as directed and include all related systems, policies, and processes.

The Department reserves the right to review the manner and timing of payments under the NF VBP program, review the results and adjust criteria as necessary to equitably and completely distribute available funding, and make other necessary changes to the NF VBP program in future years. The Department will provide notice of any such changes to program criteria prior to finalizing program payments. The Department will make all final determinations with regards to payments under the NF VBP Program, including, but not limited to, determinations of any features pertaining to payments as well as any underlying data used to determine such payments. The Department will work with stakeholders to address any disagreements in determinations on these points, but in the event that the

Department and the stakeholder are unable to come to agreement, The Department decisions are final and not subject to appeal.

12.1.8 Physician Incentive Plans

The Contractor may, at its discretion, operate a physician incentive plan only if:

1. No single physician is put at financial risk for the costs of treating a Member that are outside the physician's direct control;
2. 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
3. The applicable stop/loss protection, Member survey, and disclosure requirements of 42 CFR Part 417 are met.

The Contractor must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR §422.208 and §422.210, as well as compliance with Sections 1903(m)(5)(B)(ii) and 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR §438.700(b)(6); 42 CFR §438.726(b); and 42 CFR §438.730(e)(1)(i), which requires the Department to deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS based on the state's recommendation, when the Contractor fails to comply with the requirements for PIPs. The Contractor must submit all information required to be disclosed in the manner and format specified by the Department. The Contractor must submit all physician incentive plans in accordance with the requirements contained in the Cardinal Care Technical Manual and when appropriate to enrollees in accordance with 42 CFR §438.10(f)(3) and 42 CFR §438.3(i).

The Contractor must 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 CFR Parts 417, 434 and 1003; however, the Contractor must 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.

12.1.9 Legislatively Mandated Rates

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 Managed Care 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 FFS fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Department will make every reasonable effort to provide at least sixty (60) days advance notice of such increases. The Contractor must provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and effective date. A facsimile notice is an acceptable format. A copy of such notification must be provided to the Department upon request.

12.1.10 Interest Payments

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 must be computed daily at the legal rate of interest from the date of thirty (30) calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. See Section 22, *Definitions,* for the definition of "proof of loss." 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 MCO's obligation on such claims.

12.1.11 Minimum Required Fee Schedule

The following services are subject to a minimum fee schedule:

1. Long term services and supports (LTSS),
2. Mental Health Services,
3. ARTS and Early Intervention services,
4. Psychiatric and Anesthesiologist services,
5. Personal Care and Respite Care services,
6. Doula services, and
7. Durable Medical Equipment

All these services are subject to minimum payment based on one hundred percent (100%) of Virginia Medicaid's FFS fee schedule except DME which is subject to ninety percent (90%) of Virginia Medicaid's FFS fee schedule. See 12.2.3 through 12.2.6 for additional information.

12.2 Payment and Payment Processes for Specific Provider Types

12.2.1 Hospital Payments

12.2.1.1 **DRG Hospital Payments**

The Contractor with whom the Member is enrolled on the date of hospital admission is responsible for the full DRG hospital payment, from admission to discharge, including where the Member is disenrolled from the Contractor during the course of the inpatient hospitalization. This is an exception to loss of eligibility rules in Section 12.1.3, *Payment of New Provider Applicants*. Similarly, for Medicaid and FAMIS Members who are hospitalized under FFS at the time of admission, the Department is responsible for the full DRG, admission to discharge, in accordance with Department established coverage criteria and payment rules, including where the individual becomes enrolled with the Contractor during the inpatient stay

12.2.1.2 Per Diem Hospital Payments

For per diem provider contracts, reimbursement must 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 must each pay for the period during which the Member is enrolled with the entity.

12.2.1.3 Practitioner Service Payments During the Hospital Stay

The Contractor must 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.

12.2.2 Payment for Indian Health Care Providers

Services provided through Indian Health Care Providers (IHCPs) as defined in this contract, including tribal clinic providers, are carved out of this Contract and reimbursed through the Department's fee-for-service program, per the provider's agreement with the Department.

12.2.3 Payment for CCC Plus Waiver Services

The Contractor's reimbursement for CCC Plus Waiver services must include the Northern Virginia differential for qualifying localities, as described on the Provider Portal at this link. The Northern Virginia differential reimbursement for Waiver services is based upon the Member FIPS except for Adult Day Health Care (ADHC) services, which is based on provider FIPS.

12.2.4 Nursing Facility (NF)/LTSS, ARTS, MHS, Early Intervention, and Doula Payments

The Contractor must ensure that NF/LTSS (including when providing services covered under EPSDT), ARTS (including buprenorphine containing drugs, naltrexone, and methadone when provided as part of MAT), MHS, Early Intervention, and Doula providers are paid no less than the current Medicaid FFS rate. The Contractor must have prior approval from the Department before implementing an alternative payment arrangement or value-based payment that revises the payment method for ARTS, MHS, and Early Intervention Services such that the payment rate could be less than the current Medicaid FFS rate, such as a shared risk arrangement. The Contractor must also ensure ninety-nine percent (99%) of clean claims from these providers are adjudicated within fourteen (14) calendar days of receipt of the clean claim, and one hundred percent (100%) are adjudicated within thirty (30) calendar days, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered. Where the service is covered by Medicare, the fourteen (14) calendar day timeframe begins on the date of Medicare adjudication.

The Department requires the Contractor to implement uniform billing practices and claims submissions processes for NF/LTSS, Early Intervention, and MHS providers. The Contractor must participate in working sessions with the Department and other Managed Care program contractors to develop and implement such uniform billing practices. Consideration will be made towards the development of uniform billing procedures especially for small providers who are not familiar with electronic billing through MCOs. The Contractor must develop, train providers on, and implement uniform practices in conjunction with the Department and the other selected Managed Care program contractors.

The Contractor does not require Department approval to implement arrangements that pay at least the current Medicaid FFS rate and are mutually agreed upon by the provider and the Contractor.

12.2.4.1 NF Payments

The Contractor must pay NFs no less than the Medicaid Resource Utilization Groups (RUGS) adjusted per diem rate for Medicaid covered days, using the Department's methodology. The Contractor must pay Specialized Care Facilities and Long-Stay Hospitals no less than the per diem rate for Medicaid covered days, using the Department's methodology. In the event that rates are revised for cost settlements, in response to appeals or for other reasons, the Contractor must adjust payments including retroactively based on the Department's instructions to the revised rates for any contracts based on the minimum rates. If the RUGS adjusted reimbursement calculation exceeds the charges, the Contractor must pay the RUGS adjusted payment rate. The lesser of billed charges payment rule must not apply to RUGS NF reimbursement. If the patient has a LTSS patient pay responsibility, the Contractor must adjust the payment according to its Contract with the NF provider.

This includes and is not limited to Specialized Care Nursing Facilities, where MCOs can negotiate the process to develop their own protocols for identifying specialized care for payment purposes; this process can differ from the FFS process. For example, the Department does not oppose the process agreed upon in meetings between NF stakeholders and MCOs to use the recommended process of revenue code 199 with 65x modifier. The Department will publish Medicaid rates by NF prior to the beginning of each fiscal year.

For all Members admitted to a NF, the Contractor must not reimburse a NF for prior to a LTSS screening completed for the Member in accordance with DMAS regulations and procedures by an appropriate screening team (described below), the screening has been entered into the eMLS system (also described below), the Contractor receives a copy of the screening, and the individual is found to meet NF level of care criteria. For Members admitted to a NF under one of the Special Circumstances identified in 12 VAC 30-60-302 who do not have a Medicaid LTSS screening, the Contractor shall accept the MDS and may request the DMAS-80, Nursing Facility Admission, Discharge or Level of Care form. Following the Department's policy, the Contractor must receive a copy of the LTSS screening package for Members admitted to a NF on or after July 1, 2019, prior to payment to a NF for that admission. For Members in a NF prior to July 1, 2019, in the event that a LTSS screening has not been completed, the Contractor must accept the MDS to validate NF eligibility, and may request the DMAS-80 form.

12.2.4.2 ARTS Payments

The Contractor must reimburse practitioners for all ARTS specific services and levels of care in accordance with the ARTS Reimbursement Schedule. The Department will publish ARTS rates by level of care prior to the beginning of each fiscal year available on the Department's website.

The Contractor must 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
Preferred Office Based Opioid Treatment	CMS-1500
Substance Abuse Case Management	CMS-1500
Substance Abuse Care Coordination	CMS-1500
Peer Recovery Support Services	CMS-1500

12.2.4.3 MHS Payments

MHS must be paid in accordance with the Department rates, including for rural and urban rate localities. A list of Virginia urban and rural localities is available on the Department's website at this link.

Effective December 15, 2023, the Contractor must ensure Mobile Crisis service providers adhere to the provisions of changes to the Mobile Crisis process announced by DBHDS in its November 1, 2023, Administrative Instructional Memo titled *Crisis Services Administrative Instructional Memo: Mobile Crisis Process Changes effective December 15, 2023*, and the DMAS Crisis Services manual. The memo is available for review at this link. Mobile Crisis providers who do not adhere to this process risk denial of claims and shall not be authorized for reimbursement and the health plan shall audit claims to ensure this policy is enforced upon any post payment review or provider audit findings.

The Contractor must follow the DMAS billing guidelines for MHS as described in the Department's Mental Health Services Manual, available on the Virginia Medicaid Provider Portal.

Mental Health Services	Billing Method	Urban Rate Per Unit	Rural Rate Per Unit
23 Hour Crisis Stabilization	CMS-1500 or UB	N/A	N/A

Applied Behavior Analysis	CMS-1500	N/A	N/A
Assertive Community Treatment (ACT)	CMS-1500	N/A	N/A
Community Stabilization	CMS-1500	N/A	N/A
Functional Family Therapy (FFT)	CMS-1500	N/A	N/A
Intensive In-Home	CMS-1500	N/A	N/A
Mental Health Case Management	CMS-1500	N/A	N/A
Mental Health Intensive Outpatient Services (MH-IOP)	CMS-1500 or UB	N/A	N/A
Mental Health Partial Hospitalization Program (MH-PHP)	CMS-1500 or UB	N/A	N/A
Mental Health Peer Recovery Support Services – Individual	CMS-1500	N/A	N/A
Mental Health Peer Recovery Support Services – Group	CMS-1500	N/A	N/A
Mental Health Skill-building Services (MHSS)	CMS-1500	$91.00	$83.00
Mobile Crisis Response	CMS-1500	N/A	N/A
Multisystemic Therapy (MST)	CMS-1500	N/A	N/A
Psychosocial Rehab	CMS-1500	N/A	N/A
Residential Crisis Stabilization Unit	CMS-1500 or UB	N/A	N/A
Therapeutic Day Treatment (TDT) for Children	CMS-1500	N/A	N/A

12.2.4.4 **Early Intervention Payments**

Early intervention reimbursement is defined by ten (10) distinct codes, inclusive of appropriate modifiers. These codes can only be billed for EI enrolled children (as indicated by the EI indicator on the 834-eligibility file) by providers who are certified by DBHDS and enrolled with The Department/MCOs as an EI provider. EI codes require no authorization from the Contractor.

The Contractor must reimburse EI services no less that the EI Medicaid fee schedule in place at the time of services. The Contractor also must use the full EI rate when paying secondary claims for EI services submitted by EI providers for EI enrolled children. Two (2) or more EI services may be billed at the same time on the same day as long as they are not the same service.

The Contractor must not require an EOB for an EI child that has a decline to bill form on file.

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

1. Those services federally required to be provided at public expense as is the case for
    a. assessment/EI evaluation (T1023 and T1023 U1);

b. development or review of the Individual Family Service Plan (IFSP) (T1024 and T1024 U1); and,
c. targeted case management/service coordination (T2022);

2. Developmental services (T1027 and T1027 U1); and
3. Any covered early intervention services where the family has declined access to their private health/medical insurance.

Billing codes for EI services are reflected in Attachment E, Cardinal Care Summary of Covered Benefits Chart.

If the IFSP (Sections I – Child and Family Information, V – Services Needed to Achieve EI Outcomes, and VI – Other Services) is not on file, the Contractor must make every effort to obtain the IFSP from the LLA EI Service Coordinator or provider prior to processing the claim in order to prevent a premature denial of a claim. Lack of an IFSP (Sections I, V, and VI) on file with the Contractor will constitute a non-clean claim, except for the codes noted in the chart below.

The following codes/services are excluded from the IFSP requirement and should pay with or without the IFSP at the full EI rate.

Code	Description
T2022	1. Service coordination
T1023 T1023 U1	1. Initial Assessment for Service Planning 2. Development of initial IFSP 3. Annual IFSP
T1024 T1024 U1	1. Team Treatment activities (more than one (1) professional providing services during same session for an individual child/family 2. IFSP Review Meetings (must be in-person) 3. Assessments that are done after the initial Assessment for Service Planning 4. Providers may use T1024 and the T1024 U1 on the same day, same child, same date of service and potentially the same NPI number

12.2.5 Maternal and Infant Health Payments

12.2.5.1 **Long Acting Reversible Contraceptive (LARC) Payments**

The Contractor must provide payment for all 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 DRG reimbursement system for the inpatient hospital stay for the delivery. The Contractor must also reimburse practitioners for the postpartum insertion of the LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.

12.2.5.2 **Doula Payments**

The Contractor must ensure Doulas are paid no less than the current Medicaid FFS rate. If the Contractor and provider mutually agree to an Alternative Payment Method (for example, PMPM or bundled payment) or Value-Based Reimbursement method, the reimbursement must not go below the FFS rate. See the Department's fee schedule for specific Doula rates.

Reimbursement for attendance at delivery is a flat rate for both vaginal and cesarean deliveries. No additional reimbursement will be made for non-singleton births. Date of service on the claim should be the date of delivery.

All claims for Doula services must include diagnosis Z32.2 (encounter for childbirth instruction). Claims for Doula services will only be accepted up to three hundred and sixty-five (365) days from the date of service.

Minimum requirements for reimbursement for delivery and doula incentive payments are built in to promote delivery of the full package of services, continuity of care, and timely care. Service flexibilities emphasize individualized, culturally sensitive, and appropriate care for a given case while recognizing that not all services can be delivered in all cases. To ensure that Doulas and their services are integrated into the broader spectrum of maternal and child health available to Medicaid Members, postpartum-focused incentive payments will be made based on successful referrals for the mother and/or newborn by Doulas to other providers of complementary maternal and pediatric care. Incentive payments will be made when the following conditions are met:

1. Doula must provide a postpartum service visit within six (6) weeks of delivery;
2. Maternal postpartum visit: An obstetric clinician follow-up visit must occur within six (6) weeks of delivery; and
3. Newborn postpartum visit: A pediatric clinician visit must occur within six (6) weeks of delivery.

12.2.6 Payment for Durable Medical Equipment and Supplies

The Contractor must not pay less than ninety (90) percent of the FFS Medicaid fee schedule rate for all DME services. If no rate is available, the Contractor must utilize the reimbursement methodology in 12VAC30-80-30.A(6) to determine a FFS benchmark rate. When the Contractor and the DME provider enter into a mutually agreed upon VBP or APM (including, for example, PMPM) arrangement, the VBP or APM payment must not fall below ninety percent (90%) of the FFS rate per item.

In accordance with 2023 General Assembly action amending Va. Code § 32.1-325 and upon CMS approval of a required State Plan Amendment, the Contractor must provide reimbursement for complex rehabilitative technology manual and power wheelchair bases and related accessories for Members who reside in nursing facilities. Initial purchase or replacement of such equipment may be contingent upon (i) determination of medical necessity; (ii) requirements in accordance with regulations established through the Department's durable medical equipment program policy; and (iii) exclusive use by the nursing facility resident. The Contractor must not require Members to pay any deductible, coinsurance, copayment, or patient costs related to the initial purchase or replacement of equipment covered under this policy. The Department will inform the Contractor when the State Plan Amendment has been approved and reimbursements must begin.

13. COST SHARING AND COORDINATION OF BENEFITS

13.1 Cost Sharing

The Contractor is prohibited from imposing any cost sharing obligations (coinsurance, deductibles, and copayments) for any services covered under this Contract. This provision also precludes the Contractor from imposing any copayments on prescription drugs covered under this Contract. Refer to the CCC Plus Claims Processing memo from 9/4/2019 for additional information on cost sharing responsibilities and processes. Refer to the sections below for additional information on Member patient pay responsibility for LTSS.

13.2 Patient Pay

Patient pay refers to the Member's obligation to pay towards the cost of LTSS, if the Member's income exceeds certain thresholds. Patient pay, which is calculated by DSS, must not be confused with a Contractor's copay, deductible, or coinsurance.

13.2.1 Patient Pay for LTSS

Patient pay is required to be calculated for every individual receiving NF or waiver services unless it is not required based on eligibility category. Not every eligible individual will acquire a patient pay liability. When a Member's income exceeds an allowable amount, they must contribute toward the cost of their LTSS.

The Department will provide information to the Contractor that identifies Members who are required to pay a patient pay amount and the amount of the obligation as part of the monthly transition report. The Department's Capitation Payments to Contractors for Members who are required to pay a patient pay amount will be net of the monthly patient pay amount. The Contractor must establish a process to ensure collection of the patient pay amounts and coordinate with LTSS providers. The process for collecting patient pay amounts will be the responsibility of the Contractor and must be outlined in the Contractor's provider agreement. The Contractor must develop policies and procedures regarding the collection of the patient pay obligation and provide these policies and procedures upon a substantive change and upon request. The Contractor must explain this process in its LTSS provider contracts and must reduce reimbursements to LTSS providers equal to the patient pay amounts each month.

13.2.2 Patient Pay for Members Who Transition Between a Nursing Facility and the CCC Plus Waiver

The Contractor must ensure that for Members who transition to or from a nursing facility during the month, the Contractor collects the patient pay amount from the nursing facility claim (i.e., for the transition month) and not from the CCC Plus Waiver provider(s). This process applies regardless of the order in which the Contractor receives the claims.

13.2.3 Patient Pay for Members with Medicare

There are circumstances where individuals with Medicare may also have a patient pay responsibility towards skilled nursing facility care. For example, a Member who falls into a low RUGS category, and

who has a coinsurance responsibility through Medicare Part A, could have a cost share responsibility if the Medicare payment is lower than the Medicaid allowable amount for the same service. In this circumstance, the Member is responsible for the difference in the Medicare payment and Medicaid allowable charges, up to the Member's DSS-calculated patient pay amount.

13.3 Protecting Member from Liability for Payment

In accordance with 42 CFR §438.106 and 42 CFR §447.15, the Contractor must ensure that its Members are not held liable for payment for any services provided under this Contract other than Member patient pay liability towards LTSS. The Contractor must ensure that all in-network provider agreements include requirements whereby the Member must not be charged for any Medicaid covered service. This includes circumstances in which the provider fails to obtain necessary referrals or preauthorization, or fails to perform other required administrative functions. See Section 13, *Cost Sharing and Coordination of Benefits*.

The Contractor must not deny, and must ensure that its providers and subcontractors do not deny, any service covered under this Contract to any Member for failure or inability to pay any applicable charge or where the Member, who prior to becoming eligible for Managed Care, incurred a bill that has not been paid.

The Contractor must ensure Provider Network compliance with all Member payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any provider within the Contractor's Network that does not comply with such provisions.

Pursuant to Section 1932(b)(6), (42 USC § 1396u-2 (b)(6)), and in accordance with 42 CFR §438.106, the Contractor and all of its providers and subcontractors must not hold a Member liable for:

1. Debts of the Contractor in the event of the Contractor's insolvency;
2. Covered services provided to the Member for which the Contractor has not received payment from the Department for the services; or, the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor;
3. Payments in excess of the contracted amount;
4. 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; and
5. Coinsurance, copayments, deductibles, financial penalties, or any other amount other than any patient pay towards LTSS services.

As specified in Section 1128B(d)(1) of the Social Security Act (42 USC § 1320a-7b), as amended, the Contractor and all of its subcontractors are subject to criminal penalties if providers knowingly and willfully charge money or other consideration at a rate in excess of the rate established by the Department for any service provided to a Member under the State Plan or under this Contract. This provision remains in effect even if the Contractor becomes insolvent until such time as Members are withdrawn from assignment to the Contractor.

13.4 Coordination of Benefits

Coordination of benefits allows plans that provide health and/or prescription coverage for a person with Medicare and/or other insurance to determine their respective payment responsibilities. In all circumstances, Medicaid is the payer of last resort, as defined in Section 22, *Definitions*. Coordination of Benefits includes copayment, coinsurance and deductible.

13.4.1 Services Provided to FQHC and RHC Members

For services provided to dual-eligible Members by a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), the Contractor must pay the full Medicare coinsurance and deductible that the Department would pay. For Medicare Advantage plans, the Contractor is responsible for the full copayment that the Department would pay. The Medicaid allowed amount for FQHCs and RHCs is equal to the combined Medicare Deductible and coinsurance.

13.4.2 Payment Coordination with Medicare

In accordance with 42 CFR §438.3(t), the Contractor must enter into a Coordination of Benefits Agreement (COBA) with Medicare and participate in the automated claims crossover process for claims processing for its Members who are dually eligible for Medicaid and Medicare. The Contractor is responsible for coordinating Medicaid payments for dual-eligible Members and must be responsible for paying crossover claims. All crossover claims processing rules must account for Medicare sequestration reductions when calculating payment amounts issued by the Medicaid benefit.

The Contractor must pay the identified coinsurance and deductible for Medicare crossover claims up to the Medicaid Fee Schedule amount. If there is no corresponding fee for the service in the Medicaid Fee Schedule, the Contractor must pay the full amount identified in the coinsurance and deductible.

13.4.3 Payment Coordination with Other Sources of Coverage

Under Section 1902(a)(25) of the Social Security Act (42 USC §1396a(a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources.

For coordination with commercial payers, Medicaid is the payer of last resort. The Contractor must pay the difference between the amount paid by the commercial payer and the corresponding amount identified in Medicaid Fee Schedule or the MCO's contracted rate with the provider.

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 non-health insurance resources must remain enrolled in the Managed Care program as long as they continue to meet eligibility requirements.

The Contractor must notify the Department or its designated agent on a monthly basis of any Members identified during the previous month that are discovered to have casualty, liability, estates, child support, and personal injury claims, as well as Members with trauma injuries. The Contractor must

provide the Department with all encounter/claims data associated with care given to Members who have been identified as having non-health insurance resources/coverage.

The Contractor must provide Member claim history when requested by the Department's TPL Unit staff to aid in the pursuit of non-health insurance resources. A file layout along with turnaround times will be specified in the Cardinal Care Technical Manual.

13.4.4 Comprehensive Health Coverage

As described in Section 3, *Covered Populations and Enrollment*, Members, identified by the Department as having comprehensive health coverage other than Medicare, will be eligible for enrollment in the Managed Care program, as long as no other exclusion applies. Members will not be disenrolled due to having Medicare or other comprehensive health coverage.

The Contractor must take responsibility for identifying and pursuing comprehensive health coverage (e.g., Medicare, commercial insurance, and Workers' Compensation). Any moneys recovered by third parties must be retained by the Contractor. The Contractor must notify DMAS monthly of any Members identified during the past month that were discovered to have comprehensive health coverage. The Contractor must comply with all policies and procedures established by the Department to effectuate the sharing of this information.

Prior to processing a claim for payment, the Contractor must not require a provider and/or pharmacist to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. The Contractor's determination of non-covered services under commercial insurance (non-Medicare) must be validated with each policy renewal. The Contractor's request for an explanation of benefits (EOB) from the provider in these instances would delay timely payment of these services. Examples of these services include, but are not limited to, LTSS waiver services such as personal care and respite care services. The Contractor can pay and pursue the Commercial insurance to assist with any potential delays of claim payments.

One (1) waiver service exception is for private duty nursing (PDN) as these services are often covered through commercial insurance. The Contractor may only require an EOB for PDN services if the commercial carriers covers all or part of PDN services.

13.5 Member Third Party Liability

As described in Section 3, *Covered Populations and Enrollment*, Members identified by the Department as having comprehensive health coverage other than Medicare will be eligible for enrollment in the Managed Care program, as long as no other exclusion applies.

The Contractor is responsible for coordinating all benefits with other insurance carriers (as applicable) and following Medicaid "payer of last resort" rules, with the exception of doula services where Medicaid is the primary payer. The Contractor must also cover the Managed Care program Member's deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid in the absence of other primary insurance coverage. When the other payer is a commercial MCO/HMO organization, the Contractor is responsible for the full Member copayment amount. The Contractor must ensure that the Member is held harmless for payments and copayments for any Medicaid covered

service. Additionally, the Member may not be billed by the provider other than any Patient Pay established by DSS towards Long-term Care Services and Supports (LTSS) services. Refer to Section 13.2, *Patient Pay*. The Contractor must also ensure compliance with the requirements detailed in CMS State Medicaid Director Letter #23-002, *Third-Party Liability in Medicaid: State Compliance with Changes Required in Law and Court Rulings.*

Pursuant to Section 1902 (a)(25) of the Social Security Act and 42 U.S.C. §1396a (a)(25), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. Therefore, in accordance with 42 CFR §433 Subpart D, and 42 CFR §447.20, the Contractor must take responsibility for identifying and pursuing comprehensive health coverage (e.g. Medicare, commercial insurance, and Workers' Compensation). In accordance with 42 CFR §433 Subpart D, and 42 CFR §447.20, any moneys recovered by third parties must be retained by the Contractor, identified, submitted monthly to the Department, and submitted annually via a cost recovery report. Additionally, in accordance with 42 CFR §433 Subpart D, and 42 CFR §447.20, the Contractor must have a vendor for identifying TPL Members and must notify the Department on a monthly basis of any Members identified during that previous month who were discovered to have comprehensive or other health coverage including any changes in a Member's primary insurance. The Contractor must instruct its vendor to review potential TPL for all of its covered Members. The Contractor's timely claims filing requirement must be no shorter than two (2) years (seven hundred and thirty (730) days) for the resolution of TPL claims with providers. The Contractor must provide Member claim history when requested by the Department's TPL Unit staff to aid in the pursuit of non-health insurance resources. A file layout, along with turnaround time to the Department, is specified in the Cardinal Care Technical Manual.

See Section 1.5.1, *Requirements to Respond to Requests Regarding Liens*.

13.5.1 Workers' Compensation

If a Member is injured at their place of employment and files a workers' compensation claim, the Contractor must 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 must notify the Department on a monthly basis of any Members identified during the previous 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 must 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.

13.5.2 Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor must notify the Department on a monthly basis of any Members identified during the previous month who have died and are over the age of fifty-five (55).

13.5.3 Prenatal and Pediatric Preventive Services and Claims Related to Child Support Enforcement Beneficiaries

In accordance with § 1902(a)(25)(E) of the Social Security Act, the Contractor must use standard coordination of benefits cost avoidance instead of "pay and chase" when processing claims for prenatal services, including labor and delivery and postpartum care claims.

Additionally, in accordance with § 1902(a)(25)(E) of the Social Security Act, the Contractor must make payments without regard to third party liability for prenatal and pediatric preventive services unless the Contractor has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for ninety (90) days. The Contractor is required to make payments without regard to third party liability for services for claims related to child support enforcement beneficiaries, provided that the payments have not been made by a third party within one hundred (100) days after such service is furnished.

Providers must not be required to bill the third party in this situation. When the provider does bill Medicaid, it must certify either:

1) That it has not billed the third party documented on the claim due to medical support enforcement; or

2) That it has billed the third party documented on the claim but that it has not received payment or denial for the service from the third party within one hundred (100) days after the service was furnished. In this case one hundred (100) days must elapse from the date of the service to the date of provider certification.

14. SUBCONTRACTOR DELEGATION

The Contractor may enter into subcontracts for the provision or administration of any or all covered or enhanced services or other delegated Contractor functions required by this contract, consistent with 2 CFR § 200.331. Subcontracting does not relieve the Contractor of its responsibilities to the Department or members under this Contract. The Department must 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 must also be considered actions and/or providers of the Contractor, as prescribed by 42 CFR §§ 438.230(b)(1) and 438.3(k). For purposes of this Section, subcontractor does not include a network provider.

All new subcontracts and amendments must be submitted to the Department at least thirty (30) calendar days prior to the subcontracts' and amendments' effective dates. If the terms of a subcontract have materially changed since the Department's approval, the Contractor must submit the revised subcontract to the Department for additional review and approval. For reporting and reconciliation purposes, the Contractor must submit a comprehensive list in accordance with the requirements of the Cardinal Care Technical Manual.

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that a subcontractor fails to meet the requirements of this Contract.

All subcontracts must ensure the level and quality of care required under this Contract and the Contractor must oversee governance and review of subcontractors. The Contractor must also ensure subcontractor accountability with the same controls as the Contractor including System Security Plans, SOC Reports, Risk Analysis, Audit Reports, and COV and MARS-E requirements. Utilizing subcontracts does not relieve the Contractor of its responsibilities to the Department or Members under this Contract. The Department will 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 provider's actions must also be considered actions and/or providers of the Contractor, as prescribed by 42 CFR §§438.230(b)(1) and 438.3(k). The Contractor must ensure that there is no offshore servicing of Member PHI.

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a TPA, 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 where firewalls meet or exceed the industry standard. The Contractor and TPA 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 entity contracted with the Department. The TPA must adhere to security requirements listed in Section 11, *Information System Management*.

The Contractor must ensure that its subcontractors collect the disclosure of health care-related criminal conviction information as required by 42 CFR §455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the Department. The Contractor must screen its contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings must be provided to the Department each month. The Contractor must ensure that all subcontractor staff listed on the disclosure form 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 must neither participate with nor enter into any provider or subcontractor agreement with any individual or entity that has been excluded from participation in federal health care programs.

The Contractor must give the Department at least ninety (90) calendar days advanced written notice prior to the termination of any subcontractor agreement, unless the Department directs the Contractor to terminate with less than ninety (90) calendar days' notice or circumstances exist that justify, in the Department's sole discretion, termination with less than ninety (90) calendar days' notice. At a minimum, such notice must include the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, and any other pertinent information that may be needed. In addition to prior written notice, the Contractor must also provide the Department with a transition plan upon request, which must include, at a minimum, information regarding how continuity of the project must be maintained. The Contractor's transition plan must also include provisions to notify impacted or potentially impacted provider(s).

14.1 Delegation Requirements

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

1. All subcontracts must be in writing;
2. Subcontracts must require the Subcontractor to require its provider contracts to comply with all provider provisions of this Contract and applicable Federal and State laws and regulations;
3. Subcontracts must specify the activities and reporting responsibilities delegated to the subcontractor;
4. Subcontracts must provide that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract;
5. Subcontracts must clearly state that the subcontractor must comply with Member privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E;
6. Subcontracts must 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; and
7. Subcontracts must specify that the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor's subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, and any equipment, books, records, contracts, or other electronic systems relating to Medicaid enrollees pertaining to:
    a. The ability of the Contractor and/or its subcontractors to bear the risk of financial losses, and
    b. Services performed or payable amounts under the Contract.

    Subcontracts must 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.

14.2 Monitoring Requirements

The Contractor must have a detailed plan in place to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the Contractor, including encounter data, enrollment, credentialing and recredentialing policies and procedures. The plan must be in compliance with 42 CFR §438.230(b), the Medicaid Managed Care regulation governing delegation and oversight of subcontractual relationships by Managed Care entities.

The Contractor must:

1. Perform ongoing monitoring of all subcontractors and must ensure compliance with subcontract requirements;

2. Perform a formal performance review of all subcontractors at least annually, which must assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this Contract;
3. Monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor must apply certain key edits to the data to ensure accuracy and completeness. These edits must include, but not be limited to, Member and provider identification numbers, dates of service, diagnosis and procedure codes, etc.;
4. Monitor the subcontractor's provider enrollment, credentialing, and recredentialing policies and procedures to assure compliance with Federal disclosure requirements described in 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 must monitor to ensure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federal health care programs as described in this Contract; and
5. As a result of monitoring activities conducted by the Contractor (through ongoing monitoring and/or annual review), identify to the subcontractor deficiencies or areas for improvement, and must require the subcontractor to take appropriate corrective action.
6. The Contractor must perform an annual review on all subcontractors to ensure that the health care professionals under contract with subcontractor are qualified to perform the services covered under this contract.

14.3 Data Sharing Capabilities

The Contractor must ensure that the interface between the Contractor and its subcontractors includes data sharing capabilities and that data sharing occurs timely and effectively and remains seamless to the Member. The interface must include a viable means of exchanging clinical, authorization, and service information between the Contractor and its subcontractors.

14.4 DMAS Service Authorization Contractor

The Contractor must work cooperatively on behalf of Managed Care program Members to coordinate behavioral health, MHS and ARTS care with the DMAS Service Authorization Contractor 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.

The Contractor must ensure that coordination efforts occur for Members as needed and on a frequent and ongoing basis with the DMAS Service Authorization Contractor for Members in need of or receiving those services currently carved out of Managed Care. Care coordination activities between the Contractor's Care Manager and the DMAS Service Authorization Contractor must ensure:

1. Comprehensive care planning;
2. Necessary crisis services;
3. Provider collaboration; and
4. Ongoing monitoring.

The Contractor and the DMAS Service Authorization Contractor must share specific points of contact with names and contact information for a primary and back-up behavioral health Care Manager for use by the Department, the DMAS Service Authorization Contractor, and the Contractor as necessary for care coordination purposes.

The Contractor and the DMAS Service Authorization Contractor must work closely together and with the Department to expand these care coordination policies 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.

Care coordination opportunities that must be in place between the Contractor and the DMAS Service Authorization Contractor must include, but are not limited to, the following circumstances:

1. Receiving referrals for services covered under this Contract from the DMAS Service Authorization Contractor;
2. Providing care coordination assistance along with referrals for Members with special medical and/or behavioral health needs, high-risk cases, and other circumstances as warranted;
3. Ensuring Warm Transfer of telephone calls from Members to the correct entity;
4. Ensuring collaborative discussions between the Member's Care Manager and the DMAS Service Authorization Contractor;
5. Facilitating effective transition and continuity of care for Members who move between fee-for-service and Managed Care enrollment, or who move between levels of care managed by the Contractor and DMAS Service Authorization Contractor, or who need or receive services concurrently through the Contractor and the DMAS Service Authorization Contractor See Section 8.11, *Administrative Transitions*; and
6. Sharing clinically relevant information for care coordination purposes in a manner that complies with State and Federal confidentiality regulations, including:
    a. HIPAA regulations at 45 CFR 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
    b. Federal regulations at 42 CFR §2.31(a) pertaining to substance use prevention 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 public interest purpose.]

15. CONTRACTOR PAYMENT AND FINANCIAL PROVISIONS

15.1 Financial Liability for Covered Services

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.

15.2 Capitation Payments

The Contractor must accept, as payment in full for all covered services, the capitation rate(s) and the terms and conditions of payment set forth herein.

Notwithstanding any contractual provision or legal right to the contrary, the parties to this Contract agree there must be no redress against the other party, or their actuarial contractors, over the actuarial soundness of the capitation rates.

By signing this contract, the Contractor accepts that the capitation rate(s) offered is reasonable; that operating within the capitation rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Department, the Contractor must rely on its own resource to project likely experience under the Contract.

15.2.1 General Capitation Payments and Processes

The Department will issue capitation payments on behalf of members at the actuarially sound 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 CFR §438.3(c)(2). The Contractor must accept the established capitation rate paid monthly by the Department and any "kick payments," one-time fixed, supplemental payments from the Department to enable the Contractor to provide coverage without assuming financial risk, 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. In accordance with 42 CFR §438.604(a)(2); 42 CFR §438.606; 42 CFR §438.3; 42 CFR §438.5(c), the Contractor must be required to submit data, including encounter data, on the basis of which the Department certifies the actuarial soundness of the capitation rates to the contracted health plans, including base data that is generated by the contracted health plans.

The capitation payments to the Contractor must 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 Contractor has the responsibility of providing services to that member for the entire month. If the member moves outside of the Contractor's plan, 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 Contractor if that individual's FIPS is outside of the Contractor's service area/region. Any and all costs incurred by the Plan

in excess of the capitation payment will be borne in full by the Contractor. The Contractor must accept the Department's electronic transfer of funds to receive capitation payments.

In accordance with 42 CFR §438.5, capitation rate cells are based on several factors (e.g., eligibility group, age, locality, level of care, primary payer, etc.) and are automatically generated by the system using the information in the system at the time of payment. The Contractor must be entitled to a capitation payment for the member based on the recoupment/reconciliation procedures in Section 15.2.2, *Medicaid Capitation Reconciliation and Recoupment* and the Cardinal Care Technical Manual. The Contractor is not be entitled to payment during any month subsequent to status change determination.

Under 42 CFR §438.608(c), the Contractor and any subcontractor must 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. Capitation payments already paid by the Department for months beyond the month in which the event occurred must be repaid to the Department in accordance with the provisions of this Contract. The Contractor must provide the Department with its policies and procedures for identifying excess payments as required by the Cardinal Care Technical Manual.

The rate cells are included on the rate pages attached to this contract. The Department will utilize a blended rate for populations that meet Nursing Facility Level of Care criteria and receive services either in a nursing home setting or in the community under the CCC Plus Waiver, at the standard benefit. The blended rate will be based on target percentages for the mix of Member months in nursing homes and the CCC Plus Waiver standard benefit that are designed to keep improving the percentage of Members in the community under the CCC Plus Waiver, standard benefit. Blended rates will be determined prospectively based on each plan's Nursing Facility/CCC Plus Waiver standard benefit population mix.

The Department will conduct periodic audits to validate rate category assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by the Department.

The Department may suspend payments to Contractor in accordance with 42 CFR §455.23 as determined necessary or appropriate by the Department.

The Department may propose modifications, additions, or deletions to the rate cell structure over the course of the Contract or in future contracts. Any changes will be reflected in a modification to the Managed Care Contract.

Rates are updated using a similar process for each contract year. Rate changes would be considered for budget changes effective during the contract year that affect one (1) or more adjustments to the capitation rates, any changes to contracts that are used as the basis for adjustments to the capitation rates, other policy changes or more current information necessary to calculate accurate payment rates for the Contract. Changes would be considered material if it exceeds half of one percent (0.5%) for any eligibility category. Changes will be applied, if necessary on a retrospective basis, to effectuate accurate payments for each month.

In accordance with 438.4(c), if the Department is increasing or decreasing rates within a previously certified rate range without submitting a rate certification, the rate change must be within 1 percent (1%) per rate cell within the rate range previously certified for the application rating period.

All incentive arrangements described in this contract comply with 42 CFR §438.6(b) and 42 CFR §438.6(c).

15.2.2 Medicaid Capitation Reconciliation and Recoupment

The Department will implement a process to reconcile Enrollment and Capitation Payments for the Contractor that will take into consideration the following circumstances:

1. Transitions between rate categories;
2. Retroactive changes in eligibility, rate categories, or Member contribution amounts, level of care, Member FIPS; and
3. Changes through new Enrollment, disenrollment, or death.

The capitation rates will be updated following a change in a Member's status relative to the rate cell. As part of capitation payment processing, the rating category of each Member will be determined based on their status on the first (1st) day of the month. The reconciliation may identify underpayments or overpayments to the Contractor.

Retroactive adjustments to enrollment and payment must be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor must cover retroactive adjustments to enrollment without regard to timelines of the adjustment. The Contractor must assure correct payment to providers as a result of enrollment updates/corrections. The Department will assure correct payment to the Contractor for any retroactive enrollment adjustments.

The Department will recoup a Member's capitation payment for a given month in cases in which a Member's exclusion or disenrollment was effective retroactively. The Contractor may retract provider payments made during a period while the enrollee was not eligible and instruct the provider to invoice the Department for payment. The Department will 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 or FAMIS eligibility, transfer to an excluded Managed Care program Medicaid category, change in level of care status, or change to Member FIPS. 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.) In these cases the total capitation payment for the month will be rescinded.

When membership is disputed between two (2) Contractors, the Department will be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

If this Contract is terminated, recoupments must 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 will reconcile payments on a quarterly basis. The quarterly reconciliation will be based on adjustments known to be needed through the end of the quarter. The reconciliation payment adjustments will be reflected in the capitation payment process. See the Cardinal Care Technical Manual for detailed information.

15.2.3 Maternity Kick Payments

In addition to monthly capitation payments, the Department will make a "kick payment" for all maternity deliveries. The maternity payment reimburses health plans for their inpatient and professional payments associated with a live birth. A delivery is defined based on the following surgical procedure codes:

1. 10D00Z0: Classical C-Section
2. 10D00Z1: Low Cervical C-Section
3. 10D00Z2: Extraperitoneal C-Section
4. 10D07Z3: Low Forceps Vaginal Delivery
5. 10D07Z4: Mid-Forceps Vaginal Delivery
6. 10D07Z5: High-Forceps Vaginal Delivery
7. 10D07Z6: Vacuum Vaginal Delivery
8. 10D07Z7: Internal Version for Vaginal Delivery
9. 10D07Z8: Other Vaginal Delivery
10. 10E0XZZ: Delivery, Products of Conception, External, No Device, No Qualifier

A maternity kick payment will be triggered upon receipt of a valid encounter with one (1) of the qualifying procedure codes above. Maternity kick payments will be generated once a month for all qualifying encounters in the prior month.

15.2.4 Payments for Newborns

Until such time that a newborn is assigned a Medicaid, FAMIS, or FAMIS Plus 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. The Department will reconcile newborn payments on a monthly basis.

15.2.5 Hospice Claims

Non-institutional hospice services must be paid by the Contractor based on the Member FIPS. The Department's hospice revenue codes and rates for non-institutional claims are available on the DMAS website.

For Members that reside in a nursing facility and are enrolled in a Medicaid approved hospice program, the Contractor must pay the nursing facilities payment for room and board charges directly rather than paying the hospice provider. Payments made to the nursing facility must be the full amount that would be paid to the nursing facility if the Member was not receiving hospice services. The hospice provider is reimbursed for the hospice services provided to the Member in the nursing facility.

Refer to Attachment E, Cardinal Care Summary of Covered Benefits Chart.

15.2.6 Performance Withhold Program (PWP)

The PWP includes measures designed to evaluate Managed Care quality by setting performance standards and expectations for Contractors in key areas influencing member health and health outcomes. The PWP utilizes a financial incentive structure withholding a set percentage of the Contractor's PMPM capitation rate system payments that the Contractor can subsequently earn back based on performance attainment or improvement against the designated measures. By tying financial incentives to Contractor performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members.

15.2.6.1 **PWP Assessment and Program Measures**

The Department contracts with its EQRO to implement the methodology for validation and performance assessment of all metrics included in the PWP. 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 distributed as part of the Cardinal Care Technical Manual and can also be found on the Department's VBP website.

The PWP withhold percentage is one percent (1%) of the Contractors' PMPM capitation rate system payments. Consistent with the methodology developed with the EQRO, the Department will determine the portion of the withhold each Contractor can earn back based on the extent to which the Contractor's performance compares favorably against benchmarks set for each measure.

The PWP Measures below are further described in PWP Technical Manual.

PWP Measures

Measure Indicator	Appendix A Measure Number	Measure Specification Source	Required Reporting Method
Behavioral Health			
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total	1.4	HEDIS	Administrative
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—30-Day Follow-Up— Total		HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	1.2	HEDIS	Administrative

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total		HEDIS	Administrative
Initiation of SUD Treatment		HEDIS	Administrative
Engagement of SUD Treatment		HEDIS	Administrative
Child Health			
Child and Adolescent Well-Care Visits—Total		HEDIS	Administrative
Childhood Immunization Status—Combination 3		HEDIS	Hybrid
Chronic Conditions			
Asthma Admission Rate (per 100,000 MM)		AHRQ PDI	Administrative
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	1.5	HEDIS	Hybrid
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	1.39	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	1.38	CMS Adult Core Set	Administrative
Maternal Health			
Timeliness of Prenatal Care		HEDIS	Hybrid
Timeliness of Postpartum Care		HEDIS	Hybrid

The Department reserves the right to amend the measures included under the PWP composite in future years and may further amend performance thresholds associated with satisfactory performance, the withhold percentage, and other features necessary for implementation of the PWP at its discretion and will make any such changes to the PWP known to Contractors and the public through adjustments to the Managed Care program Contract and PWP methodology documents posted on the Department's VBP website.

15.2.7 Clinical Efficiencies (CE)

In December 2016, the Joint Legislative Audit and Review Commission (JLARC) published a study titled *Managing Spending in Virginia's Medicaid Program*. Among the study's recommendations, JLARC called for the Department to work with its actuary to identify potential inefficiencies in the Medicaid Managed

Care programs and adjust capitation rates to account for these efficiencies. The Virginia General Assembly subsequently enacted, and the Governor signed, budget language to execute this recommendation. To implement this mandate, the Department contracted with its actuary to identify CE under its Managed Care programs. The first set of CE analyses focus on medically unnecessary, avoidable, or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits, as well as efficient utilization and management of prescription drugs.

In accordance with 42 CFR § 438.6(b)(3)(i) – (v) and 42 CFR § 438.340, CE:

1. Is for a fixed period of time and will not be renewed automatically;
2. Is available to both public and private Contractors under the same terms of performance;
3. Does not condition Contractor participation in CE on the Contractor entering into or adhering to intergovernmental transfer agreements; and
4. Is necessary for activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the Department's quality strategy.

15.2.7.1 CE Performance Measurement

To allow for more current and active measurement of the CE areas, the Department developed CE performance measures relating to hospital admissions, hospital readmissions, and emergency department visits. These measures allow the Department to run the CE analysis on the most recently completed contract performance year data and facilitate transparency in the calculation of each measure. As part of this transparency, the Department makes the CE performance measure technical specifications, associated value sets, and measure output available on the Department's VBP website. The Department also provides annual performance reports to the Contractor illustrating the Contractor's performance across these three (3) CE areas through the Department's online Clinical Efficiencies Dashboard. Performance is measured during the rating period under the contract in which CE is applied.

15.2.7.2 CE Performance Incentives

The Department will apply a quarter of one percent (0.25%) capitation rate withhold specifically devoted to the Contractor's performance on the three (3) CE performance measures pertaining to hospital admissions, hospital readmissions, and emergency department visits. Prior to the start of each SFY, Contractors will receive a customized report from the Department illustrating the performance levels it must achieve on each measure to earn back the CE withhold amount. This report will illustrate the Contractors results on each measure and thresholds for full and partial credit in a given SFY for each of the three (3) CE performance measures. This withhold methodology has the benefit of rewarding Contractors that remove inefficient utilization from the health care system through the provision of high quality care that improves member health and health outcomes.

The Department will evaluate Contractor performance using an SFY performance window (July 1 through June 30) after allowing a six (6) month claims run-out period to ensure data completeness. The Department will evaluate CE measure performance using only encounter data submitted by the Contractor. No other data will be used in assessing the Contractor's performance under these three (3)

CE performance measures, so all Contractors should take the necessary steps to ensure their data are accurate and complete prior to the end of the six (6) month claims run-out period following each SFY.

15.2.7.3 **CE Final Determinations**

The Department reserves the right to amend, adjust, or otherwise modify any and all provisions, in part or in whole, associated with application of the CE performance measures and associated withhold, including, but not limited to, the adjustment of performance thresholds associated with CE measures in the event mitigating and/or unforeseen factors make the achievement of such results unreasonable.

The Department will make all final determinations on Contractor CE measure performance, reasonableness determinations, and the corresponding amount of the CE withhold the Contractor earns back based on its CE measure performance. The Department will work with the Contractors to address any disagreements in determinations on these points, but in the event that the Department and the Contractor are unable to come to agreement, Department decisions are final and not subject to appeal.

15.2.8 Discrete Incentive Transition Program

The Managed Care Discrete Incentive Transition Program (as used in this section, the "program") provides financial rewards for Contractors that successfully transition complex Members residing in a nursing facility (NF) to a home- and community-based setting for a sustained period. Members' ability to receive services in their community offers the potential for improved health status and quality of life at a lower cost. Transitions from a NF or institutional setting to the community can be challenging, particularly for Members doing so following an extended NF stay. For those Members, it is often necessary to research and rebuild a significant number of medical and social supports essential for them to sustain a successful transition to their community. Such transitions require additional effort and resources, and the Department will reward Contractors when these transitions result in better care outcomes and quality of life for Members. For the purposes of this program, the Department defines a successful transition as the transition of a NF resident that has received NF services for at least one (1) continuous year to a community setting for a period of at least nine (9) consecutive months, during which the Member does not receive more than thirty (30) combined days of care in an inpatient hospital setting.

15.2.8.1 **Eligible Member Requirements**

Managed Care Members eligible for this program are those Members with:

1. Continuous residence in a NF for a period of at least twelve (12) consecutive months; and,
2. Continuous benefit package of indicator of one (1) or two (2); and,
3. Are enrolled in the Managed Care Program in the month prior to their transition.

The Department will send each Contractor a list of its Members who meet these criteria and are thus eligible under the program. The Department will work with Contractors to verify and validate that the identified Members are eligible under the program. The Department will distribute such lists three (3) times a year in May, September, and January. All Member transitions to the community under this program must be voluntary and done with the informed consent of the Member. No requirements of this program may be interpreted to impinge on a Member's ability to return to a NF setting of care at

any time and for any reason should they so choose when such return is consistent with appropriate medical practice.

15.2.8.2 **Successful Transition Requirements**

For an eligible Member to be deemed a successful transition under the program, the Member must:

1. Transition to a community setting and receive waiver services;
2. Maintain their waiver status for at least nine (9) consecutive months; and
3. Experience no more than thirty (30) combined days of care in an inpatient hospital setting during this nine (9)-month period.

For those individuals included on the list of eligible Members, the Department will track transitions to the community, the duration of the eligible Member's community status, and any instances of care the Member receives in an inpatient hospital setting. For those eligible Members that register nine (9) months of continuous community status, the Department will notify the Contractor of successful transitions three (3) times a year in August, December, and April. The Department will verify, in consultation with the relevant Contractors, whether an identified Member constitutes a successful transition.

15.2.8.3 **Financial Incentives**

Contractors will receive a one (1) time payment of $7,500 for each successful transition accomplished under the program. The Department will verify all successful transitions accomplished by Contractors annually, making applicable bonus payments to Contractors in May/June of a Contract year. A Contractor may only earn a bonus payment one (1) time for an eligible Member in a three (3)-year period.

15.2.8.4 **Final Determinations**

The Department will make all final determinations on what constitutes an eligible Member, successful transition, and proper application of financial incentives earned by the Contractor. The Department will work with Contractors to address any disagreements in determinations on these points, but in the event the Department and the Contractor are unable to come to agreement, Department decisions are final and not subject to appeal.

15.3 Financial Processes

15.3.1 Certification (Non-Encounters)

The Contractor must submit non-encounter financial information (sub-capitation payments, rebates, other financial transactions, etc.) requested by the Department at least quarterly to be used in capitation rate setting. Any payment information from the Contractor that is used for rate setting purposes which has not been submitted through the Encounter Processing System of the Medicaid Enterprise System 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 the Certification of Data form (see Attachment F, Certification of Data (Non-Encounter)), for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form and compliance with Va. Code §2.2-4342(F) will ensure that the amount paid to providers by the Contractor must not be subject to Freedom of Information Act (FOIA) requests, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance and Title XXI.

15.3.2 Financial Transactions

The Contractor must:

1. Collect and maintain one hundred percent (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 two (2) business 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 must be detailed in supporting documentation.

15.3.3 Financial Report to the Department

The Contractor must submit quarterly financial reports to the Department's Provider Reimbursement Division broken out by Base Medicaid and Medicaid Expansion that details revenue, medical expenditures by category, total Member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, balance sheets, detailed information on related party transactions and all administrative expenses associated with the Managed Care program using the format developed by the Department as specified in the Cardinal Care Technical Manual. The report must be submitted on a quarterly basis to the Department following the same schedule as reports for the BOI with the exception of the 4th quarter report also known as the annual report which must be submitted within two (2) weeks after the BOI due date. This report is subject to audit and verification by the Department.

On an annual basis, each Contractor must 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. In reporting expenses to the Department, the Contractor must ensure that expenses must be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses.

Non-allowable expenses for Medicaid reimbursement include but are not limited to:

1. Related party management fees in excess of actual cost;
2. Lobbying expenses, Contributions, State and Federal income taxes;
3. Administrative fees for services provided by a parent organization, which did not represent a passthrough of actual costs;

4. Management fees relating to non-Virginia operations;
5. Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific MCO enrollees;
6. Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a passthrough of actual costs;
7. Accruals for future losses;
8. Reserves based on estimates for bankrupt providers; and/or
9. Unsupported medical expenses.

15.3.4 Financial Records

Throughout the duration of the Contract term, the Contractor must 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 must have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor must enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Department at least thirty (30) calendar days prior to making any changes to its basis of accounting.

15.3.5 Financial Solvency

Pursuant to Section 1903(m)(1) of the Act and § 438.116(b), 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.

The Contractor must 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. Pursuant to 42 CFR §438.3(m), the annual audited financial report must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The Contractor must provide the Department a copy of such an audit within sixty (60) calendar days of completion of the audit.

The Department will be working to develop enhanced level financial reporting modeled closely after BOI reports. Report specifications and templates can be found in the Cardinal Care Technical Manual.

15.4 Minimum Medical Loss Ratio (MLR) and Limit on Underwriting Gain

The Contractor must 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. The MLR is calculated first followed by the calculation of the Underwriting gain limit. In accordance with 42 CFR §438.8(k) and §438.8(n), the Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

In accordance with 42 CFR §438.8(c), the Contractor must be subject to a minimum MLR of eighty-five percent (85%). Pursuant to 42 CFR §438.8, the MLR must be determined as the ratio of (i) incurred

claims plus expenditures for activities that improve health care quality plus expenditures on activities related to fraud prevention, divided by (ii) adjusted premium revenue. Pursuant to 42 CFR §438.8, if the MLR for a reporting year is less than eighty-five percent (85%) then the Contractor must make payment to the Department equal to the deficiency percentage applied to the amount of adjusted premium revenue.

Pursuant to 42 CFR §438.8, the Contractor is required to submit a report annually that includes information for each MLR reporting year for both Base Medicaid Members as well as Medicaid Expansion Members. The Contractor must 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 must be the contract year.

Pursuant to 42 CFR §438.8, when reporting expenses, the Contractor must ensure that each expense must be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. In accordance with 42 CFR §438.8, expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. The MLR must reflect the following, if applicable:

1. Expenditures that benefit multiple contracts or populations (such as Medicaid Expansion and non-Expansion), or contracts other than those being reported, must be reported on a pro rata basis, per 42 CFR §438.8(g)(1)(ii);
2. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract and/or population incurring the expense, per 42 CFR §438.8(g)(2)(ii); and
3. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities, per 42 CFR §438.8(g)(2)(iii).

In accordance with 42 CFR §438.8(k) and § 438.8(m) and, in any instance where the Department makes a retroactive change to the capitation rates for an MLR reporting year where the MLR report has already been submitted to the Department, the Contractor must recalculate the MLR for all MLR reporting years affected by the change and meeting the applicable requirements. Additionally, in any instance where a state makes a retroactive change to the capitation rates for a MLR reporting year where the MLR report has already been submitted to the state, the MCO must submit a new MLR report meeting the applicable requirements.

In accordance with 42 CFR §438.8(h), the Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the Department as described in 42 CFR §438.8(j). The Contractor must not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

In accordance with 42 CFR §438.8(k)(3), the Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the

Contractor within one hundred and (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. Reporting specifications will be included in the Cardinal Care Technical Manual and the Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

In accordance with 42 CFR §§ 438.8, 438.608, and 438.3, the Contractor must report to the Department the following information for each MLR reporting year based on data through March 31st of the following the MLR reporting year:

1. Total incurred claims;
2. Expenditures on quality improving activities;
3. Expenditures on activities related to fraud prevention;
4. Non-claims costs;
5. Premium revenue;
6. Taxes, licensing and regulatory fees;
7. Methodology for allocation of expenditures;
8. Any credibility adjustment applied;
9. The calculated MLR;
10. Any remittance owed to the State;
11. A reconciliation of the information reported in this report with the audited financial report;
12. A description of the aggregation method by covered population; and
13. The number of member months.

Total incurred claims must exclude non-claim costs such as amounts paid to third party vendors or subcontractors for network development, administrative fees, claims processing, and utilization management. If the Contractor utilizes a sub capitation arrangement for certain members or services, then the total incurred claims must include the amount paid to the subcontractor to provide those benefits less any portion of the sub capitation which represents non-claim costs.

If the Contractor is required to make a payment to the Department, the payment will be due to the Department no later than June 15th of the subsequent MLR reporting year.

The Contractor will be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid adjusted premium revenue. The percentage must be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid adjusted premium revenue for the calendar year developed in the same manner as the MLR (i.e. with data through the March 31st following the MLR reporting year). Such amounts will be determined consistent with the reporting requirements for the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance with one (1) exception. The non-claims costs should exclude the amount, if any, of non-allowable expenses as described in Section 15.3.3, *Financial Report to the Department*.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds three percent (3%) then the Contractor must make payment to the Department equal to one-half (1/2) of the underwriting gain in excess of three percent (3%) of Medicaid adjusted premium revenue up to ten percent (10%). The Contractor must return one hundred percent (100%) of the underwriting gain

above ten percent (10%). 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 must refund to the Department three percent (3%) of Medicaid adjusted premium revenue. If the underwriting gain is eleven percent (11%) then the Contractor must refund to the Department four and one half percent (4.5%) of Medicaid adjusted premium revenue. If the underwriting gain is four percent (4.0%) then the Contractor must refund to the Department half of one percent (0.5%) of Medicaid adjusted premium revenue.

All of the variables used in the calculation of the underwriting gain limit and the amount of any resulting payment must be determined as if the limit did not exist but must 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 contract year if the Contractor has fewer than 120,000 member months during the contract year. If the Contractor is required to make a payment to the Department under this Contract provision, the payment must be due to the Department no later than June 15th following the contract year.

The Contractor is prohibited from providing bonus and/or incentive payments to network providers or subcontractors which are determined based in whole or in part on the applicability of this Contract provision.

15.5 Pharmacy Reinsurance Pool

The Department will operate a Pharmacy Reinsurance pool. The objective of the pool is to spread the risk of excessive pharmacy claims equitably across all participating Contractors. Ninety percent (90%) of a Member's annual prescription drug costs above a $200,000 attachment point will be aggregated/pooled across all Contractors participating in the Managed Care program. The $200,000 attachment point is used for an annual contract. The attachment point amount will be prorated for contract durations other than annual. Such claims will be referred to as pharmacy reinsurance claims.

The amount to be used in the computation of a Member's annual prescription drug costs will be the Contractor paid amount after reduction by any Medicare/TPL payment. A Member's annual prescription drug costs must include retail and mail order prescriptions, as well as prescription drugs administered in a physician's office or outpatient hospital setting. Prescription drugs administered in an inpatient hospital setting will be included if they meet the following requirements:

1. The drug (NDC included) and drug cost are itemized and identifiable on the claim and the claim is not paid as a bundled payment; and
2. The drug is classified by the FDA as a cell and gene therapy with the requirement that the therapy is only available to be administered in an inpatient setting.

The Department will notify the Contractor quarterly of all Members whose prescription drug costs have exceeded the $200,000 attachment point during the contract year. All reinsurance claims are subject to medical review by the Department.

The Department will allocate the aggregate/pooled reinsurance claims to each MCO on the basis of premium revenue. Contractors whose total pharmacy reinsurance claims in the contract year exceed the allocated pooled amount will be reimbursed for the excess. Contractors whose total pharmacy reinsurance claims are less than the allocated pooled amount will be required to reimburse the Department for the deficiency. The total of the excess and deficient amounts for all Contractors will offset such that the Department bears no risk with regard to the underlying pharmacy reinsurance claims. The Department will send each Contractor a report documenting pharmacy reinsurance claims (including thirty [30] days of runout) within sixty-five (65) calendar days of each quarter end for the first three (3) quarters of the contract year. The quarterly periods end on March 31, June 30, September 30 and December 31 of the contract year. The deadline for the final quarter, ending June 30 (including ninety [90] days of runout), will be four and one half (4.5) months following the quarter end, to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will determine and report the allocated/pooled amount quarterly by Contractor or provide notice to each Contractor if additional information is required.

The Department reserves the right to perform audits on reinsurance claims. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

15.6 Refund of Capitation Payment for IMD Stays Exceeding 15 Days in a Calendar Month

Per section 5.5.1.2*, IMD Enhanced and State Plan Substituted (In Lieu of) Services for Certain Medicaid Members,* the Contractor must refund the full capitation payment paid by the Department for any treatment provided to the Member in a psychiatric IMD where the length of stay in the IMD exceeds fifteen (15) days during the calendar month. Such amount will be remitted to the Department as a refund of an overpayment.

16. CRITICAL INCIDENT REPORTING

16.1 Critical Incident Policies and Procedures

The Contractor must provide its Critical Incident policies and procedures to the Department for review and approval. The policies and procedures must reflect how the Contractor: (1) identifies, documents, tracks, reviews, and analyzes Critical Incidents, including Sentinel Events, and (2) addresses potential and actual quality of care and/or health and safety issues.

The Contractor must develop a process for identifying Critical Incidents that occur during:

1. The provision of Medicaid-funded services to Members in nursing facilities, inpatient behavioral health settings, and inpatient substance use disorder treatment facilities; and
2. Participation in or receipt of Mental Health Services, ARTS, or CCC Plus Waiver services in any setting (e.g., an adult day care center, a Member's home, any other community-based setting).

16.2 Provider Reporting and Notification to the Contractor of Critical Incidents

The Contractor must require all providers to comply with Critical Incident requirements. The process for the identification of Critical Incidents must include both provider education as well as use of the Critical Incident reporting form which must be used by all staff and network providers. (Refer to Section 16.3, *Reporting and Notification to the Department of Critical Incidents*). Provider agreements for applicable providers must include Critical Incident reporting requirements. Critical Incidents must be categorized as a Quality of Care Incident, Sentinel Event (see Section 16.4, *Reporting to the Department of Sentinel Events*), or Other Critical Incident. See Section 22, *Definitions*.

The Contractor must require its staff and network providers to report, respond to, and document Critical Incidents in accordance with the Department's requirements and 42 CFR § 438.330(b). The Contractor must require Contractor staff and network providers to report Critical Incidents within twenty-four (24) hours. If the initial report of a Critical Incident is submitted verbally, the party (person/agency/entity) making the initial report must submit a follow-up written report to the Contractor within forty-eight (48) hours. The Contractor must describe how these reporting requirements are ensured in the submission of its policies and procedures.

16.3 Reporting and Notification to the Department of Critical Incidents

The Contractor must report Critical Incidents, including Sentinel Events, to the Department quarterly. All reporting elements must be reported as specified in the Cardinal Care Technical Manual, including a concise summary of the follow-up performed and Member outcomes. The Contractor must provide appropriate follow-up on reported Critical Incidents within thirty (30) days or as expeditiously as the Member's condition or situation warrants.

The Contractor must regularly review the number and types of Critical Incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (e.g., findings from Adult Protective Services (APS), Child Protective Services (CPS)); identify trends/patterns and opportunities for improvement; and develop, implement, and evaluate strategies to reduce the occurrence of Critical Incidents.

As a part of Critical Incident Reporting and Management, the Contractor must participate, when requested by the Department, in a Mortality Review Team. The purpose of the team will be to review findings, cause, and prevention of Critical Incidents. The Mortality Review Team must consist of individuals from the Department and other Cardinal Care Contractors.

16.4 Reporting to the Department of Sentinel Events

Sentinel Events, as defined in Section 22, *Definitions*, signal the need for immediate investigation and response. The Contractor must provide the Department with reports of Sentinel Events within one (1) business day of discovery. This includes Sentinel Events reported by staff and network providers for all Members. See the Cardinal Care Technical Manual for details. Not all Critical Incidents will be considered Sentinel Events. Therefore, the Contractor must maintain a specific system for identifying and recording any Member's Sentinel Event as a Sentinel Event; and, in addition to reporting them as such within the

required timeframe, Sentinel Events must be reported as Critical Incidents on the quarterly Critical Incident report.

17. OVERSIGHT

17.1 Contract Violations and the Compliance Enforcement Process

The Contractor must meet or exceed all the performance standards that are part of this Contract. The Department is responsible for conducting ongoing contract compliance monitoring and enforcement and reserves the right to impose any and all remedies available under the Contract, law, and regulations. These remedies include, but are not limited to, remedial actions, intermediate sanctions, escalating compliance enforcement actions, liquidated damages, and/or termination of the Contract as described in Section 21.2.40, *Contract Termination*. In no event will the application of any remedies preclude the Department's right to any other remedy available in law or regulation.

As part of this process, the Department will review the performance of the Contractor in relation to the performance standards outlined in this Contract and those described in the Cardinal Care Technical Manual, Encounters Technical Manual, and in any other applicable DMAS directive. Compliance enforcement actions related to performance standards are described in Section 17.1.2, *Escalating Compliance Enforcement Points Violations* and 17.1.3, *Liquidated Damages*.

The Department's compliance monitoring program includes:

1. Collecting and reviewing standard hard copy and electronic reports and related documentation, including encounter and other data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;
2. Conducting Contractor, network provider, and subcontractor site visits; and,
3. Reviewing Contractor policies and procedures, and other internal documents.

A maximum of one compliance enforcement action will be applied by the Department per individual contract violation, however, unresolved or ongoing non-compliance may result in the escalation of compliance enforcement actions. The Department reserves the right to impose any applicable compliance enforcement action upon discovery of non-compliance or violation that was not previously known or reported to the Department.

Compliance Enforcement Actions, including the assessment of Liquidated Damages or imposition of sanctions issued through the Department's Compliance Enforcement Process, will be deducted from the Contractor's monthly capitation payment. Deductions will be initiated within thirty (30) calendar days from the end of the Comment Period described in any issued compliance letters, unless disputed through the process described in Section 20, *MCO Contract Disputes*. Each month is a separate period for measuring the failure to achieve the performance standards.

If any failure to meet a performance standard is directly and solely attributable to (i) a force majeure event; (ii) actions or omissions of the Department or a breach by the Department of the contract; or (iii), unforeseeable actions or omissions by a third party outside of Contractor's reasonable control (any

action or inaction taken by a third party which causes an adverse effect on Contractor's ability to provide the Services to meet the performance standard(s) under the contract), the Department will not take Compliance Enforcement Action(s) against the Contractor. The use of subcontractors is foreseeable and any actions or omissions by a subcontractor are within the Contractor's reasonable control.

If the Contractor is unable to meet a performance standard or requirement that is not within its control (i.e. weather, system down, etc.) a written request may be submitted to the Department to waive or forego any / all or part of a particular day, month, or period of when such occurrence took place. Any such requests must be received within five (5) business days of the occurrence or period and detail why the expected standard or requirement could not be met in its entirety. Exceptions shall be reviewed on an occurrence-by-occurrence basis by the Department. The Department's approval of an exception request for a performance standard or requirement is not deemed a waiver of any Compliance Enforcement Action or remedy available to the Department under the Contract, law, or regulation.

Each performance standard is unique unto itself. If the failure to meet a performance standard affects another performance standard, each will be treated separately and an appropriate cure period and liquidated damages or remedies will apply.

17.1.1 Compliance Point System

The Department and the Contractor agree that if the Contractor or its subcontractor violates the Contract, the Contractor will be subject to the compliance point system described in this Contract in addition to any remedies the Department may have pursuant to the Contract, law, or regulation. The Department will evaluate non-compliance based on the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident

The Department will utilize a compliance point system in response to the Contractor's, or its subcontractor's, non-compliance with the standards and requirements outlined in this Contract and all technical manuals incorporated by reference. Points will be issued for each incident of non-compliance as outlined in Section 17.1.2, *Escalating Compliance Enforcement Points Violations*. Contractor compliance from the previous calendar month will be reviewed by the Department on a monthly basis and any points issued will accumulate over a rolling twelve (12)-month schedule. The failure to resolve a compliance issue in the timeframe specified by the Department will result in a new, escalated compliance action as detailed in Section 17.1.2, *Escalating Compliance Enforcement Points Violations*.

As compliance points accrue, escalating Contract Enforcement Actions will apply. These escalating Compliance Enforcement Actions, including liquidated damages as described in the chart below, will be assessed each month in which the Department issues new points to the Contractor as a result of any new compliance violations. The liquidated damages assessed will be based on the total number of points the Contractor has accumulated through the current month. For example, if the Contractor has accumulated one (1) point during the previous twelve (12) months and is issued a five (5) point violation, no liquidated damages would be assessed as a result of the new five (5) point violation because the Contractor's accumulated points would total six (6) for the twelve (12)-month period. However, if the Contractor has accumulated ten (10) points during the previous twelve (12) months and is issued a five (5) point violation, $15,000 in liquidated damages will be assessed in response to the new five (5) point

violation because the Contractor would now have accumulated fifteen (15) total points. Compliance enforcement action, including liquidated damages, will not be assessed under this Section if the Contractor is not issued any new points for non-compliance for the current month.

Points Accumulated During Twelve (12)-month Period	Compliance Enforcement Actions
0-10	None
11-25	$15,000 liquidated damages
26-50	$30,000 liquidated damages
51-70	$60,000 liquidated damages
71-100	$90,000 liquidated damages
101-150	Suspend Enrollment
>150	Possible Agreement Termination

17.1.2 Escalating Compliance Enforcement Points Violations

One (1) Point Violations:

1. Inaccurate or improperly formatted submissions of a deliverable or report as described in this Contract, the Cardinal Care Technical Manual, or Cardinal Care Encounter Technical Manual. One (1) point will be assessed for each deliverable that is inaccurate or improperly formatted.
2. Failure to submit a report or deliverable in the timeframe established by the Department or in accordance with the Cardinal Care Technical Manual or Cardinal Care Encounter Technical Manual.
3. Failure to provide data to DMAS in a timely or accurate manner, as required by this Contract and any Technical Manuals issued by the Department.
4. Failure to timely or accurately adjudicate claims in compliance with Section 12.1, *General Provider Payment Processes*.
5. Use of unapproved marketing or Member materials. Requirements for the approval of marketing or Member materials are described in Section 4.3, *Member Materials* and Section 4.4 *Marketing Requirements*.
6. Failure to comply with the reporting requirements of the Virginia All-Payer Claims Database per Section 11.15, *All-Payer Claims Database*.
7. Failure to appropriately stratify a member into the appropriate intensity of care management, as required by Department and/or the Contractor's policies described in Section 8.4, *Care Management*.
8. Failure to meet the target set for the Payment Cycle Certification Timeliness, as defined in the Encounters Technical Manual.
9. Failure to meet the target set for Encounter File Certification Timeliness, as defined in the Encounters Technical Manual.

10. Failure to ensure that the Contractor's systems allow the Care Coordination Platform and Triage Algorithm to be continuously updated with ADT feeds from the Emergency Department Care Coordination solution. Reference Section 5.7.6, *Virginia Emergency Department Care Coordination Program*.
11. Failure to meet any additional requirement as specified in this Contract that is not specifically identified in this Section.

Five (5) Point Violations:

1. Failure to provide Member materials to a new Member in a timely manner, as described in Section 4.3, *Member Materials*.
2. Failure to appropriately notify the Department, or Members, of provider panel terminations as required by Section 7.3.7.2, *Notice to the Department of Provider Termination*.
3. Failure to submit a CAP (Corrective Action Plan) required by the Department in Section 17.1.6.3, *Corrective Action Plans*.
4. Failure to actively participate in quality improvement projects or performance improvement projects facilitated by the Department and/or the EQRO as described in Section 10, *Quality Improvement* and Section 10.11, *EQRO Quality Activities*
5. Failure to achieve quality metrics set forth in Section 10.6, *HEDIS® and CAHPS Quality Measures and Reporting,* and Section 10.7, *Other Department Priority Quality Measures and Reporting*. This compliance enforcement action will not be imposed in addition to the Performance Withhold Program (PWP) should failure to meet performance expectations occur for those identified quality measures in the PWP program.
6. Failure to meet or maintain required ratios for care managers to members as required in Section 8.4.4, *Care Management Staffing Ratios*.
7. Failure to complete a Health Risk Assessment within the time frames established by Section 8.5.3, *HRA Completion Timeframes* of this Contract for at least ninety-five (95%) of members in receipt of/eligible for care management on a monthly basis.
8. Failure to remedy noncompliance related to a one (1)-point violation in a subsequent, but consecutive measurement period.
9. Failure to disclose ownership and control changes within the timeframes established in Section 2.9, *Ownership and Control Interest*.
10. Failure to meet the target set for Payment Cycle Entry Timeliness, as defined in the Encounters Technical Manual.
11. Failure to meet the target set for Encounter Submission Timeliness, as defined in the Encounters Technical Manual.
12. Failure to meet for the target set for Encounter Completeness Reconciliation, as defined in the Encounters Technical Manual.
13. Failure to meet the target set for General Provider Payment Timeliness, as defined in the Encounters Technical Manual.
14. Failure to meet the target set for Exception Provider Payment Timeliness, as defined in the Encounters Technical Manual.
15. Failure to comply with requirements set forth in the Encounters Technical Manual for hospital claims.

Ten (10) Point Violations:

1. Failure to maintain and update an Internal Monitoring and Audit Plan, as required by Section 18.2.1, *Monitoring and Auditing Plan*.
2. Failure to notify DMAS of suspected fraud, waste or abuse, allegations of potential improper payments and/or safety concerns of enrollees, as required by Section 18.8, *Reporting Suspected Fraud and Abuse to the Department*.
3. Failure to suspend payments following receipt of payment suspension notice within the timeframes established in Section 12.1.2, *Payment Suspension*.
4. Failure to participate in transition of care activities or discharge planning activities as required by Section 8.10, *Transitional Care Management,* Section 8.11, *Administrative Transitions,* and Section 8.13*, Coordination with the Member's Medicare or Other MCO Plan.*
5. Failure to process service authorization requests within the prescribed timeframes described in Section 6, *Utilization Management Requirements*.
6. Failure to implement or comply with a CAP as required by Section 17.1.6.3, *Corrective Action Plans*.
7. The imposition of cost sharing on Members that are in excess of the cost sharing limits permitted under the Medicaid and FAMIS programs. Reference Section 13, *Cost Sharing and Coordination of Benefits* and the FAMIS Summary of Covered Services chart.
8. Failure to remedy noncompliance related to a five (5)-point violation in a subsequent consecutive measurement period.
9. Violation of mental health parity standards. Reference Section 5.6, *Mental Health Parity and Addition Equity Requirements (MHPAEA)*
10. Failure to meet network adequacy requirements for any provider type listed in the Cardinal Care Technical Manual. Ten (10) points will be assessed per provider type that is deficient and for which the MCO does not have a DMAS approved exception.
11. Failure to monitor network adequacy as required under Section 7.1.8, *Assurances that Access Standards are Being Met*.
12. Failure to appropriately staff the member clinical triage line/behavioral health crisis line, as required by Section 2.12.2.2, *Clinical Triage Line Requirements*.
13. Failure to meet the requirements for Warm Transfer of Member calls that need immediate attention, as required by Section 2.12.2.2 *Clinical Triage Line Requirements*.
14. Failure to comply with internal appeal or grievance requirements set forth in Section 9, *Grievances and Appeals*.
15. Issuance of an Adverse Benefit Determination that fails to meet the requirements of Section 9.4, *Notice of Adverse Benefit Determination*.
16. Failure to comply with the requirements for authorization of EPSDT services, as provided in Section 5.8, *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)*.

17.1.3 Liquidated Damages

The Department reserves the right to assess liquidated damages against the Contractor for specific contract violations, as well as other violations which, in the Department's discretion, have resulted in serious or specific harm to Members, the Department, or other parties.

For the specific contract violations described below, the Department reserves the right to assess liquidated damages in the amount specified.

Liquidated Damages	
Failure to maintain one hundred percent (100%) accuracy for all PDL coding changes based on drug files provided by the Department as required by Section 5.15.1, *Legend and Non-Legend Drug Coverage: Common Core Formulary.*	$5,000 per coding error
Failure to maintain a ninety-five percent (95%) compliance rate to the closed classes of the Department PDL as required by Section 5.15.1, *Legend and Non-Legend Drug Coverage: Common Core Formulary*. The only exception will be for established pharmacological treatment regimens, which must be continued for up to thirty (30) days when a Member transitions from another plan.	$25,000 per quarter
Incomplete or insufficient care plans, described in Section 8, as identified during audits (certain percentage of sample to be defined in audit protocols).	$15,000 per occurrence
Deficiencies in provider access, as required by Section 7, *Provider Network and Access to Care*, identified by secret shopper surveys.	$10,000 per occurrence
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, as described in Section 9, *Grievances and Appeals*.	$15,000 per occurrence
Failure to confirm a valid LTSS screening has been completed documenting the Member meets the level of care requirements for enrollment in the CCC Plus Waiver or Nursing Facility admission, as required by Section 5.12.1, *LTSS Screening Requirements*.	$25,000 per occurrence
Failure to document member care goals in an ICP, as described in Section 8.6, *Person-Centered Individualized Care Plan (ICP)*. Liquidated damages will be assessed when care goals are not documented in at least ninety-five percent (95%) of ICPs reviewed by the Department.	$25,000 when threshold is not met
Failure to provide the required number of minimum care management contacts to at least ninety-five percent (95%) of Members, as required under Section 8.4.5, *Care Management Contact and Format Requirements*.	$25,000 when threshold is not met

The Department further reserves the right to assess liquidated damages for any contract violation not specifically described in this Section.

17.1.3.1 **Other Liquidated Damages**

The Department reserves the right to assess liquidated damages for other contract violations which have resulted in serious or specific harm to Members, the Department, or other parties. Liquidated damages will be calculated based on the specific nature of each contract violation. Where the specific damages resulting from the contract violation may be quantified or calculated with accuracy, the Department will assess liquidated damages in that amount. Where the damages may not be precisely calculated, for whatever reason, the Department reserves the right to assess general liquidated damages in the amount of $250 to $5,000 per day and/or per occurrence based on the severity of the violation and its impact on Members, the Department, or other parties.

17.1.4 Intermediate Sanctions

17.1.4.1 **Basis for Intermediate Sanctions**

In accordance with 42 CFR §700(a), the Department may impose intermediate sanctions based on findings from onsite surveys, member or other complaints, financial status or other sources, if it is determined that the Contractor:

1. Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
2. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
3. Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
4. Misrepresents or falsifies information that it furnishes to CMS or to the State.
5. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§ 422.208 and 422.210 of this chapter.
7. Distributed directly, or indirectly, through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

17.1.4.2 **Types of Intermediate Sanctions**

In accordance with 42 CFR §§438.700, 438.702(a), 438.704(b), and Sections 1903(m)(5)(A)(i), 1903(m)(5)(B), 1932(e)(1)(A)(i), 1932(e)(2)(A)(i), 1932(e)(2)(C), 1932(e)(2)(D), and 1932(e)(2)(E) of the Social Security Act, if the Department, in its sole discretion, determines that the Contractor or its

subcontractor is in violation of the Contract or any other applicable law or regulation, the Department also may impose the following intermediate sanctions against the Contractor:

1. Civil monetary penalties in accordance with 42 CFR §438.704;
2. Appointment of temporary management of the Contractor in accordance with 42 CFR §438.706(a)-(d) and Section 1932(e)(2)(B)(i) of the Social Security Act;
3. Notification to Members of their right to terminate their enrollment with the Contractor without cause in accordance with 42 CFR §438.702(a)-(d);
4. Suspension of all or part of new enrollment, including default enrollment, after the effective date of the sanction in accordance with 42 CFR §438.702(a)(4).
5. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
6. Suspension, recoupment, or withholding of payment in accordance with 42 CFR §438.730;
7. Suspension of all or part of Contractor's marketing activities;
8. Termination of the Contract in accordance with 42 CFR §438.708 and Sections 1903(m), 1905(t) and 1932 of the Social Security Act.
9. Exclusion from participation in Managed Care; and
10. Any other intermediate sanctions, fines, compliance enforcement actions, withholds, or actions that may be set forth in applicable federal law or CMS regulations or permitted under State law, including without limitations, those set forth in 12 VAC 30-120-410.

The Department will give written notice to CMS when it imposes or lifts a sanction for a violation listed in 42 CFR § 438.700.

17.1.4.3 **Notice of Intermediate Sanction**

In accordance with 42 CFR §438.710, except as provided in §438.706(c), before imposing any of the intermediate sanctions specified in this Contract, the Department will give the affected entity timely written notice that explains the following:

1. The basis and nature of the sanction; and
2. The escalation procedures available to the Contractor pursuant to Section 20.1.1, *Escalation Procedures.*

Unless the Department specifies the duration of a sanction, a sanction will remain in effect until the Department is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

17.1.4.4 Civil Money Penalties (CMP)

Per 42 CFR §438.704, if the Department imposes CMP as provided under §438.702(a)(1), the maximum CMP imposed varies depending on the nature of the Contractors action or failure to act as provided in §438.702(a)(1). CMP limits are as follows:

1. $25,000 for each determination under §438.700(b)(1), (5), (6), and (c).
2. $100,000 for each determination under §438.700(b)(3) or (4).

3. $15,000 for each Member the Department determines was not enrolled because of a discriminatory practice under §438.700(b)(3), with an overall limit of $100,000 in accordance with item §438.700(b)(2).

For premiums or charges in excess of the amounts permitted under federal Medicaid regulation, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. Per §438.700(c), the Department will deduct the amount of the overcharge from the penalty and return it to the affected Members.

17.2 Notification of and Response to Non-Compliance

The Department will notify the Contractor of identified compliance concerns. Each compliance notification type described below may impose points, liquidated damages, or intermediate sanctions.

17.2.1 Notice of Non-Compliance (NONC)

The Department may issue Notices of Non-Compliance (NONC) to document compliance concerns. Depending on the noncompliance, the Department may impose compliance enforcement points, liquidated damages, or intermediate sanctions as a result of the noncompliance identified. The Contractor is required to acknowledge receipt of the notice, but is not required to submit a formal MCO Improvement Plan (MIP) or Corrective Action Plan (CAP).

17.2.2 MCO Improvement Plans (MIPs)

The Department may require the Contractor to submit an MCO Improvement Plan to address compliance violations, failures, or deficiencies. A MIP is only used for issues that do not rise to the level of requiring formal CAP and are not intended to be disclosed by the Contractor in its business outside of the Commonwealth of Virginia.

MIPs must always include the necessary information and be submitted in the method as required in the Cardinal Care Technical Manual, unless otherwise directed by the Department. The Contractor must submit a completed MIP to the Department within fifteen (15) calendar days from the date of the requested MIP, unless an alternative timeframe is requested by the Department.

The MIP must identify how the Contractor plans to remedy the issue within a thirty (30) calendar-day timeframe, which will begin from the date the Contractor receives the MIP request, unless an alternative timeframe is requested by the Department. If the Contractor's proposed MIP does not contain the necessary information to fully resolve the identified noncompliance, the Department will be entitled to impose additional points, liquidated damages, or other sanctions, and the Contractor may be required to submit a Corrective Action Plan.

17.2.3 Corrective Action Plan (CAP)

The Contractor must submit a completed CAP to the Department within fifteen (15) calendar days from the date of the received notification of noncompliance requesting a CAP, unless an alternative timeframe is requested by the Department. The CAP must identify how the Contractor plans to remedy the issue, including the timeframes within which such remediation will occur, and the person(s) responsible for the remediation, and any other information requested by the Department. The

Contractor must provide the Department with progress reports regarding its implementation of the CAP at intervals required by the Department.

If the Contractor fails to respond to the Department's request to provide a Corrective Action Plan within the timeframe specified, the Department will notify the Contractor in writing of its failure to respond to the Department, which is a violation of this Contract. If the Contractor continues to not provide the corrective action plan within one (1) week of the date of the failure-to-respond letter, the Department's Director will notify the Contractor that its continued failure to act will result in one (1) or a combination of the following remedies to the Department:

a. Withhold of capitation payment;
b. Withhold/suspension of future enrollment; and,
c. Impose civil money penalties or liquidated damages not to exceed $100,000 per occurrence per Section 17.1.5, *Civil Money Penalties*; and/or termination of the Contract.

If the Contractor has not submitted an acceptable correction action plan within the required time period, 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 contract enforcement actions seven (7) calendar days prior to withholding any capitation payment.

17.3 Contractor Compliance Infrastructure Requirements

The Contractor must have an effective compliance program that meets the requirements of and is consistent with 42 CFR §438.608. The compliance program must, at a minimum, include:

1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements, including:
    a. Implementation and maintenance arrangements or procedures for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Managed Care program, including termination of the provider agreement with the Contractor. 42 CFR §438.608(a)(4);
    b. Reporting to the Department within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. 42 CFR §438.608(c)(3); and
    c. 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 pursuant to 42 CFR §438.608(a)(5).
2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors;

3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's Compliance Program and its compliance with the requirements under the Contract;
4. A system for training and education for the Compliance Officer, the Contractor's senior management, and the Contractor's employees on the federal and state standards and requirements under the Contract;
5. Effective lines of communication between the Compliance Officer and the Contractor's employees;
6. Enforcement of standards through well-publicized disciplinary guidelines;
7. Identification of potential and actual compliance risks;
8. Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future compliance concerns. The Contractor must implement, or as applicable, require its network providers or subcontractors to implement, appropriate corrective actions in response to potential violations. A corrective action plan must be tailored to address the particular compliance concern identified. The corrective action plan included timeframes within which correct action must occur at a minimum, include repayment of any identified overpayments;
9. 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) calendar days after the determination that there is a potential violation);
10. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract; and,
11. The Program Integrity Plan and PI Policies and Procedures, as required in Section 18, *Program Integrity* below.

The Contractor must require its subcontractors which perform delegated functions under this Contract to maintain a compliance program that meets the requirements set forth above.

The Contractor must report any instance of compliance concerns for which the Department issues a notice of noncompliance (NONC) or imposes a Corrective Active Plan (CAP), MCO Improvement Plan (MIP), points, liquidated damages or other sanctions to its Regulatory Compliance Committee of senior management and the Board of Directors. The Contractor must provide the Department with evidence of such reporting upon the Department’s request in the format set forth in the Cardinal Care Technical Manual.

The Department has the right at any time to request the compliance program documents to assess compliance with the requirements set forth in this Section.

17.3.1 Compliance Collaborative

The Contractor must participate in the Department's Compliance Collaborative meetings. The Contractor must ensure that at least one (1) member of the Contractor's Compliance Team will participate in-person, as required.

17.3.2 Inspection and Audit of Records and Access to Facilities

In accordance with 42 CFR §438.3, the Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, CMS, the Office of the Inspector General, the Comptroller General, and/or their duly authorized representatives may, at any time, inspect and audit any records or documents of the Contractor or its subcontractors pertaining to (1) the ability of the Contractor or subcontractors to bear the risk of financial losses, and (2) services performed or payable amounts under the Contract. In addition, these entities may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted to evaluate 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 this Contract period or from the date of completion of any audit, whichever is later. The Contractor does not have the right to audit the Department or to require that the Department be audited.

The Contractor must provide the Department with timely responses and corrective action plans for any audit or review findings and provide quarterly status updates until the finding is remediated.

17.3.3 Public Disclosure on Compliance Activity

In order to provide transparency to the public surrounding MCO compliance performance, the Department reserves the right to publish information regarding the MCO's performance, including, without limitation, audit results, MCO compliance metrics, imposition of points, penalties or requirements imposed under a CAP.

18.PROGRAM INTEGRITY

18.1 General Program Integrity Principles

The Contractor and its subcontractors must have policies and procedures for ensuring protections against actual or potential fraud, waste and abuse ("Program Integrity" Policies), which include the Virginia Medicaid Program Integrity Plan described below, and which is a component of the Compliance Program discussed in Section 17, *Oversight*. Program Integrity Policies must be submitted to the Department as required by the Cardinal Care Technical Manual. The Contractor must cooperate with the Department on all initiatives relative to program integrity and must submit all applicable reports as required by this Contract and the Cardinal Care Technical Manual.

The Contractor must comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act. The Contractor must ensure that all of its activities related to prevention, detection, and remediation, including referrals of suspected fraud, waste and abuse comply with federal and State laws and regulations.

18.2 Program Integrity Plan

The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan to detect, correct and prevent fraud, waste, and abuse that meets the requirements set forth below, and is reviewed and updated annually.

The Virginia Medicaid Program Integrity Plan must be submitted annually. The plan must include all of the following:

1. The Contractor PI Lead as required in Section 2.10.11, *Managed Care Program Integrity Lead*;
2. An organizational chart showing each staff member assigned to program integrity activities, identifying the amount of time dedicated by each person to such activities and the titles of such staff;
3. A listing of the Contractor's subcontractors that perform PI functions;
4. A process to act as or subcontract with a Contractor for Recovery Audit purposes;
5. A monitoring and auditing plan described below;
6. As required in 42 CFR §438.608, a description of the 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;
7. How the Contractor receives referrals to investigate fraud, waste and abuse, and how those investigations are conducted; and
8. A description of how the Contractor will cooperate with, and make referrals to, the Department and the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) of credible allegations of fraud and other misconduct identified through the Contractor's program integrity activities, as required under 42 CFR §438.608(a)(7).

18.2.1 Monitoring and Auditing Plan

The Contractor's Monitoring and Auditing Plan must demonstrate a coordinated, cohesive strategy to assess and address program integrity risks. The Contractor will be expected to explain to the Program Integrity Division the current year Monitoring and Audit Plan as it relates to the results of the prior year's program integrity activities.

In developing the Monitoring and Auditing Plan, the Contractor must:

1. Determine which risk areas will most likely affect the Contractor and prioritize the monitoring and auditing strategy accordingly;
2. 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.); and,
3. Review areas previously found noncompliant to determine if the corrective actions taken have fully addressed the underlying problem.

The Monitoring and Auditing Plan must describe the risk evaluation methodology and identified areas of program integrity risk.

The Internal Monitoring and Auditing Plan must also include a schedule that includes a list of all planned monitoring activities, investigations, and other program integrity activities for the calendar year. Contractors must consider a combination of desk and onsite investigations, including unannounced investigations or "spot checks," when developing the schedule. Monitoring and auditing of network providers and subcontractors must be addressed in the Internal Monitoring and Auditing Plan. The Contractor must include in its compliance monitoring and auditing work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing and monitoring, and the plan to conduct onsite audits.

For all program integrity investigations planned for the upcoming year, the annual plan should include the following information:

1. Monitoring Activity Title/Type;
2. Description;
3. Priority/Risk Level;
4. Method of provider/claim selection;
5. Manner in which investigations will be conducted; and
6. Number of Investigations Planned.

The Monitoring and Audit Plan must also include a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

1. All requirements from section above;
2. Number of Audits Planned for Each Type identified in items 1 – 6 listed above;
3. Number of Audits Completed for Each Type identified in items 1 – 6 listed above;
4. Trends Identified;
5. Investigator Assigned (if applicable);
6. Findings;
7. Recommendations; and
8. Action Taken.

18.2.2 Pre-Payment Review

The Contractor must choose to utilize a pre-payment review process as a part of its Program Integrity Plan and these activities should be included as planned activities in the Monitoring and Auditing Plan. Pre-payment review, for the purposes of this Section refers specifically to a process in which the Contractor pends payment of a claim and then requests and reviews medical record documentation prior to releasing the claim for payment.

18.3 Program Integrity Reporting and Investigation Process

The Contractor must submit electronically to the Department all activities conducted on behalf of PI by the Contractor and include findings related to these activities, as required by the Cardinal Care Technical Manual.

On a quarterly basis, the Department will share with Contractor any information it obtains or discovers regarding providers engaged in potential fraudulent activity.

The Contractor will be required to notify the Department in a timely manner, within no more than five (5) business days, regarding any identified or reported concerns regarding improper payments. The Contractor will be expected to promptly perform a preliminary investigation of all concerns of fraud, waste, or program abuse. The Contractor must track each of these concerns and the outcome of the preliminary review and report them to the Department on the Quarterly Summary of PI Allegations tab~~le~~ as required by the Cardinal Care Technical Manual. A unique Case ID should be created for each investigation that is consistently used to identify that case in all reporting to the Department.

Once the concerns have been determined to warrant further investigation/audit, the Contractor must notify the Department within forty-eight (48) hours of the determination and prior to initiating a full investigation, using the Notification of Provider Investigation form as specified by the Department in the Cardinal Care Technical Manual. 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.

If the Contractor determines that the results of the investigation require claims to be pended or recouped, then Contractor must report investigation results to the Department as required by the Cardinal Care Technical Manual. If the Contractor identifies a pattern of fraud, waste, or program abuse during a pre-payment review, then Contractor must conduct a retrospective review of that provider to identify any prior overpayments.

The Contractor must 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. Providers must also have the right to appeal to DMAS after exhausting the Contractor's internal appeal process. Refer to Section 9.8.1, *Reconsiderations*.

18.4 Written Program Integrity Policies and Procedures

The Contractor must have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws, regulations and requirements for the prevention, detection and reporting of incidents of potential fraud, waste and abuse by Members, network providers, subcontractors and the Contractor.

The Contractor must have PI policies and procedures, in addition to those required above, that address:

1. Retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. 42 CFR §438.608(d);
2. Processes, 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 of overpayments. 42 CFR §438.608(d));

3. Process for providers to report and promptly return overpayments within sixty (60) days of identifying the overpayment. 42 CFR §438.608(d)(2);
4. 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 must include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook must 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 and Section 1902(a)(68) of the Act; 42 CFR §438.608(a)(6); and
5. 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) calendar days after the determination that there is a potential violation).

The Compliance Officer must maintain a system to track all identified noncompliance, actions taken to remediate noncompliance and the results of audits or reviews performed to evaluate the success of implementation efforts. Documentation demonstrating compliance with this requirement must be provided, if requested, to the Department, CMS or law enforcement. The Compliance Officer or his or her designee must report on any identified non-compliance, actions taken to remediate noncompliance and the results of audits or reviews performed to evaluate the success of implementation efforts at the Contractor's Regulatory and Compliance Committee of the senior management compliance committee on a quarterly basis.

In its contracts with subcontractors, the Contractor must require its contractors to perform routine and auditing, as well as be subject to monitoring and auditing by the Contract.

The Contractor is encouraged to invest in data analysis software applications that provides 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.

The Contractor must cooperate with Department auditors on any Recovery Audit activity/findings.

18.5 Subcontractor Compliance Requirements

Under 42 CFR §§438.608(a), the Contractor must require its subcontractors, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract to:

1. Implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that the identifies to the Contractor Department or any credible allegation of fraud to the Virginia Medicaid Fraud Control Unit; and
2. Implement and maintain arrangements or procedures that include provisions for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

18.6 Program Integrity Audit Report

The Contractor must produce and provide to the Department upon conclusion of the investigation a standard audit report for each completed investigation. This report should utilize the Notification of Provider Investigation Form and include, at a minimum, the following:

1. Purpose;
2. Methodology;
3. Findings (including identified overpayments);
4. Proposed Action and Final Resolution; and
5. Claims Detail List/Spreadsheet.

18.7 Program Integrity Training and Education

The Contractor must have staff members who are assigned to perform desk audits and/or field audits, to attend training and orientation programs required by the Department, and to facilitate additional PI activities such as reviews, analytics, and/or provider sanctions.

18.8 Reporting Suspected Fraud and Abuse to the Department

The Contractor is required to use the templates, formats, and methodologies specified by the Department in the Cardinal Care Technical Manual.

Prior to submitting a referral to the Department, the Contractor must have conducted a preliminary investigation of any allegation of fraud, waste and abuse, regardless of how the concern was identified. Once the Contractor has vetted the allegation and determined that it warrants a full investigation, it is at this point that the Notification of Provider Investigation must be sent to the Department.

All confirmed or credible allegations of fraud (as defined in 42 CFR §455.2), including those related to marketing, by a provider or subcontractor must be reported to the Department within forty-eight (48) hours of discovery on the Referral of Suspected Provider Fraud form via email. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

All suspected member fraud or other program-related misconduct must 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.

MFCU investigations may verify that some of these referrals constitute a “credible allegation of fraud.” In these instances, Contractors will be notified by the Department and must suspend payments to those providers as set forth in 42 CFR §455.23.

The Contractor must 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.

18.8.1 Quarterly Fraud/Waste/Abuse Report

The Contractor must 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 Cardinal Care Technical Manual. This report will serve as the annual report of overpayment recoveries required under 42 CFR §§438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following:

1. Allegations received and results of preliminary review;
2. Investigations conducted and outcome;
3. Payment Suspension notices received and suspended payments summary;
4. Claims Edits/Automated Review summary;
5. Coordination of Benefits/Third Party Liability savings and recoveries;
6. Service Authorization/Medical Necessity savings;
7. Provider Education Savings;
8. Provider Screening reviews and denials;
9. Unsolicited Refunds (Provider-identified Overpayments);
10. Archived Referrals (Historical Cases); and
11. Other Activities.

18.9 Cooperation with State and Federal Investigations

The Contractor must cooperate with all fraud, waste and abuse investigation efforts by the Department and other State and Federal offices.

18.10 Minimum Audit Requirements

A minimum number of audits must be conducted annually by the Contractor based on total dollars in medical claims expenditures. For this Contract, audits conducted by the Contractor must involve the review of medical records for claims representing at least three percent (3%) of total medical expenditures.

19.PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES

19.1 Formal Initiation of Recovery

The Contractor must promptly notify the Department when it initiates recovery of payments from a network provider due to fraud or abuse, using the Notification of Provider Investigation form as required by the Cardinal Care Technical Manual. The Contractor must submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered).

19.2 Class Action & Qui Tam Litigation

The Contractor must 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.

19.3 Treatment of Recoveries

Generally, the Contractor must be permitted to retain recoveries of overpayments identified through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three (3) years prior to the date that the Contractor formally notified the Department of the

overpayment will be retained by the Department. In addition, if the Contractor has not recovered an overpayment within one (1) year of being authorized to recovery such overpayment, then the Department is entitled to recoup and retain such overpayment.

19.4 Fraudulent Provider Recovery with MFCU

Pursuant to the Department 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.

19.5 Payment Suspension

Pursuant to 42 CFR §§ 455.23 and 438.608(a)(7)-(8), the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. When the Department makes a credible allegation of fraud determination, the Department will issue a Notice of Payment Suspension to the Contractor. The Contractor must suspend payment as soon as possible and within one (1) business day or in accordance with the timeframes communicated by the Department in the notice. As set forth below, the Department will handle issuing payment suspension notices to providers.

If the Contractor believes there is good cause, as defined in 42 CFR §455.23, to not suspend payments or to suspend payment only in part to such a provider, 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 (Final Determination). Upon notification from the Department of the Final Determination to suspend payments, the Contractor must suspend payments immediately in accordance with the timeframes communicated by the Department in the Final Determination.

The Contractor must confirm in writing to the Department the implementation date of the payment suspension and the service claim types suspended, if directed by the Department to suspend payments only in part. Confirmations must be submitted to the Department within one (1) business day of (i) receipt of the Notice of Payment Suspension from the Department, or (ii) receipt of the Final Determination of the Contractor submitted a good cause exemption form. Confirmations will be directed to providerenrollment@dmas.virginia.gov. Upon receipt of confirmation from the Contractor, the Department will issue a Notice of Payment Suspension to the provider.

The Department will notify the Contractor upon termination of any provider payment suspension. The Contractor must list any payment suspension as directed by the Department.

19.6 Prohibited Actions

19.6.1 Prohibited Affiliations with Entities Debarred by Federal Agencies

In accordance with 42 USC § 1396u-2(d)(1), and further explained in 42 CFR §§438.610 and 455 Subpart B, and the CMS SMD #08-003 (available here), the Contractor or its subcontractors must not knowingly

have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, in accordance with 42 CFR §§438.808, 431.55, 1001.1901(c), and 1002.3(b), and Section 1903(i)(2) of the Social Security Act, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse.

In accordance with 42 CFR §438.610(d)(3); 42 CFR §438.610(a); Exec. Order No. 12549, if the Department finds that the Contractor is not in compliance and has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR), or from participating in non-procurement activities under regulations issued under Executive Order No. 12549, or if the Contractor has a relationship with an individual who is an affiliate of such an individual, the Department:

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

In accordance with 42 CFR §438.610(d)(3) and 42 CFR §438.610(b) if the Department learns that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the Department may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Department's and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

19.6.2 Other Categorical Prohibited Affiliations with Entities

In accordance with 42 CFR §§438.808, 431.55, 1001.1901(c), and 1002.3(b) and Section 1903(i)(2) of the Social Security Act, the Contractor must, 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):

1. 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 percent (5%) or more in the entity has:
    a. Been convicted of any of the following crimes:

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);
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);
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);
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,
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.

b. Been excluded from participation in Medicare or a State health care program;
c. Been assessed a civil monetary penalty under § 1128A 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.); and,
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 CFR 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 must immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this Section, an entity currently participating.

2. Entities which have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. 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 2. a. through c. below. A substantial contractual relationship is defined as any contractual relationship which provides for one (1) or more of the following services:
    a. The administration, management, or provision of medical services;
    b. The establishment of policies pertaining to the administration, management, or provision of medical services; or,
    c. The provision of operational support for the administration, management, or provision of medical services. [42 CFR §431.55(h)(3)].
3. Entities who are to be excluded per Code of Virginia § 32.1- 325(D)(4); and,

4. Prohibited Affiliations with Entities Debarred by Federal Agencies, see §13.3(a).

19.6.3 Prohibited Affiliations with Contractor and Subcontractor Service Providers

In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 CFR §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) must 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 Health Care Programs.

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. 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.

20. MCO CONTRACT DISPUTES

The Contractor has the right to dispute any direct financial action taken by the Department, as permitted by this Contract, following the escalation process described in Section 20.1.2, *Escalation Procedures.* Direct financial actions include, but are not limited to, compliance enforcement actions, liquidated damages, intermediate sanctions, and quality withholds.

This Section does not apply to any dispute relating to Medicaid/FAMIS eligibility determinations or member or provider appeal decisions. Contract terminations will follow the process described in Section 21.2.41, *Termination Procedures*.

20.1 Resolution Process

As provided for in Code of Virginia § 2.2-4363, as amended, disputes arising out of this 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, following the processes outlined in Section 20.1.1, *Escalation Procedures*.

Disputes arising out of this Contract ("Contract Claim") will not be considered if submitted later than sixty (60) calendar days after (i) the date on which the Contractor knew or reasonably should have

known of the occurrence giving rise to the Contract Claim; (ii) the beginning date of the work upon which the Contract Claim is based; or (iii) written notification that an amount is due, whichever is earlier.

For any Contract Claims arising out of this Contract, except for any dispute based upon a breach of statute or regulation, the parties must first attempt to resolve their differences informally using the escalation procedures below ("Escalation Procedures"). Should the parties fail to resolve their differences after good faith efforts to do so under the Escalation Procedures, then the Contractor may institute legal action.

20.1.1 Escalation Procedures

The following escalation procedures must be followed with respect to Contract Claims arising out of this Contract by both parties (the "Escalation Procedures"). Contract Claims must first be raised by personnel for either party; i.e., by either the Department or the Account Manager for the Contract ("First Level of Escalation"). The Contractor must submit written notice of intent to file a Contract Claim (the "Notice of Intent") to the Division Directors for Health Care Services and Integrated Care at the time when the Contractor knew or reasonably should have known of the occurrence giving rise to the claim, the beginning date of the work upon which the claim is based, or written notification that an amount is due, whichever is earlier. The Notice of Intent must include a brief statement of the nature of the Contract Claim that will be filed. The Contractor must timely file the Contract Claim in writing, including the basis for the claim, the financial action(s) at issue, and any other information supporting the claim. The Division Directors for Health Care Services and Integrated Care will issue an Initial Decision within thirty (30) calendar days of receipt of the Contract Claim.

If the Initial Decision is unsatisfactory, the Contractor's Account Manager must file a written notice requesting a Second Level review. The notice must be submitted within thirty (30) calendar days of receipt of the Initial Decision and must explain the basis for the reconsideration request, including references to the Initial Decision. The second Escalation Level is with a panel of members of the Department's executive leadership team with knowledge of the nature of the dispute and the Contractor's Chief Executive Officer (CEO) or their designee. For example, for Contract Claims connected with clinical matters, the panel will include the Department's Chief Medical Officer. An Intermediate Decision will be issued within thirty (30) calendar days of receipt of the request from the Contractor's CEO or her designee. If the Intermediate Decision is also unsatisfactory, the Contractor may file a written notice requesting a Third Level review. The notice must be submitted within thirty (30) calendar days of receipt of the Intermediate Decision. The notice must explain the basis for the reconsideration request, including references to the Intermediate Decision. The Third Escalation Level is with the Department Director or designee. The Department Director will issue a written Final Decision within sixty (60) calendar days of receipt of the request for a Third Escalation Level from the Contractor's CEO.

Level of Escalation	**The Department**	**Contractor**
First	Director of Integrated Care and Director of Health Care Services, or designees	Account Manager for the Contract

Level of Escalation	The Department	Contractor
Second	Executive Leadership Team Panel, or designees	Chief Executive Officer (CEO) or designee
Third	Department Director or designee	Chief Executive Officer (CEO) or designee

At the Third Escalation level, the Contractor and the Department are obligated to present all documents necessary to support their claims. The Contractor has the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

For Contract Claims involving intermediate sanctions to be imposed by the Department or a termination of the Contract, the Contractor shall proceed directly to the Third Escalation Level. The Contractor must file a Notice of Intent with the Agency Director within thirty (30) calendar days of the Notice of Non-Compliance or Notice of Termination from the Department. The Notice of Intent shall include a brief statement of the basis for and financial actions underlying the Contract Claim and any other relevant information. The Contractor must file the corresponding Contract Claim within sixty (60) calendar days of the Notice of Non-Compliance or Notice of Termination from the Department.

Pursuant to 42 CFR § 438.710, the Third Escalation Level for Contractor terminations, will be a pre-termination hearing before the Department Director or her designee.

Either party may change the name and/or title of one (1) or more of the Escalation Levels set forth above, and such change will be effective upon written notice to the other party provided under this Contract. Either Party may request an additional thirty (30) calendar days at each level to resolve the Contract Claim.

If a required Notice of Intent is not timely filed with the Department, or is incomplete, then the Department shall render a written Final Decision dismissing the Contract Claim. No written decision denying a claim or addressing issues related to the claim shall be considered a denial of the claim unless the written Final Decision is signed by the Agency Director or her designee. The Contractor may not institute legal action prior to receipt of the written Final Decision on the claim unless the Department fails to render a decision within sixty (60) calendar days of the request for a Third Escalation Level and an additional thirty (30) calendar days was not requested. No relief or award for the Contractor or penalty against the Department will result from the Department’s failure to issue a written Final Decision within sixty (60) calendar days, or within ninety (90) calendar days if an extension was requested. The sole remedy for the Department's failure to render a written Final Decision within sixty (60) calendar days, or ninety (90) calendar days if an extension was requested, shall be the Contractor's right to institute legal action.

The Contractor must exhaust the Escalation Procedures prior to instituting legal action in circuit court. The Department’s written Final Decision will stand unless the Contractor institutes timely legal action in circuit court pursuant to Virginia Code § 2.2-4364 within sixty (60) days of the Final Decision or the day the Final Decision was required to be issued pursuant to this Contract.

21. TERMS AND CONDITIONS

By signing this Contract, the Contractor must 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 must serve as a waiver of any and all objections by the Contractor to the contents of this Contract. The Contractor must adhere to the following General and Special Terms and Conditions unless otherwise noted in the body of the Cardinal Care Contract.

The Director of the Department hereby delegates most of the Department's authority to establish, maintain, monitor, sanction, credential, recredential, 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 1.1, *Applicable Laws, Regulations and Interpretation*, are silent, reflects the Department's intent for the Contractor to follow its own clearly delineated policies and procedures.

21.1 General Terms and Conditions

21.1.1 Vendors Manual

This Contract is subject to the provisions of the Commonwealth of Virginia Vendors Manual and any changes or revisions thereto, which are hereby incorporated into this Contract in their entirety. The process for filing a complaint about this Contract is in Section 7.13 of the Vendors Manual. (Note section 7.13 does not apply to protests of awards or formal contractual claims.) A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.eva.virginia.gov under "I Sell to Virginia".

21.1.2 Applicable Laws and Courts

This Contract shall be governed in all respects by the laws of the Commonwealth of Virginia, without regard to its choice of law provisions, and any litigation with respect thereto shall be brought in the circuit courts of the Commonwealth. The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

21.1.3 Anti-Discrimination

In accordance with 42 CFR § 438.100, the Contractor and all subcontractors must comply with all applicable Federal and State laws and regulations relating to nondiscrimination and equal employment opportunity and assure physical and program accessibility of all services to individuals with disabilities pursuant to § 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 CFR 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.

Any of the Contractor's contracts with subcontractors must comply with Virginia Code § 2.2-4311, the Virginia Fair Employment Contracting Act of 1975, as amended, and where applicable, the Virginians with Disabilities Act.

If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the Contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender sexual orientation, gender identity, or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (Code of Virginia, § 2.2-4343.1E).

Furthermore, the Contractor must ensure that its network providers provide contract services to Members under this Contract in the same manner as they provide those services to all non-Medicaid and non-FAMIS Members, including those with limited English proficiency or physical or mental disabilities. Additionally, in accordance with 42 CFR §438.206(c)(1)(ii), the Contractor must ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members if the provider serves only Medicaid and/or FAMIS Members.

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices setting forth the provisions of the non-discrimination clause.

The provisions of this section apply in every Contract over $10,000, as follows. During the performance of this contract, the Contractor agrees as follows:

1. The Contractor will not discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, sexual orientation, gender identify, physical condition, disability, veteran status, political affiliation, or national origin relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
2. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that Contractor is an equal opportunity employer.
3. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.
4. If the Contractor employs more than five employees, the Contractor shall (i) provide annual training on the contractor's sexual harassment policy to all supervisors and employees providing services in the Commonwealth, except such supervisors or employees that are required to complete sexual harassment training provided by the Department of Human Resource Management, and (ii) post the Contractor's sexual harassment policy in (a) a conspicuous public place in each building located in the Commonwealth that the Contractor owns or leases for business purposes and (b) the contractor's employee handbook.

5. The requirements of Section 21.1.1 and 21.1.2 are a material part of the Contract. If the Contractor violates any of these anti-discrimination provisions, the Department may terminate the affected part of this Contract for breach, or at its option, the whole Contract. Violation of one of these provisions may also result in debarment from State contracting regardless of whether the specific contract is terminated.
6. In accordance with Executive Order 61 (2017), a prohibition on discrimination by the Contractor, in its employment practices, subcontracting practices, and delivery of goods or services, on the basis of race, sex, color, national origin, religion, sexual orientation, gender identity, age, political affiliation, disability, or veteran status, is hereby incorporated in this Contract.

The Contractor shall include the provisions of item 1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

21.1.4 Antitrust

By entering into this Contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under this Contract.

21.1.5 Ethics in Public Contracting

By submitting their proposals, Contractors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

21.1.6 Immigration Reform and Control Act Of 1986

By entering into a written Contract with the Commonwealth of Virginia (COV), the Contractor certifies that the Contractor does not, and shall not during the performance of the Contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the Federal Immigration Reform and Control Act of 1986.

21.1.7 Debarment Status

By participating in this procurement, the Contractor certifies that it is not currently debarred by the Commonwealth of Virginia from submitting a response for the type of goods and/or services covered by this solicitation. The Contractor further certifies that they are not debarred from filling any order or accepting any resulting order, or that they are an agent of any person or entity that is currently debarred by the Commonwealth of Virginia.

If a Contractor is created or used for the purpose of circumventing a debarment decision against another Contractor, the non-debarred vendor will be debarred for the same time period as the debarred vendor.

21.1.8 Payment

21.1.8.1 To Primary Contractor:

1. The Contractor will be reimbursed by the Department using a per-member-per-month (PMPM) risk-based capitated payment method as described in Section 15, *Contractor Payment and Financial Provisions*.
2. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
3. Any payment terms requiring payment in less than thirty (30) days will be regarded as requiring payment thirty (30) days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than thirty (30) days, however.
4. All goods or services provided under this Contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
5. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
6. Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges which appear to be unreasonable will be resolved in accordance with *Code of Virginia* §§ 2.2-4363 and 2.2-4364. Upon determining that invoiced charges are not reasonable, the Department shall notify the Contractor of defects or improprieties in invoices within fifteen (15) days as required in Code of Virginia, § 2.2-4351. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges which are not in dispute (Code of Virginia, § 2.2-4363).

21.1.8.2 To Subcontractors:

1. Within seven (7) days of the Contractor's receipt of payment from the Department, a Contractor awarded a contract under this solicitation is hereby obligated:
    a. To pay the subcontractor(s) for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
    b. To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold all or part of the subcontractor's payment and the reason.
2. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one (1) percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the contractor that remain unpaid seven (7) days following receipt of payment from the Department, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to

each sub-tier contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Department. A contract modification shall not be made for the purpose of providing reimbursement for the interest charge. A cost reimbursement claim shall not include any amount for reimbursement for the interest charge.

3. Each prime Contractor who wins an award in which provision of a SWaM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWaM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.
4. The Commonwealth of Virginia encourages Contractors and subcontractors to accept electronic and credit card payments.

21.1.9 Precedence of Terms

The following General Terms and Conditions: *VENDORS MANUAL,* APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this Contract, the Special Terms and Conditions shall apply.

21.1.10 Qualifications of Offerors

The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Department all such information and data for this purpose as may be requested. The Department reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Department that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

21.1.11 Testing and Inspection

The Department reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

21.1.12 Assignment of Contract

A Contract shall not be assignable by the Contractor in whole or in part without the written consent of the Department. Any assignment made in violation of this section will be void.

21.1.13 Changes to the Contract

Changes can be made to the Contract in any of the following ways:

1. The parties may agree in writing to modify the terms, conditions, or scope of the Contract. Any additional goods or services to be provided shall be of a sort that is ancillary to the Contract goods or services, or within the same broad product or service categories as were included in the Contract award. Any increase or decrease in the price of the Contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the Contract. In any such change to the resulting Contract, no increase to the Contract price shall be permitted without adequate consideration, and no waiver of any contract requirement that results in savings to the Contractor shall be permitted without adequate consideration. Pursuant to Code of Virginia § 2.2-4309, the value of any fixed-price contract shall not be increased via modification by more than 25 percent without the prior approval of the Division of Purchases and Supply of the Virginia Department of General Services.
2. The Department may order changes within the general scope of the Contract at any time by written notice to the Contractor. Changes within the scope of the Contract include, but are not limited to, things such as services to be performed, the method of packing or shipment, and the place of delivery or installation. The Contractor shall comply with the notice upon receipt, unless the Contractor intends to claim an adjustment to compensation, schedule, or other contractual impact that would be caused by complying with such notice, in which case the Contractor shall, in writing, promptly notify the Department of the adjustment to be sought, and before proceeding to comply with the notice, shall await the Department's written decision affirming, modifying, or revoking the prior written notice. If the Department decides to issue a notice that requires an adjustment to compensation, the Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:
    a. By mutual agreement between the parties in writing; or
    b. By agreeing upon a unit price or using a unit price set forth in the Contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department’s right to audit the Contractor’s records and/or to determine the correct number of units independently; or
    c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the Contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this Contract. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this Contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the Contract generally.

21.1.14 Default

In case of failure to deliver goods or services in accordance with this Contract's terms and conditions, the Department, after due oral or written notice, may terminate this Contract and procure all goods and/or services contracted for, from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Department may have.

21.1.15 Insurance

By signing this Contract, the Contractor certifies that it will have the following insurance coverage at the time the Contract is awarded. The Contractor further certifies that the Contractor and any subcontractor will maintain this insurance coverage during the entire term of the Contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

21.1.15.1 **Minimum Insurance Coverages and Limits Required for Most Contracts:**

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Department of increases in the number of employees that change their workers' compensation requirements under the Code of Virginia during the course of the Contract shall be in noncompliance with the Contract.
2. Employer's Liability: $100,000.
3. Commercial General Liability: $1,000,000 per occurrence and $2,000,000 in the aggregate. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 combined single limit. (Required only if a motor vehicle not owned by the Commonwealth is to be used in the Contract.) Contractor must assure that the required coverage is maintained by the Contractor (or third-party owner of such motor vehicle.)
5. Profession/Service - Health Care Practitioner (to include Dentists, Licensed Dental Hygienists, Optometrists, Registered or Licensed Practical Nurses, Pharmacists, Physicians, Podiatrists, Chiropractors, Physical Therapists, Physical Therapist Assistants, Clinical Psychologists, Clinical Social Workers, Professional Counselors, Hospitals, or Health Maintenance Organizations): Amount sufficient to pay the malpractice judgment limit amount specified in Code of Virginia § 8.01-581.15.

21.1.16 Announcement of Award

[Reserved]

21.1.17 Drug-Free Workplace

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;

2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.
5. For the purposes of this section, *"drug-free workplace"* means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

21.1.18 Nondiscrimination of Contractors

The Contractor shall not be discriminated against in the award of this Contract because of race, religion, color, sex, sexual orientation, gender identity, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or offeror employs ex-offenders unless the Department makes a written determination that employing ex-offenders on this specific Contract is not in its best interest. If the award of this Contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

21.1.19 eVA Business-To-Government Vendor Registration, Contracts, and Orders

The eVA Internet electronic procurement solution, web site portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for the Contractor to conduct business with state agencies and public bodies. All Contractors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution by completing the free eVA Vendor Registration. All bidders or offerors must register in eVA and pay the Vendor Transaction Fees specified below; failure to register will result in the bid/proposal being rejected.

Vendor transaction fees are determined by the date the original purchase order is issued and the current fees are as follows:

1. For orders issued July 1, 2014, and after, the Vendor Transaction Fee is:
    a. DSBSD-certified Small Businesses: 1%, capped at $500 per order.
    b. Businesses that are not DSBSD-certified Small Businesses: 1%, capped at $1,500 per order.

2. Refer to Special Term and Condition "eVA Orders and Contracts" to identify the number of purchase orders that will be issued as a result of this solicitation/contract with the eVA transaction fee specified above assessed for each order.

For orders issued prior to July 1, 2014, the vendor transaction fees can be found at www.eVA.virginia.gov.

The specified vendor transaction fee will be invoiced, by the Commonwealth of Virginia Department of General Services, typically within sixty (60) days of the order issue date. Any adjustments (increases/decreases) will be handled through purchase order changes.

21.1.20 Availability of Funds

It is understood and agreed between the parties herein that the Department shall be bound hereunder only to the extent that the legislature has appropriated funds that are legally available or may hereafter become legally available for the purpose of this Contract.

When the Department makes a 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 Contractor does not have the right to a pre-termination hearing for termination due to funding appropriations.

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 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 restricted 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. If the Contractor shall 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 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.

21.1.21 Price Currency

Unless stated otherwise in the solicitation, Contractors shall state offer prices in US dollars.

21.1.22 Authorization to Conduct Business in the Commonwealth

The Contractor organized as a stock or non-stock corporation, limited liability company, business trust, or limited partnership or registered as a registered limited liability partnership shall be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the *Code of Virginia* or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the *Virginia Public Procurement Act* shall not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time

during the term of the contract. The Department may void the Contract with the Contractor if the Contractor fails to remain in compliance with the provisions of this section.

21.1.23 Civility in State Workplaces

The Contractor shall take all reasonable steps to ensure that no individual, while performing work on behalf of the Contractor or any subcontractor in connection with this agreement (each, a "Contract Worker"), shall engage in 1) harassment (including sexual harassment), bullying, cyber-bullying, or threatening or violent conduct, or 2) discriminatory behavior on the basis of race, sex, color, national origin, religious belief, sexual orientation, gender identity or expression, age, political affiliation, veteran status, or disability.

The Contractor shall provide each Contract Worker with a copy of this Section and will require Contract Workers to participate in agency training on civility in the State workplace if Contractor's (and any subcontractor's) regular mandatory training programs do not already encompass equivalent or greater expectations. Upon request, the Contractor shall provide documentation that each Contract Worker has received such training.

For purposes of this Section, "State workplace" includes any location, permanent or temporary, where a Commonwealth employee performs any work-related duty or is representing his or her agency, as well as surrounding perimeters, parking lots, outside meeting locations, and means of travel to and from these locations. Communications are deemed to occur in a State workplace if the Contract Worker reasonably should know that the phone number, email, or other method of communication is associated with a State workplace or is associated with a person who is a State employee.

The Commonwealth of Virginia may require, at its sole discretion, the removal and replacement of any Contract Worker who the Commonwealth reasonably believes to have violated this Section.

This Section creates obligations solely on the part of the Contractor. Employees or other third parties may benefit incidentally from this Section and from training materials or other communications distributed on this topic, but the Parties to this agreement intend this Section to be enforceable solely by the Commonwealth and not by employees or other third parties.

21.2 Special Terms and Conditions

21.2.1 Access to Premises

The Contractor shall allow duly authorized agents or representatives of the state or federal government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor 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 or subcontractor's activities. The Contractor shall 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 (including the Medicaid Fraud Control Unit or MFCU), the Auditor of Public Accounts of the Commonwealth of Virginia, the U.S. 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.

21.2.2 Access to and Retention of Records

In addition to the requirements outlined below, the Contractor shall comply, and shall require compliance by its subcontractors, with the security and confidentiality of records standards with respect to the Department's confidential records. For additional information, please see Section 11.16, *Record Retention*.

21.2.2.1 **Access to Records**

The Department, the Office of the Attorney General of the Commonwealth of Virginia (including the Medicaid Fraud Control Unit or MFCU), the Auditor of Public Accounts of the Commonwealth of Virginia, the Centers for Medicare and Medicaid Services (CMS), state and federal auditors, or any of their duly authorized representatives shall have access to and shall be allowed to inspect, copy, and audit any books, fee schedules, documents, papers, and records, including, medical and/or financial records, of the Contractor and any of its subcontractors.

The Contractor and its subcontractors will provide network connectivity for visitors from DMAS, Federal, and State auditors, including the execution of outside audit tools and audit test software for guest auditors from the U.S. Department of Health and Human Services (HHS) Office of the Inspector General, the HHS CMS Virginia Auditor of Public Accounts (APA) or any other authorized auditors as determined by the Department.

21.2.2.2 **Retention of Records**

The Contractor shall retain all books, records, and reports relating to this Contract for a period of no less than ten (10) years, as required by 42 CFR §438.3. 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 or longer if such action is still ongoing. All records shall be electronically scanned and stored in searchable format with OCR (optical character recognition) capabilities. Copies on electronic media or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the media 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. The records, regardless of format, remain the property of the Department.

21.2.3 Anti-Boycott Covenant

During the time this Contract is in effect, neither the Contractor nor any affiliated company must participate in or cooperate with an international boycott, as described in 42 USC 999(b)(3) and (4), or

engage in conduct in violation of the Code of Virginia §38.2-505. Without limiting such other rights as it may have, the Department will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51) percent of the ownership interests of the Contractor.

21.2.4 Attorney Fees

In the event the Department prevails in any legal action arising out of the performance or non-performance of this Contract, the Contractor must pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. Attorney's fees may include fees the Department must pay to a Member or Provider due to the Contractor's performance or non-performance of this Contract or due to any decisions made or actions taken by the Contractor that are appealed to the Department. The term "legal action" must be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

21.2.5 Audit Findings

The Department will 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 must 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 in accordance with Section 20 of this Contract, *MCO Contract Disputes*.

21.2.6 Business Associate Agreement (BAA)

The Contractor shall be required to enter into a Department-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) (See Attachment B, *Business Associate Agreement*). 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, and agrees to comply with all terms set out in the Department's BAA, including any future changes to the Department's BAA.

21.2.7 Confidentiality of Personally Identifiable Information

The Contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients will be collected and held confidential, during and following the term of this

agreement, and unless disclosure is required pursuant to court order, subpoena or other regulatory authority, will not be divulged without the individual's and the Department's written consent and only in accordance with federal law or the Code of Virginia. Contractors who utilize, access, or store personally identifiable information as part of the performance of a contract are required to safeguard this information and immediately notify the Department of any breach or suspected breach in the security of such information. Contractors shall allow the Department to both participate in the investigation of incidents and exercise control over decisions regarding external reporting. Contractors and their employees working on this project may be required to sign a confidentiality statement.

21.2.8 Covenant Against Contingent Fees

The Contractor must 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 must 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.

21.2.9 Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any Federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

21.2.10 Changes to Legal Authorization for State Programs

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

21.2.11 Compliance with VITA Standards on Information Technology Accessibility

The Contractor shall comply with all state laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. These accessibility standards are state law (*see* § 2.2-3502 and § 2.2-3503 of the *Code of Virginia)*. The Contractor shall comply with the Accessibility Standards at no additional cost to

the Department. The Contractor must also keep abreast of any future changes to the Virginia Code as well as any subsequent revisions to the Virginia Information Technologies Standards. The current Virginia Information Technologies Accessibility Standards are published online at this link.

21.2.12 Confidentiality Statutory Requirements

The Contractor understands and agrees that the Department may require specific written assurances and further agreements regarding the security and privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 CFR parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations under the Code of Virginia § 32.1-127.1:03. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws, including 42 CFR §§438.208(b) and 438.224 and 45 CFR, parts 160 and 164. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 USC § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

21.2.13 Federal Confidentiality Rules Related to Drug Abuse Diagnosis and Treatment

The Contractor must comply with Federal confidentiality law and regulations (codified as 42 USC § 290dd-2 and 42 CFR Part 2 ("Part 2")) outlines under what limited circumstances information about the patient's substance use disorder treatment may be disclosed with and without the client's consent. 42 CFR Part 2 applies to any individual or entity that is Federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR §2.11). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any Federally assisted alcohol and drug abuse program (42 CFR §2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser…" (42 CFR §2.12(a)(1)). 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.

21.2.14 Confidentiality of Information

By signing this Contract, the Contractor agrees that information or data obtained by the Contractor from the Department during the course of determining and/or preparing a response to this Contract renewal may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this Contract renewal. This paragraph does not apply to public records that would be required to be disclosed in response to a request pursuant to the Virginia Freedom of Information Act.

21.2.15 Conflict of Interest

For the duration of this Contract, neither the Contractor nor its subcontractors may have any interest that will conflict, as determined by the Department, with the performance of services under the

Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, the Department requires that neither the Contractor nor its subcontractor have any financial, legal, contractual, or other business interest in any entity performing program enrollment functions for the Department or any Related Entity(ies).

Nothing in this Contract must 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 must comply with Federal conflict of interest provisions and requirements described in 42 CFR §438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

21.2.16 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 by this Contract and the Cardinal Care Technical Manual. Any release by the Department of any contractual requirement must be approved by the Department's management. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for Members.

21.2.17 Contractor Internal Controls Report

The Contractor shall provide the Department, at a minimum, a report from its external auditor on the effectiveness of its internal controls. If the report discloses deficiencies in internal controls, the Contractor shall include management's correction action plans to remediate the deficiency. If available, report shall be compliant with the AICPA Statement on Standards for Attestation Engagements (SSAE) No 16, Reporting on Controls at a Service Organization, Report on Controls at a Service Organization Relevant to User Entities' Internal Control Over Financial Reporting (SOC 1), Service Organizations Controls (SOC) 2 Type 2 Report, and include the Contractor and its third-party service providers. The internal control reports shall be provided annually each June 1st for the preceding calendar year. The most recent version of the report shall be provided to the purchasing office upon request. Trade secrets or proprietary information contained within the report shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the contractor must invoke the protection of Code of Virginia, § 2.2-4342F, in writing, prior to or upon submission of the report, and must identify the data or other materials to be protected and state the reasons why protection is necessary. The contractor's obligations for certification of internal controls shall survive and continue after completion of this agreement unless the contractor certifies the destruction of the sensitive data at the end of the contract term.

The Contractor must have a Virginia-based operation that is dedicated to this Contract. The Department does not require claims, utilization management, customer service, pharmacy management, or member services to be physically located in Virginia; however, pursuant to 42 CFR § 438.602(i) these service areas must be located within the United States.

21.2.18 eVA Orders and Contracts

The Contract will result in one (1) purchase order(s) with the applicable eVA transaction fee assessed for each order.

Contractors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following: If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

21.2.19 E-Verify Program

Pursuant to *Code of Virginia*, §2.2-4308.2, any employer with more than an average of 50 employees for the previous twelve (12) months entering into a contract in excess of $50,000 with any agency of the Commonwealth to perform work or provide services pursuant to such contract shall register and participate in the E-Verify program to verify information and work authorization of its newly hired employees performing work pursuant to such public contract. Any such employer who fails to comply with these provisions shall be debarred from contracting with any agency of the Commonwealth for a period up to one year. Such debarment shall cease upon the employer's registration and participation in the E-Verify program. If requested, the employer shall present a copy of their Maintain Company page from E-Verify to prove that they are enrolled in E-Verify.

21.2.20 Governing Law

The Contract must be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

21.2.21 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, all liability, loss, damage, costs, or expenses which the Department may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor.

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.

21.2.22 Independent Contractor

Any Contractor awarded a contract under this Contract will be considered an independent contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of the Department.

21.2.23 Liability Notification

The Contractor must notify the Department immediately in writing when it or one (1) of its subcontractors 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.

21.2.24 Loss of Licensure

If, at any time during the term of this Contract, the Contractor or any of its Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary Federal or State approvals, the Contractor must report such loss to the Department. Such loss may be grounds for termination of this Contract.

21.2.25 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.

21.2.26 No Third Party Rights of Enforcement

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

21.2.27 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. The Department must have open access to the above. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

21.2.28 Prevailing Contract

This Contract supersedes all prior agreements, representations, negotiations, and undertakings not set forth the Contract or incorporated herein. The terms of this Contract must prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

21.2.29 Presentations and Publication Involving Virginia Data and Information

The Contractor must 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.

21.2.30 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

21.2.31 Qualified Signatory

The Contractor must, in order to meet the necessary requirements to qualify as a signatory to this Contract, meet all the requirements outlined in this contract 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).

21.2.32 Records and 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 Department.

21.2.33 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.

21.2.34 Right to Recovery 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.

21.2.35 Severability

Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. The Department and the Contractor further agree that in the event any provision is deemed an invalid part of this Contract, they shall immediately begin negotiations for a suitable replacement provision.

21.2.36 Sovereign Immunity

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Virginia of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

21.2.37 Specific State Laws and Regulations Governing the Provision of Medical Services

The Contractor must 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 and Chapter 5-210; (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.

21.2.38 State Corporation Commission Identification Number

Pursuant to *Code of Virginia*, § 2.2-4311.2 subsection B, an Offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its proposal the identification number issued to it by the State Corporation Commission (SCC). Any Offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its proposal a statement describing why the Offeror is not required to be so authorized. Indicate the above information on the SCC Form provided (Reference Attachment V- State Corporation Commission Form). Contractor agrees that the process by which compliance with Titles 13.1 and 50 is checked during the solicitation stage (including without limitation the SCC Form provided) is streamlined and not definitive, and the Commonwealth's use and acceptance of such form, or its acceptance of Contractor's statement describing why the Offeror was not legally required to be authorized to transact business in the Commonwealth, Shall not be conclusive of the issue and shall not be relied upon by the Contractor as demonstrating compliance.

21.2.39 Subcontracts

No portion of the work shall be subcontracted without prior written consent of the Department. In the event that the Contractor desires to subcontract some part of the work specified herein, the Contractor shall furnish the Department with the names, qualifications and experience of their proposed subcontractors. The Contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

21.2.39.1 **Notice of Subcontractor Termination**

When a subcontract that relates to the provision of program services to participants is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor’s intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how continuity of care will

be maintained. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted provider and/or participants of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of performance penalties as described in Appendix F of this Contract Extension. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

21.2.40 Termination of Contract

The Contractor may elect not to renew its Contract with the Department at the end of the term of the Contract for any reason, provided it meets the timeframe for doing so set forth in this Contract. The Contractor may opt out of automatic renewal clause if it provides notice to the Department in writing at least six (6) full calendar months prior to the renewal. For it to be effective, the Contractor must receive from the Department a written acceptance of a nonrenewal of less than six (6) months. If the Contractor fails to notify the Department of the nonrenewal on or before this date, the Contract will be automatically renewed.

At the Department's sole discretion and for good cause shown, a nonrenewal notice with less than six (6) full calendar months' notice may be accepted by the Department. The notice must include an explanation of the Contractor's grounds for nonrenewal and acceptance, if any, must be in writing from the Department.

21.2.40.1 **Terms of Contract Termination**

This Contract may be terminated in whole or in part:

1. By the Contractor, for convenience, with not less than one hundred eighty (180) calendar days advance written notice;
2. By the Department, for convenience, with not less than ninety (90) calendar days advance written notice;
3. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
4. By the Department, as specified below, if the Department determines that the instability of the Contractor's financial condition threatens delivery of Managed Care services and continued performance of the Contractor's responsibilities; or
5. By the Department, as specified below, if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

If at any time the contract is terminated by either the Contractor or the Department, the Contractor's D-SNP contract with the Department will also be terminated.

Each of these conditions for Contract termination is described in the following paragraphs.

21.2.40.2 **Termination for Convenience**

The Contractor may terminate this Contract upon one hundred and eighty (180) calendar days advance written notice. In addition, the Contractor may terminate the Contract by opting out of the renewal

clause. The Department may terminate this Contract upon ninety (90) calendar days advance written notice.

21.2.40.3 Termination for Unavailable Funds

See Section 21.1.20 above for provisions on Termination for Unavailable Funds.

21.2.40.4 Termination for Financial Instability

In the event that the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceasing to conduct business in normal course, making 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 must be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor must 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 must immediately so advise the Department. The Contractor must ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

21.2.40.5 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 must 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 must 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.

In the event the Department determines that the Contractor's failure to perform its duties and responsibilities under this Contract results in a substantial risk to the health and safety of its Members, the Department may impose temporary management under 42 CFR § 438.702(a)(2). The Department must also grant Members the right to terminate enrollment without cause, as described in 42 CFR § 438.702(a)(3), and must notify the affected Members of their right to terminate enrollment.

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 must be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties must 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 must be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor must 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 must be governed by the procedures defined by the Department for handling Contract termination. Nothing herein must 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 must be paid for any outstanding capitation payments due less any assessed damages.

21.2.40.6 Termination for Debarment

Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The Contractor will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

Prior to terminating this Contract for default, financial instability, or debarment, the Department will provide the Contractor with pre-termination hearing, pursuant to Section 20.1.1, *Escalation Procedures*.

21.2.41 Termination Procedures

21.2.41.1 Pre-Termination Hearing

In accordance with 42 CFR §438.710(b) and 438.710(b)(2)(i)-(iii), the Department:

1. Will provide the Contractor with a pre-termination hearing before terminating the Contractor's contract pursuant to the third escalation level in Section 20.1.1, *Escalation Procedures*;
2. Must give the Contractor written notice of its intent to terminate and the reason for termination;
3. Must provide the Contractor with the time and place of the pre-termination hearing;
4. Must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract;
5. For an affirming decision, the Department will give Members of the Contractor notice of the termination and information, consistent with 42 CFR § 438.10, on the individual's options for

receiving Medicaid services following the effective date of termination or the right of Members to disenroll immediately without cause.

21.2.41.2 Continued Obligations of the Parties

In the event of termination, expiration, or nonrenewal of this Contract, or if the Contractor otherwise withdraws from the Virginia Medicaid program, the continuing obligations imposed by this Contract or applicable law on the Contractor remain in effect. These include, without limitation, the obligations to continue to provide Covered Services to each Member at the time of such termination or withdrawal until the Member has been disenrolled from the Contractor's health plan. The Department will disenroll the Member by the end of the month that termination, expiration, or nonrenewal of this contract is effective.

21.2.41.3 Continuity of Services

The Contractor recognizes that the services under this Contract are vital to the Department and must be continued without interruption and that, upon Contract termination, a successor, either the Department or another Contractor, may continue them.

The Contractor agrees:

1. To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
2. To make all the Department owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor such as training, transferring records and encounter data, etc.;
3. That the Department has final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.
4. The Contractor must, upon written notice from the Department, furnish phase-in/phase-out services for up to ninety (90) calendar days after this contract expires and must negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan is subject to the Department's approval; and
5. The Contractor will be reimbursed for all reasonable, preapproved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the Department in writing prior to commencement of said work.

21.2.41.4 Liability for Medical Claims

The Contractor is liable for all medical claims incurred up to the date of termination. This must include all of the hospital inpatient claims incurred for Members hospitalized at the time of termination.

21.2.41.5 Refunds of Advanced Payments

If the Contract is terminated under this Section, the Contractor is entitled to be paid a prorated 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 is not entitled to be paid for any services

performed after the effective date of the termination. The Contractor must, 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.

21.2.41.6 Notification of Members

In all cases of termination, the Contractor must notify Members about the termination. All notifications from Contractor must be approved by the Department in advance. The Department will reassign Members to new MCOs, as appropriate, and will notify all Members covered under this Contract of the date of termination and the process by which those Members will continue to receive care or the right of Members to disenroll immediately without cause. In cases of termination for default or financial instability, the Contractor is liable for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification must 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 will be responsible for the costs associated with Department-issued notifications. The Contractor must conduct these notification activities within a time frame established by the Department.

21.2.41.7 Transition of Membership

Upon cancellation of the Contract in any region of the Commonwealth, the Department will reassign individuals to the remaining health plans in the region.

21.2.41.8 Notification of Network Providers

In all cases of termination, the Contractor must notify its network providers about the termination of the Contract and about the reassigning of its Members by the Department to other MCOs and for covering the costs associated with such notification. The Contractor must conduct these notification activities within a time frame established by the Department.

21.2.41.9 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 must:

1. Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;
2. Place no further orders or subcontracts for materials, services, or facilities;
3. 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;
4. Assign to the Department in the manner and to the extent directed all the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department has the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
5. 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;

6. Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;
7. 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
8. 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 must 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 Contractor must return to the Department any property made available for its use during the Contract term.

21.2.42 Remedies for Violation, Breach, or Non-Performance of Contract

If the Contractor violates, breaches, or otherwise fails to perform per the provisions of this Contract, the Department reserves the right to employ, at the Department's sole discretion, any and all remedies available under this Contract, at law or in equity, including but not limited to, payment withholds and/or termination of the contract as described in Section 17, *Oversight*, Section 20.1.1, *Escalation Procedures*, and Section 21.2.40, *Termination of Contract*.

21.2.43 Waiver of Rights

The Contractor or the Department is not deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor or the Department in exercising any right must operate as a waiver of such right or any other right. A waiver on any occasion must not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by the Department of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

21.2.44 Contractor Certifications

The Contractor understands that all procurement procedures are to be conducted in a fair and impartial manner with avoidance of any impropriety or appearance of impropriety (Code of Virginia § 2.2 – 4300).

By executing this Contract, the Contractor makes the following certifications:

1. The Contractor did not solicit or receive, whether intentionally or unintentionally, any non-public information concerning the Cardinal Care program from an employee, subcontractor, or any other source at any time prior to the execution of this Contract.
2. The Contractor understands that this is an ongoing certification, and if at any time the Contractor becomes aware that non-public information about the procurement was solicited or received from an employee, subcontractor, or any other source, the Contractor certifies it will inform the Department in writing immediately.

22. DEFINITIONS

Abuse, Member – The suspected or known physical or mental mistreatment of a Member which must be reported immediately upon discovery.

Abuse, Provider – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that 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 CFR §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. 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.

Activities of Daily Living – Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs. Also see Instrumental Activities of Daily Living (IADLs).

Actuarially Sound Capitation Rates – As defined in 42 CFR §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.

Acute Care - Preventive care, primary care, and other inpatient and outpatient medical care and behavioral health care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital - Includes an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

Addiction and Recovery Treatment Services (ARTS) – A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This includes: (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); (vi) substance use case management; (vii) opioid use treatment service and (viii) peer recovery support services. Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and the Department's medical necessity criteria using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

Adjudicated Claim – A clean claim that has been paid in full, denied in full or denied in part by the Contractor or its subcontractors. Clean claims are considered to be paid on the date the payment is made via EFT or the date the check has been postmarked. Pended clean claims must not be considered adjudicated.

Administrative Dismissal – Means:

1. A 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; or
2. A Member appeal dismissal made on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the Contractor.

Administrative Transitions – The process of assisting a Member with a transition to a different MCO, between Managed Care and FFS (including transitions that result in disenrollment from Managed Care), and/or between providers upon a provider's termination from an MCO's network.

Adoption Assistance – A social services program, under Title XX of the Social Security Act, that provides the adoptive parents with the necessary assistance to adopt and care for the child who has special needs and who meets eligibility criteria. It is not intended to cover the full cost of raising the child. Rather, it supplements the resources of the adoptive parents.

Adult Day Health Care – Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at-risk of placement in a nursing facility.

Adverse Action – The denial, suspension, or reduction in services or the denial or retraction, in whole or in part, of payment for a service that has already been rendered.

Adverse Benefit Determination – For Members, pursuant to 42 CFR §438.400, means any of the following: (i) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for service solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b) is not an adverse benefit determination; (iv) the failure to provide services in a timely

manner, as defined by the State; (v) the failure of the Contractor to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) for a resident of a rural area with only one (1) MCO, the denial of a Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Agency-Directed Services - A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

Agency Provider - A public or private organization or entity that holds a Medicaid provider agreement and furnishes services to individuals using its own employees or subcontractors.

AllPayers Claim Database - Established by the Virginia General Assembly to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system as provided by Virginia Code § 32.1-276.7:1.

Alternate Formats - Provision of enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternate Formats must include, but not be limited to, braille, large font, audio tape, video tape, and information read aloud to an enrollee.

Alternative Benefit Plan (ABP) – Medicaid state plan option to provide certain groups of Medicaid enrollees with benchmark or benchmark-equivalent coverage through an alternative benefit plan (ABP) instead of following the traditional Medicaid benefit plan. ABPs can be specifically tailored to meet the needs of certain Medicaid population groups. In accordance with 42 CFR §440.347, ABPs authorized under Section 1937 of the Social Security Act are required to meet essential health benefit (EHB) standards. Programs that operate under an ABP must cover the 10 EHBs as described in Section 1302(b) of the Affordable Care Act. Individuals in the MAGI Adult Medicaid expansion and Medicaid Works covered groups operate through an ABP.

Ameliorate - To improve a condition or to prevent a condition from getting worse.

American Indian/Alaska Native – An individual, defined at Title 25 of the U.S.C. Sections 1603(c), 1603(f), 1679(b) who has been determined eligible, as an Indian, pursuant to 42 CFR §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. Also refer to the population referenced in 42 CFR §438.14.

Annually - For the purposes of contract reporting requirements, annually must 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 Managed Care Contract or Cardinal Care Technical Manual.

Appeal - Means:

1. For Members, in accordance with 42 CFR § 438.400, a Member appeal is defined as a request to the Department for a State Fair Hearing of a Contractor's internal appeal decision to uphold the Contractor's adverse benefit determination. After a Member exhausts the Contractor's one-step internal appeal process, the Member may appeal to the Department. Member appeals to the Department will be conducted in accordance with regulations at 42 CFR §431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
2. For Providers, a Provider appeal is a request made by a Provider (in-network or out-of-network) to review the Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a Provider exhausts the Contractor's reconsideration process, Virginia Medicaid affords the Provider the right to two (2) administrative levels of appeal (informal appeal and formal appeal) with the Department in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 et seq., and Virginia Medicaid's Provider appeal regulations, 12 VAC 30-20-500 et seq.

Applicable Law - Without limitation, all Federal and State law, and the regulations, policies, procedures, and instructions of CMS and the Department all as existing now or during the term of this Contract.

Applicable Integrated Plan - According to 42 CFR §422.561, Applicable integrated plan means:

1. A fully integrated dual-eligible special needs plan with exclusively aligned enrollment or a highly integrated dual-eligible special needs plan with exclusively aligned enrollment, and
2. The Medicaid MCO, as defined in Section 1903(m) of the Act, through which such dual-eligible special needs plan, its parent organization, or another entity that is owned and controlled by its parent organization covers Medicaid services for dually eligible individuals enrolled in such dual-eligible special needs plan and such Medicaid MCO.

Applied Behavior Analysis (ABA) – Means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Assertive Community Treatment (ACT) – Means intensive nonresidential treatment and rehabilitative mental health services provided in accordance with the fidelity model of ACT. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients with serious mental illness (SMI) whose needs have not been well met by more traditional service delivery approaches.

Assess - To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

Assessment - Processes used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the person-centered Individualized Care Plan (ICP) and the determination of whether an individual requires HCBS waiver services.

Assistive Technology - Specialized medical equipment and supplies including those devices, controls, or appliances specified in the ICP, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs/IADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual's assessed medical needs and deficits. Assistive Technology items are expected to be portable.

Attendant - An individual who provides consumer-directed personal assistance, respite or companion services through a consumer-directed model.

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.

Authorized Representative - A person who is authorized to conduct the personal or financial affairs for an individual who is eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

Bachelor's-Level Social Worker (BSW) – A person who holds a Bachelor's degree from an accredited school of social work. Individual is not currently licensed and may or may not be working toward meeting licensure requirements.

Balance Billing - When a provider bills a Medicaid enrollee for the difference between the provider's charge and the allowed amount.

Base Medicaid Member - A Member whose eligibility is not governed by Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act; i.e., any Member who is not a MAGI Adult Medicaid Expansion Member.

Behavioral Health Home - A team based services delivery model that provides comprehensive and continuous care to patients, including care coordination, with the goal of maximizing health outcomes. For this Contract, Health Homes will not need to meet the standards set forth in §2703 of the Patient Protection and Affordable Care Act.

Behavioral Health Inpatient Services - Acute psychiatric or substance use disorder treatment services provided to Members in a psychiatric unit of a general acute care hospital, a free-standing psychiatric setting (state or private).

Behavioral Health Outpatient Services - Non-acute psychiatric services that are provided to Members in a variety of non-facility-based settings including community settings.

Behavioral Health Services - An array of therapeutic services provided in inpatient and outpatient psychiatric and community mental health settings. Services are designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

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 (4) basic comparisons: with self, with others, with standards, and with best practices.

Building Independence (BI) Waiver -The CMS-approved HCBS § 1915(c) waiver whose purpose is to provide support in the community for individuals eighteen (18) years of age or older who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by the Department and DBHDS.

Birth Injury Fund - Virginia Birth-Related Neurological Injury Compensation Fund is commonly known as the Birth Injury Fund. More information can be found on the Virginia Department of Health website.

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 CFR §160.103.

Business Days - Monday through Friday, 8:00 AM to 5:00 PM, Eastern Time, except for legal holidays and unless otherwise stated.

Capitation Payment - A payment the Department makes periodically to the Contractor on behalf of each Member enrolled under the Contract for the provision of services under the State Plan or waivers, regardless of whether the Member receives services during the period covered by the payment. Any and all costs incurred by the Contractor in excess of the capitation payment must be borne in full by the Contractor.

Capitation Rate - The monthly amount, payable to the Contractor, per Member, for the provision of contract services as defined herein. The Contractor must accept the annually established capitation rates paid each month by the Department as payment in full for all Medicaid services to be provided pursuant to the Contract and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Case Management – As described in the Social Security Act, § 1915(g)(2), case management services include those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service.

Case Relationship - Managed Care Member included in the same case record with the Member's local Department of Social Services.

Care Coordination – The act of organizing patient care activities, available for all MCO members including those not identified for ongoing care management. Activities include ensuring an ongoing source of care, coordinating services between settings/delivery systems and conducting initial screenings in accordance 42 CFR § 438.208.

Care Management – Team-based, person-centered approach to effectively managing patients' medical, social and behavioral conditions with consideration given to utilization trends, quality factors and provider performance.

Care Management Contacts – Instances where a Care Manager engages the Member (or their guardian/caretaker, as appropriate) in one or more Care Management interventions. Contacts that are not required to be in-person may be telephonic or via videoconference.

Care Management Intensity – Describes level of care management services provided to the member and reflects care manager caseload requirements, assessment modality (e.g., in-person, telephonic or via videoconference), and Care Management contact requirements.

Care Manager – Individual with primary responsibility for delivering Care Management to Members.

Cardinal Care Technical Manual - 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.

Caregiver - A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends, or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

Carved-Out Services - The subset of Medicaid covered services for which the Contractor will not be responsible under this Contract.

Centers for Medicare and Medicaid Services (CMS) - The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Titles XVIII, 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 and Youth with Special Health Care Needs (CYSHN) - Children and youth with special needs that 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 categories of foster care and adoption assistance (aid category 076 and 072), youth who have aged out of the foster care system (Aid Category 70), children identified as Early Intervention (EI) participants, Members identified as experiencing childhood obesity and others as identified through the Contractor's assessment or by the Department.

Children's Health Insurance Program (CHIP) - Insurance program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500 or UB-92.

Clean Claim - Consistent with 42 CFR §438 §447.45, a claim that can be processed without obtaining additional information from the provider of the service or from a third party. A clean claim 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.

Clinical Laboratory Improvement Amendments - A laboratory testing program regulated by the Centers for Medicare and Medicaid Services and implemented by the Division of Laboratory Services under the Center for Clinical Standards and Quality. CLIA covers approximately 254,000 laboratory entities. CLIA defines a clinical laboratory as any facility which performs laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention, or treatment of disease or impairment.

Clinical Trial (Qualifying Clinical Trial) - In accordance with SMD # 21-005 this includes a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition, as further defined in SMD#21-005.

Coinsurance – The percentage of costs of a covered health care service that the Member pays after the Member has paid his or her deductible.

"Cold Call" Marketing - Any unsolicited personal contact by the Contractor with a potential Member for the purpose marketing.

Common Core Formulary - A subset of the Contractor's formulary that includes all the preferred drugs from the Department's Preferred Drug List (PDL). The Contractor may add drugs to the therapeutic drug classes on the Department's PDL/Common Core Formulary but cannot remove drugs.

Commonwealth Coordinated Care Plus Program - The Department's former mandatory integrated care initiative for certain qualifying individuals, including dual-eligible individuals and individuals receiving long-term services or supports (LTSS). The CCC Plus program included individuals who receive services through Nursing Facility (NF) care, or from the Department's home- and community-based services (HCBS) 1915(c) waivers.

Commonwealth Coordinated Care Plus (former) Managed Care Program Participants - Individuals in the Aged, Blind and Disabled (ABD), LTSS, and Medically Complex MAGI Adult Covered Population Groups.

Commonwealth Coordinated Care Waiver - The Department's Home- and Community-Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two (2) benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital

body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the CCC Plus program.

Community-Based Team – Community-based screening team. A nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, VDH or the LDSS. CBTs conduct screenings for adults and children who live in the community and are not currently inpatients.

Community Living (CL) Waiver - The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have Developmental Disability (DD) and meet the ICF/IID level of care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver.

Community Service Board (CSB)/Behavioral Health Authority (BHA) - A citizens' board established pursuant to Virginia Code §37.2-500 and §37.2-600 that provides mental health, developmental disability and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases, the term CSB also includes Behavioral Health Authority (BHA).

Community Stabilization - Short-term services designed to support an individual and their natural support system following contact with an initial crisis response service. Interventions may include brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services.

Complaint - An expression of Provider dissatisfaction about any matter other than an “adverse action.” Possible subjects for complaints include, but are not limited to, claims or service authorization processing time, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Contractor staff or employee, or failure to respect the Member’s grievance.

Compliance Notification – A formal notification to the Contractor detailing the compliance issue and requirements to become compliant. (Depending on the severity of the issue, the notification may include a Notice of Noncompliance (NoNC), Managed Care Improvement Plan (MIP), or Corrective Action Plan (CAP).) The three (3) "Compliance Notification Types" are defined in Section 17.2.

Consumer Assessment of Healthcare Providers and Systems (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.

Consumer-Directed (CD) Employee/Attendant - A person who is employed by a CCC Plus Waiver individual who is receiving services through the consumer-directed model or their representative to provide approved personal care, companion services, or respite care, or any combination of these three (3) services, and who is exempt in Virginia from Workers’ Compensation.

Consumer-Directed (CD) Services – HCBS (personal care and respite services) for which the CCC Plus Waiver individual or his or her representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) - The Medicaid enrolled provider who is responsible for supporting the CCC Plus Waiver Member or his or her representative, as appropriate, by ensuring the development and monitoring of the ICP, providing attendant management training, and completing ongoing review activities as required by the Department for CCC Plus Waiver Members who are consumer-directing personal care and respite services.

Continuity of Care – Activities to ensure a Member's safe and effective transitions that do not result in a disruption of care between Medicaid fee-for-service, Managed Care contractors, and/or contracted providers.

Contract - This signed and executed Managed Care program document, including all attachments or documents incorporated by reference.

Contract Amendment or Contract Modification – 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.

Contract Claim – Disputes arising out of this Contract, whether for money or other relief.

Contractor - A Managed Care health plan selected by the Department and contracted by execution of this Contract to participate in the Cardinal Care program.

Coordination of Benefits (COB) - The transmission from any entity to the Contractor for the purpose of determining the relative payment responsibilities of a health plan for health care claims or payment information.

Copayment – The portion of Medicaid allowed charges which the Member is required to pay directly to the provider for a covered service or drug.

Corrective Action Plan (CAP) – A detailed plan requested by the Department which requires the Contractor to identify the root cause of an issue and specify the plan of remediation to prevent further recurrence.

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 opinion, medical necessity review, and other pre-and post-payment /service reviews.

Cost Sharing – A global term that encompasses coinsurance, deductibles, patient pay, and copayments.

COV SEC - Commonwealth of Virginia (COV) Information Technology Resource Management (ITRM) policies, standards, and guidelines that may be updated from time to time.

Coverage Decision Letter - Describes the actions required by the enrollee and the enrollee's rights in the unified appeals process, including the date the determination was made, the date the determination will take effect, and language on continuation of benefits during appeal, as required under 42 CFR §422.631.

Covered Services – Services as outlined in this Contract that the Contractor must cover for its enrolled Members.

Cover Virginia – Virginia's telephonic customer service center and online portal providing statewide eligibility information and assistance for Medicaid FAMIS, newborns, Department of Corrections, Plan First, Fee-for-service, and other insurance options. Cover Virginia's website provides easy access to information about Virginia's FAMIS and Medicaid programs, including eligibility and how to apply. Staff at the Cover Virginia statewide customer service center at 1-855-242-8282 provide confidential application assistance and program information. Individuals can apply, report changes or renew an individual's coverage by calling Cover Virginia.

Credentialing - The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver covered services.

Credibility Adjustment - As defined in 42 CFR §438.8, an adjustment to the Medical Loss Ratio (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.

Crisis Support Services - Services designed for individuals experiencing circumstances such as (i) marked reduction in psychiatric, adaptive, or behavioral functioning; (ii) an increase in emotional distress; (iii) needing continuous intervention to maintain stability; or (iv) causing harm to themselves or others. Crisis support service means intensive supports by trained and, where applicable, licensed staff in crisis prevention, crisis intervention, and crisis stabilization for an individual who is experiencing an episodic behavioral or psychiatric event in the community that has the potential to jeopardize the current community living situation. This service is designed to prevent the individual from experiencing an episodic crisis that has the potential to jeopardize his current community living situation, to intervene in such a crisis, or to stabilize the individual after the crisis. This service must prevent escalation of a crisis, maintain safety, stabilize the individual, and strengthen the current living situation so that the individual can be supported in the community beyond the crisis period.

Critical Incident - A Critical Incident is any actual or alleged event or situation that threatens or impacts the physical, psychological, or emotional health, safety, or wellbeing of the Member. Critical Incidents include, but are not limited to, the following incidents: medication errors, theft, suspected physical, mental, verbal or sexual abuse or neglect, financial exploitation, and Sentinel Events.

Cultural Competence – The ability of health care providers and health care organizations to understand and respond effectively to a patient's cultural health beliefs, preferred languages, health literacy levels and communication needs.

Days - Business days, unless otherwise specified.

Deductible - The dollar amount that the Contractor may pay towards the cost of covered services for a dual-eligible Member.

Default Enrollment - An enrollment process that permits the automatic enrollment of a newly eligible dually-eligible beneficiary into a D-SNP if the enrollee is enrolled in an affiliated Medicaid Managed Care plan and will remain enrolled in an affiliated Managed Care plan upon become Medicare eligible.

Department of Behavioral Health and Developmental Services (DBHDS) - The state agency responsible for coordination of behavioral health, developmental disabilities, and substance use services through the local community services boards (CSBs). This agency has responsibility for the day-to-day operations of the Community Living Waiver, Family and Individual Supports Waiver, and the Building Independence Waiver. DBHDS also serves as the state Lead Agency for Virginia's early intervention system and is responsible for certification of early intervention providers and service coordinators/case managers.

Department of Health Professions (DHP) - The state agency that issues licenses, registrations, certifications, and permits to health care practitioner applicants that meet qualifications established by law and regulation. In addition to the Board of Health Professions, the following applicable boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Nursing, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, and Board of Social Work.

Department of Medical Assistance Services (Department) - The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children's Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

Developmental Disability (DD) Waivers - The CMS-approved HCBS §1915(c) waivers for individuals with developmental disabilities. The individuals are enrolled in either the Building Independence (BI), Community Living (CL), or the Family and Individual Supports (FIS) Waivers.

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

Disenrollment - The process of changing enrollment from one (1) Contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

Doula or "Community-Based Doula" - An individual based in the community who is trained to provide extended, culturally congruent support to families throughout pregnancy to include antepartum, intrapartum, during labor and birth, and up to one (1) year postpartum. Community-based doulas provide an expanded set of services and play a crucial role in improving outcomes and experiences for communities most affected by discrimination and disparities in health outcomes.

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

Dual-Eligible Individual - A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as Specified Low-Income Medicare Member (SLMBs), Qualified Medicare Member (QMBs), Qualified Disabled and Working Individuals (QDWIs), or Qualifying Individuals (QIs)) are not included in the CCC Plus program.

Dual-Eligible Special Needs Plan (D-SNP) - A type of Medicare Advantage (MA) plan that enrolls only dual-eligible individuals in Medicare and Medicaid.

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - Includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under twenty-one (21) years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service under the State Plan.

Early Intervention (EI) - Services provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR §440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth through the day before the third (3rd) birthday who have (i) a twenty-five percent (25%) developmental delay in one (1) 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. Per 12 VAC 35-225-70 children are not eligible to receive EI services on or after their third (3rd) birthday. Early intervention services provided in the child's natural environment to the maximum extent appropriate. EI services are covered by this Contract

Early Intervention Individualized Family Service Plan (IFSP) - A written plan developed by the Member's interdisciplinary team for providing early intervention supports and services to eligible children and families that:

1. Is based on evaluation for eligibility determination and assessment for service planning;
2. Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and
3. Is implemented as soon as possible once parental consent is obtained.

Electronic Visit Verification (EVV) – Verifies visit activity for in-home and in-community care services delivered and offers a measure of accountability to ensure that individuals receive the care and services they need and are authorized to receive.

Emergency Custody Order (ECO) – Judicial intervention to order law enforcement personnel to take into custody and transport for needed mental health evaluation and care or medical evaluation and care a person who is unwilling or unable to volunteer for such care pursuant to 42 CFR §441.150 and Code of Virginia, § 16.1- 335 et seq, § 37.2-808, § 16.1-340 (Juvenile), § 37.2-1103 (Medical), and § 16-1.340 (Court). A magistrate is authorized to order such custody on an emergency basis for short periods. Different emergency custody statutes apply to adults than to juveniles.

Emergency Department Care Coordination - Real time communication and collaboration among hospital emergency departments, physicians, other health care providers, and health plan clinical and

care management personnel to improve outcomes for populations with high utilization of EDs as required by state law through the Virginia Emergency Department Care Coordination Program.

Emergency Medical or Behavioral Health Condition - In accordance with 42 CFR §438.114(a), Mental Health Parity rules in 42 CFR §438.910(b), and Department standards, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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 individual, the health of that individual or their unborn child) in serious jeopardy; serious impairment to body functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant individual who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the pregnant individual or the unborn child.

Emergency Medical Transportation - Medically necessary ambulance transportation to the nearest appropriate facility where prompt medical services are provided in an emergency such as accident, acute illness or injury.

Emergency Room (also known as "Emergency Department") - A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency Services - Covered inpatient and outpatient services that are: (1) rendered by participating or non-participating providers qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR §438.114.

Employer of Record (EOR) - The individual who directs their own care and receives consumer-directed services from a CD attendant who is hired, trained, and supervised by the individual or the individual's representative.

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

Encounter Data – Data collected by the Contractor that documents all of the health care and related services provided to a Member. These services include, but are not limited to, professional services, medical supplies or equipment, and medications. Encounter data is collected on an individual Member level and includes the person's Medicaid ID number. It is also specific in terms of the provider, the medical procedure, and the date the service was provided. The Department and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring Managed Care plan's performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

Encounter Processing System (EPS) - The Department's Encounter Processing Solution (EPS) is a component module of the overall Medicaid Enterprise System (MES). The EPS is designed to fulfill all Department encounter data collection and validation needs.

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

Enhanced Benefits or 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 or FAMIS beneficiary who is currently enrolled in an MCO, used interchangeably with Member in this Contract.

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 entity 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 (Cardinal Care Managed Care Program) - Assignment of an individual to a health plan by the Department in accordance with the terms of this Contract. This does not include attaining eligibility for the Medicaid program.

Enrollment Period - The period of time that a Member is enrolled with a health plan.

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

Enrollment (Waiver) - The process whereby an individual has been determined to meet the eligibility requirements (financial and functional and medical/nursing) for a service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a HCBS waiver, effective the first (1st) day a waiver service is rendered. This does not include attaining eligibility for the Medicaid program.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined by Federal requirements set forth in 42 CFR §438.610.

Excluded Services - Services that are not covered under the Medicaid benefit.

Expedited Appeal - The accelerated process by which the Contractor must respond to an appeal by a Member if a denial of care decision by the Contractor may jeopardize life, physical or mental health, or ability to attain, maintain or regain maximum function.

External Appeal - An appeal, subsequent to the Contractor's appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions.

External Quality Review or EQR - Analysis and evaluation by an External Quality Review Organization (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 CFR §438.320.

External Quality Review Organization (EQRO) - An organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR§ 438.358.

F/EA - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 that has a separate Federal Employer Identification Number used for the sole purpose of filing Federal employment tax forms and payments on behalf of program individuals who are receiving CD services.

Family and Individual Supports (FIS) Waiver – The CMS-approved home- and community-based §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have a Developmental Disability (DD) and meet the ICF/IID level of care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

Family Planning - Services that delay or prevent pregnancy. Coverage of such services must not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions.

FAMIS Children – Comprehensive health coverage for uninsured children ages 0 – 18 not eligible for Medicaid, with family income at or below two hundred percent (200%) of the FPL (plus a five percent (5%) disregard). FAMIS is the Commonwealth's CHIP program, also referred to as Title XXI, administered by the Department and jointly funded by the state and federal governments.

FAMIS MOMS – FAMIS MOMS are uninsured, pregnant and postpartum members of any age, ineligible for Medicaid, with family income at or below two hundred percent (200%) of the federal poverty level (plus a five percent (5%) disregard). FAMIS MOMS is part of Virginia's CHIP program and authorized under a Section 1115 CHIP waiver. The benefit package is aligned with that of Medicaid pregnant individuals.

FAMIS Prenatal Coverage (PC) Population – Pregnant individuals eligible for coverage through the postpartum period under Virginia's CHIP State Plan, regardless of citizenship or immigration status. FAMIS PC members receive the FAMIS MOMS benefit package.

FAMIS Select Program - FAMIS Select is a voluntary component for families that have access to health insurance through their employer.

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 CFR §405.2401(b), as amended.

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.

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. A 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.

First Tier, Downstream, and Related Entities - Any party that enters into a written arrangement, acceptable to the Department, with the Contractor to provide administrative services or health care services to a CCC Plus program Member; or any party that enters into a written arrangement, acceptable to the Department, with persons or entities involved with providing CCC Plus benefits, below the level of a first tier entity; or, a related entity by ownership and control. A subcontractor relationship or related entity that could impact the Contractor's ability to comply with the requirements of this Contract.

Former Foster Care – For the purposes of this Contract, these individuals are enrolled in Aid Category 70. Depending on which group (Title IV-E or Non IV-E), their eligibility ranges from age eighteen (18) to twenty-six (26). These individuals were formerly covered under a Foster Care designation. Refer to Section 3.6, *Foster Care and Adoption Assistance Enrollment and Health Plan Selection*.

Formulary - A list of drugs that the MCO has approved. Prescribing some of the drugs may require service authorization. The Department has developed a Preferred Drug List (PDL) that must be a subset of the Contractor's formulary that includes all the preferred drugs from the Department's Preferred Drug List (PDL).

Foster Care - Pursuant to 45 CFR §1355.20, a twenty-four (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 IVE 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 twenty-six (26) years.

Fostering Futures - Virginia's program that implements provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages eighteen (18) to twenty-one (21). The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source.

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 CFR §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 MLR is not statistically significant. An MCO that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR

Fully Integrated Dual-Eligible Special Needs Plan (FIDE SNP) - As defined in 42 CFR §422.2, is a dual-eligible special needs plan that:

1. Provides dual-eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid MCO contract under Section 1903(m) of the Act with the applicable State;
2. Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long-term services and supports, and provides coverage of nursing facility services for a period of at least one hundred and eighty (180) days during the plan year;
3. Coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and
4. Employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.

Functional Family Therapy (FFT) - A short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including cooccurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a primarily home-based service that addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as a family.

Generally Accepted Accounting Principles (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 CFR §438.400, a grievance means an expression of dissatisfaction about any matter other than an "adverse action" or "adverse benefit determination." Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights.

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

Habilitation Services and Devices - Services and devices that help an individual keep, learn, or improve skills and functioning for daily living.

Healthcare Effectiveness Data and Information Set (HEDIS) – A tool developed and maintained by the National Committee for Quality Assurance (NCQA) that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality.

Health Equity - Fair and just opportunities to be as healthy as possible, requiring reducing and eliminating disparities in health and its determinants adversely affecting excluded or marginalized groups that have been excluded or marginalized, including poverty, discrimination, and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing, and safe environments.

Health Insurance - Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Health Insurance Portability and Accountability Act of 1996 (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 Risk Assessment - A comprehensive assessment of a Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, long-term services and supports (LTSS), and social needs. The HRA is used as a tool in Care Management to assist in the development of the Member's comprehensive person-centered Individualized Care Plan (ICP).

Highly Integrated Dual-Eligible Special Needs Plan (HIDE SNP) - As defined in 42 CFR §422.2, is a dual-eligible special needs plan offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one (1) of the following arrangements:

1. The capitated contract is between the MA organization and the Medicaid agency; or
2. The capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.

Home- and Community-Based Services (HCBS) Waivers - A variety of home- and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive one (1) or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional (Nursing Facility) placement. The 1915(c) waivers are one (1) of many options available to states to allow the provision of long-term care services in home- and community-based settings under the Medicaid program. States can offer a variety of services under a HCBS waiver. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Home Health Care - Health care services a person receives in the home including nursing care, home health aide services and other services.

Homeless – In accordance with 42 U.S.C., 254b, an individual experiencing homelessness is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Hospice - As defined in § 32.1-162.1 of the Code of Virginia, a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. Children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. A hospice utilizes a medically directed interdisciplinary team. A hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care must be available twenty-four (24) hours a day, seven (7) days a week.

Hospital or Health System - A facility that meets the requirements of 42 CFR §482, as amended.

Indian Health Care Provider (IHCP) – Per 42 CFR § 438.14, a health care program, including tribal clinic providers and providers of contract health services (CHS), operated by the Indian Health Service (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). Also refer to definition of AI/AN.

Individualized (Person-Centered) Care Plan (ICP) – The Contractor's comprehensive written document developed with a Member that specifies the Member's services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the Member's strengths, skills, needs, preferences, and goals. The ICP includes all aspects of an individual's care needs including, but not limited to, medical, behavioral, social, and long-term services and supports, as appropriate.

Individualized Education Program (IEP) – A written statement for a child receiving special education services that is developed, reviewed and revised in a team meeting in accordance with 34 CFR §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 (IFSP) - A written plan developed by the Member's interdisciplinary team for providing early intervention supports and services to eligible children and families that: 1) Is based on evaluation for eligibility determination and assessment for service planning; 2) Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and 3) Is implemented as soon as possible once parental consent is obtained. The IFSP requires a physician signature for the initial IFSP, annual IFSP and anytime a service is added or services change (as

determined through the IFSP Review process). Medical necessity is established by the IFSP combined with physician certification and must serve as the authorization for the identified early intervention services. No additional service authorizations must be required for EI services.

Individuals with Disabilities Education Act Early Intervention Services" or "IDEA-EIS" A program (as described in 20 U.S.C. § 1471 and 34 CFR §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 (1) or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development.

Infant and Toddler Online Tracking System (ITOTS) – Data system that collects early intervention eligibility information from the 40 local lead agencies; meets Section 618 Federal reporting requirements for Part C of the Individuals with Disabilities Education Act (IDEA).

Informal Support – The support provided by a Member's social network and community, such as family, friends, faith-based organizations, etc., and is typically unpaid.

Institution for Mental Disease (IMD) - In accordance with 42 CFR §435.1010, an IMD is 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. 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, and 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. A State Institution for Mental Disease or State Mental Hospital is a hospital, psychiatric institute, or other institution operated by the DBHDS that provides care and treatment for persons with mental illness.

Instrumental Activities of Daily Living (IADLs) - Activities such as meal preparation, shopping, housekeeping, laundry, and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of level of care and service needs. Also see Activities of Daily Living (ADLs).

Intensive In-Home Services (IIH) for Children/Adolescents Under Age Twenty-One (21) – Time-limited interventions provided in the Member's residence and when clinically necessary in community settings. IIH services are designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of a Member who is at-risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the Member.

Intensive Outpatient Services (ASAM Level 2.1) - A structured program of skilled treatment services for adults, children, and adolescents delivering a minimum of three (3) service hours per service day for adults to achieve an average of nine (9) to nineteen (19) hours of services per week and a minimum of two (2) service hours per service day for children and adolescents to achieve an average of six (6) to

nineteen (19) hours of services per week. Withdrawal management services may be provided as necessary. 12VAC30-130-5090.

Interdisciplinary Care Team (ICT) - A team of professionals that collaborate, either in-person or through other means, to develop and implement a person-centered Individualized Care Plan (ICP) built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and meets the medical, behavioral, LTSS, early intervention, and social needs of Members. ICTs include the MCO Care Manager and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, early intervention Care Manager/providers, social workers and other appropriate entities for the individual's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to individuals with intellectual/developmental disabilities 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 Members toward the achievement of a more independent level of functioning.

Internal Appeal – Means 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 as defined in this Contract. 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.

Investigation – As used in this Contract related to program integrity activities, an investigation is a review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. The Department reserves the right to expand upon any investigation.

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.

Joint Legislative Audit and Review Commission (JLARC) - Conducts policy analysis, program evaluation, and oversight of state agencies on behalf of the Virginia General Assembly. The duties of the Commission are authorized by the Code of Virginia §30-58.1.

Laboratory - A place performing tests 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 CFR §493.3, as amended.

Legal Holiday – Twelve (12) specific days of any calendar year that State offices are closed. Contractors may elect to be closed for Legal holidays; however, it is not required. Legal holidays do not include any additional time off that may be appropriated to State employees by the Governor or legislature.

Level of Care (LOC) - The specification of the minimum amount of assistance that an individual requires in order to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive CCC Plus Waiver services.

Level of Care Review - The periodic, but at least annual, review of a Member's condition and service needs to determine whether the Member continues to need a level of care specified by a waiver. Also referred to as Level of Care Review Instrument (LOCERI). Also see the definition for nursing facility annual reassessment. For more information about LOCERI, including the Level of Care User Guide and Tutorial, is available on the Virginia Medicaid Web Portal, Provider Resources tab.

Licensed Child-Placing Agency or "Child-placing agency" - Means (i) any person who places children in foster homes, adoptive homes, or independent living arrangements pursuant to § 63.2-1819; (ii) a local board that places children in foster homes or adoptive homes pursuant to §§63.2-900, 63.2-903, and 63.2-1221; or (iii) an entity that assists parents with the process of delegating parental and legal custodial powers of their children pursuant to Chapter 10 (§ 20-166 et seq.) of Title 20. "Child-placing agency" does not include the persons to whom such parental or legal custodial powers are delegated pursuant to Chapter 10 (§ 20-166 et seq.) of Title 20. Officers, employees, or agents of the Commonwealth or any locality thereof, acting within the scope of their authority as such, who serve as or maintain a child-placing agency must not be required to be licensed.

Licensed Bachelor's-Level Social Worker (LBSW) – Person who holds a Bachelor's degree from an accredited school of social work and has met all requirements necessary to achieve licensure in Virginia.

Licensed Master's Social Worker (LMSW) – Person who holds a Master's degree from an accredited school of social work and has met all requirements necessary to achieve licensure in Virginia.

Licensed Mental Health Professional (LMHP) - An individual licensed in Virginia as a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker (LCSW), licensed substance abuse treatment practitioner, licensed marriage and family therapist, certified psychiatric clinical nurse specialist, licensed behavior analyst, or licensed psychiatric/mental health nurse practitioner.

Limited English Proficient (LEP) - In accordance with 42 CFR §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 (LEIE) - When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs, information about the provider is

entered 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 Web site 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).

Local Education Agency - A local public 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 that has enrolled with the Department as a provider of Local Education Agency-Based Services.

Local Education Agency-Based Services - State plan-approved health care services rendered to Member students in a school setting by qualified providers employed or contracted by a Department-enrolled Local Education Agency Provider. Claims for these services are processed as FFS and the local education agency is reimbursed using a reconciled cost-based methodology. These services are carved-out of the Managed Care contracts.

Local Lead Agency - 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 Distance Trip – A trip at least twenty one (21) miles or greater from the point of pick up.

Long-Stay Hospital (LSH) – Hospitals that provide a slightly higher level of care than Nursing Facilities. The Department recognizes two (2) facilities that qualify the individual for exemption as Long-Stay Hospitals: Lake Taylor Transitional Care Hospital (Norfolk) and Hospital for Sick Children Pediatric Center (Washington, DC).

Long-term Acute Care Hospitals (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 and are covered under this Contract.

Long-term Services and Supports (LTSS) – Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

MAGI Adults (also known as the Medicaid expansion group) - This population includes adults who are aged nineteen (19) through sixty-four (64) years of age, with incomes up to one hundred thirty eight percent (138%) of the federal poverty level (one hundred thirty three percent (133%) plus a five percent (5%) income disregard), who do not have Medicare, and who are not otherwise eligible for a Medicaid mandatory coverage group. Low-income families, qualified pregnant women and children, individuals eligible under the aged, blind, and disabled groups are examples of mandatory eligibility groups, as described in 12 VAC 30-30-10.

Managed Care Improvement Plan (MIP) – A detailed plan requested by the Department requiring the Contractor to identify and address the root cause of compliance violations, failures, or deficiencies.

Managed Care Plan or Managed Care Organization (MCO) – An organization which offers Managed Care health insurance plans (MCHIP), as defined by Virginia Code § 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 (1) 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 (1) 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 must be deemed to be offering one (1) or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider must 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 must encompass only one (1) provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR §438.2, an entity that has qualified to provide the services covered under this Contract to qualifying Members must be as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other individuals within the area served, and meets the solvency standards of 42 CFR §438.116.

Managed Care Program - As defined in 42 CFR §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.

Managing Employee – In accordance with 42 CFR §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.

Mandatory High Priority Population – Members, as defined in Section 8.4.2, *Priority Populations*, whom the Contractor must assign to receive High Intensity Care Management.

Mandatory Priority Population – Members, as defined in Section 8.4.2, *Priority Populations*, whom the Contractor must assign to receive Care Management.

Marketing - In accordance with 42 CFR §438.104 means any communication, from an MCO to a Medicaid Member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the Member 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 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.

Master's-Level Social Worker (MSW) – Person who holds a Master's degree from an accredited school of social work. Individual is not currently licensed and may or may not be working toward meeting licensure requirements.

Material Adjustment - As defined in 42 CFR §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.

MCO-Determined Priority Population – Members, as defined in Section 8.4.2*, Priority Populations*, whom the Contractor must assign to receive either Care Management or Care Coordination, at the Contractor's discretion.

Medallion 4.0 - Former statewide mandatory Medicaid program, approved by the Centers for Medicare and Medicaid Services through a 1915(b) waiver, which utilizes contracted MCOs (MCOs) to provide medical services to qualified individuals.

Medallion 4.0 (former) Managed Care Program Participants – Individuals in the Medicaid and FAMIS Low-Income Families and Children Covered Population Groups.

Medicaid Enterprise System (MES) - The Department's modernized technology system which will replace the current Medicaid Management Information System (MMIS).

Medicaid Fraud Control Unit (MFCU) - 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 (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 Program - A voluntary Medicaid plan option that enables workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid.

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

Medically Complex MAGI Adult – Individuals eligible in a MAGI adult aid category, i.e., 100, 101, 102, or 103, who receive LTSS, or are a former Governor's Access Plan (GAP) participant, or have a complex medical or behavioral health condition and a functional impairment, or who have an intellectual or developmental disability.-.

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 eighteen (18), foster care and adoption assistance, and those in ICF/IIDs up to

age twenty-one (21), ABD up to age twenty-one (21). Parents and caretaker relatives do not qualify under medically needy.

Medically Necessary or Medical Necessity – Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age twenty-one (21)), and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Medication Monitoring - An electronic device only available in conjunction with Personal Emergency Response Systems (PERS) that enables certain waiver individuals who are at-risk of institutionalization to be reminded to take their medications at the correct dosages and times.

Medicare Title XVIII of the Social Security Act - the Federal health insurance program for people age sixty-five (65) or older, people under sixty-five (65) with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment (DME), and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare Member with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage - Sometimes referred to as "MA Plans," includes all of an individual's Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Medicare Part A - Insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Medicare Part B - Insurance that helps cover medically necessary services like doctors' services, outpatient care, durable medical equipment (DME), home health services, and other medical services. Part B also covers some preventive services

Medicare Part D - Medicare prescription drug coverage.

Member - A person eligible for Medicaid or CHIP/FAMIS 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 Contractor to the Member prior to the first (1st) day of the month in which their enrollment starts.

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

Member Medical Record – Documentation containing medical history, including information relevant to maintaining and promoting each Member's general health and wellbeing, as well as any clinical information concerning illnesses and chronic medical conditions.

Mental Health Parity Addiction Equality Act (MHPAEA) – A federal law that generally prevents group health plans and health issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical (M/S) benefits.

Mental Health Case Management - Service to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services.

Mental Health - Intensive Outpatient - (MH-IOP)- Intensive Outpatient Services (IOP) are structured programs of skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment. (State Plan Amendment and Appendix E of Mental Health Services Manual).

Mental Health Parity Addiction Equality Act (MHPAEA) – Requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

Mental Health - Partial Hospitalization Program – (MH-PHP) - Mental Health Partial Hospitalization Programs are standard, short-term, non-residential, medically-directed services for adult and youth members who require intensive, highly coordinated, structured and interdisciplinary ambulatory treatment within a stable environment that is of greater intensity than Intensive Outpatient, Mental Health Skill Building, or Psychosocial Rehabilitation.

Mental Health Professional – In accordance with the Virginia Department of Health Professions (DHP), a Mental Health Professional is a person who by education and experience is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual's achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development. See Virginia Administrative Code for more information.

Mental Health Skill-Building Services – Goal directed training to enable Members to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services must include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the Member's health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Minimum Data Set (MDS) - Part of the federally-mandated process for assessing individuals receiving care in Certified Nursing Facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for Nursing Facility residents to return to

community settings. All Medicare and Medicaid certified nursing facilities were required to use the MDS 3.0.

Mobile Crisis Response – Provides rapid response, assessment, and early intervention to individuals experiencing a behavioral health crisis. This service is provided twenty-four (24) hours a day, seven (7) days a week.

Model of Care – A comprehensive plan that describes the Contractor's population; identifies measurable goals for providing high quality care and improving the health of the enrolled population; describes the Contractor's staff structure and Care Management roles; describes the interdisciplinary care team; system of disseminating the Model to Contractor staff and network providers; and, provides other information designed to ensure that the Contractor provides services that meet the needs of Members.

Money Follows the Person (MFP) – A former demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain institutions into the community. To participate in MFP, individuals must: 1) have lived for at least ninety (90) consecutive days in a Nursing Facility, an intermediate care facility for persons with intellectual disabilities (ICF/ID), a long-stay hospital licensed in Virginia, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof; and, 2) move to a qualified community-based residence. The MFP program ceased effective December 31, 2017. Individuals enrolled in MFP were not eligible for the CCC Plus program.

Monitoring - The ongoing oversight to determine that services are administered according to the individual's ICP and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include, but are not limited to, telephone contact; observation; interviewing the Member and/or the Member's family, as appropriate, in-person or by telephone; and/or interviewing service providers.

Monthly – For the purpose of Contract reporting requirements, monthly must be defined as the fifteenth (15^{th}) day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's monthly reports are due by March 15th, etc.

Multisystemic Therapy (MST) - An intensive, evidence-based treatment program provided in home- and community settings for youth who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes engagement with the youth's family, caregivers and natural supports and professionals delivering interventions in the recovery environment.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

National Provider Identifier (NPI) - NPI is a national health identifier for all health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The

assigned NPI does not expire. All providers who provide services to individuals enrolled in this contract will be required to have and use an NPI.

Network Provider - Any provider, group of providers, or entity that has a network provider agreement with a MCO or a subcontractor, and receives Medicaid or CHIP/FAMIS 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. A network provider is not a subcontractor by virtue of the network provider agreement.

No Credibility - As defined in 42 CFR §438.8, a standard for which the experience of an MCO is determined to be insufficient for the calculation of a Medical Loss Ratio (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 CFR §438.8, expenses for administrative services that are not: Incurred claims (as defined in 42 CFR §438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 CFR §438.8(e)(3)); or licensing and regulatory fees, or Federal and State taxes (as defined in 42 CFR §438.8 (f)(2)).

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

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

Notice – A written statement that meets the requirements of 42 CFR §438.404.

Notice of Non-Compliance (NoNC) – A written warning notifying the Contractor of the compliance concern.

Nursing Facility (NF) – Any licensed skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether free-standing or a portion of a free-standing medical care facility. This includes, but is not limited to, a facility that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the Code of Virginia, §32.1-137.

Nursing Facility Annual Reassessments - Annual reassessments (functional and medical/nursing needs) for continued Nursing Facility placement, including the incorporation of all MDS guidelines.

Nursing Facility LTSS Screening Team - Nursing facility staff trained and certified in the use of the LTSS screening tool who are responsible for performing LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. Nursing facility LTSS screening staff must include at least one (1) registered nurse and physician, but may include social worker or other members of the interdisciplinary team. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

Office Based Opioid Treatment Providers or "Preferred OBOTs" - Deliver addiction treatment services to Members with a primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related addictive disorders, marked by a cluster of cognitive, behavioral, and

physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems. Services are provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020).

Ombudsman - The independent State entity that will provide advocacy and problem-resolution support for Cardinal Care managed care participants, and serve as an early and consistent means of identifying systemic problems.

Ongoing Care Management - Providing regular, ongoing support to address a member's health care needs, functional needs, accessibility needs, social needs, strengths and supports, goals and other characteristics in alignment with the member's ICP and regular courses of treatment. **Open Enrollment** – The timeframe in which Members are allowed to change from one (1) MCO to another, without cause, at least once every twelve (12) months per 42 CFR §438.56(c)(2) and (f)(1), as described in this contract.

Other Critical Incident - An event or situation that creates a significant risk to the physical or mental health, safety, or wellbeing of a Member not resulting from a quality of care issue and less severe than a Sentinel Event.

Out-of-Network - 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 or its subcontractors.

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

Overpayment - As defined in 42 CFR §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.

Partial Credibility - As defined in 42 CFR §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) 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.

Participating Provider - Providers, hospitals, home health agencies, clinics, and other places that provide 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."

Partial Hospitalization Services (ASAM Level 2.5) - are a minimum of twenty (20) hours per week and at least five (5) service hours per service day of skilled treatment services with a planned format, including individual and group psychotherapy, substance use disorder counseling, medication management, education groups, occupational and recreational therapy, and other therapies. Withdrawal management services may be provided as necessary. 12VAC30-130-5100.

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.

Passthrough Payment - Any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR §438.6(a) for services and enrollees covered under the contract; a subcapitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

Patient Pay - When an individual's income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals who are not covered through MAGI adult (Medicaid expansion) and who reside in a NF (skilled or custodial) or are enrolled in a home- and community-based waiver. Patient pay is required to be calculated for every individual (including AI/AN) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be the responsibility of the Contractor and must be outlined in the Contractor's provider agreement.

Payer Of Last Resort - The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual-eligible for Medicaid.

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

Person-Centered Planning - A process, directed by an individual or his or her family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired outcomes for the individual.

Person with Ownership or Control Interest - In accordance with 42 CFR §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.

Personal Care Provider - A provider that renders personal care services to an eligible Member in order to prevent or reduce institutional care, or, in the case of Local Education Agency-based services, in order to allow the child to participate in a free and appropriate public education.

Personal Care Services (EPSDT) - EPSDT Personal Care Services are designed to assist children under the age of twenty-one (21) who meet the criteria for EPSDT Personal Care as defined in the EPSDT Personal Care Services Supplement with activities of daily living (ADLs), instrumental activities of daily living (IADLs), medically necessary supervision and monitoring of self-administered medications. The child's need for assistance with ADLs due to a health condition must be documented by the child's primary care provider on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician's assistant or nurse practitioner and updated every year. EPSDT Personal Care criteria is utilized for children not enrolled in CCC Plus Waiver. For Members enrolled in CCC Plus Waiver, including those Members under twenty-one (21) years old, personal care will be provided under the waiver. As such CCC Plus Waiver criteria and forms are used to determine personal care hours for these Members. See Section 5.12.2, *Commonwealth Coordinated Care Plus Waiver*.

Personal Care Services (Non-EPSDT) - A range of support services that includes assistance with ADLs/IADLs, access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and physical condition provided through the agency-directed or consumer-directed model of service. Personal care services must be provided by PCAs or attendants within the scope of their licenses or certifications, as appropriate.

Pharmacy Benefit Manager (PBM) - An entity responsible for the provision and administration of pharmacy services.

Pharmacy Benefits Manager - The administration or management of prescription drug benefits provided by a MCO for the benefit of covered individuals.

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.

Physician Services - Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.

Plain Language - Language written in a manner that can be understood by any audience.

Plan (Health Plan) - An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. They all work together to provide the care you need.

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. Individuals not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS who have income between one hundred thirty-eight percent (138%) and less than or equal to two hundred percent (200%) of the federal poverty level (plus a five percent (5%) disregard) and meet citizenship and identity requirements may be eligible for Plan First.

Plan of Safe Care - A guide developed by the Contractor with their Members to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each mother and infant's needs vary.

Population Health - The health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services, as well as the equitable distribution of such outcomes within the population.

Post-Adoption Case Management (PACM) Services - PACM will provide families for Members in adoption assistance with twelve (12) months of case management services after the finalization of an adoption from foster care. Families will automatically be referred to PACM by the VDSS Adoption Negotiator and families may start services right away or they can enroll at a later date when needed.

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.

Post-Stabilization Care Services - As defined at 42 CFR §438.114(a), 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 Member – A Medicaid Member who is subject to mandatory enrollment (42 CFR §438.2).

Pre-Payment Review - A type of program integrity activity that requires a provider to submit additional documentation to support a billed claim before that claim is processed for payment. Pre-payment review is often focused on a claim type, a provider type, or a specific provider based on an indication that additional scrutiny is needed. It may be used after identifying an area/provider that presents a program integrity risk, or prior to evidence of risk, in order to mitigate potential issues.

Premium Revenue – Calculation of revenue from capitation and other payments made by the Department to the Contractor, as defined in 42 CFR §438.8 paragraph (f)(2), used to determine the Contractor's MLR percentage.

Prevalent Language – When five percent (5%) or more of the Contractor's enrolled population in any participating region is non-English speaking and speaks a common language other than English.

Previously Authorized – As described in 42 CFR §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 Contractor authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the Contractor. 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.

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 - As defined in 42 CFR §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 Caregiver - The primary person who consistently assumes the role of providing direct care and support of the Member to live successfully in the community without compensation for providing such care.

Primary Care Provider (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.

Priority Population – Members, as defined in Section 8.4.2, *Priority Populations*, as requiring Care Management under Cardinal Care based on the Member's need and risk level.

Privacy - Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 CFR §§431.300 through 431.307, as well as relevant Virginia privacy laws.

Private Duty Nursing – Nursing care services available for children under age twenty-one (21) under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

Program Integrity - The process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities.

Program of All-inclusive Care for the Elderly (PACE) - PACE provides the entire spectrum of medical (preventive, primary, acute) and long-term services and supports to their enrollees without limit as to duration or dollars. PACE participants are excluded from the CCC Plus program.

Protected Health Information (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.

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.

Provider - As defined in 42 CFR §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.

Provider Contract - An agreement between a Contractor and a provider which describes the conditions under which the provider agrees to furnish covered services to Members under this Contract. All provider contract templates for Medicaid-funded services between the Contractor and a provider must be approved by the Department.

Provider Network - A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. Also see Network Provider.

Provider Preventable Condition - (also called Provider Preventable Event) - A condition that (1) meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 CFR §447.26(b); and/or (2) a hospital acquired condition or a condition occurring in any health care setting that has been found by the State, 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, and is auditable. The Department's policy regarding Provider Preventable Conditions is set out in 12 VAC 30-70-201 and 12 VAC 30-70-221.

Psychosocial Rehabilitation Services – A treatment program of two (2) or more consecutive hours per day provided to groups of adults in a non-residential setting. Members must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the Member about mental illness, substance use disorders (SUD), and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Psychiatric Residential Treatment Facilities (PRTF) - Means the same as defined in 42 CFR §483.352 and are a twenty-four (24)-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than twenty-one (21) years of age in order to prevent or minimize the need for more intensive treatment.

Qualified Mental Health Professional (QMHP) – Person who is certified by the Virginia Board of Counseling to provide collaborative mental health services to adults (QMHP-A) or children (QMHP-C).

Qualifying CCC Plus Waiver Services - Qualifying Services can be authorized as stand-alone services. Qualifying services include: ADHC, personal care, respite, and private duty nursing services. The following CCC Plus Waiver services are not qualifying waiver services: AT, EM, and PERS, and must be authorized in conjunction with at least one (1) qualifying CCC Plus Waiver service.

Quality - As defined in 42 CFR §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 MCOs. 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. For more information, reference: https://www.ncqa.org/report-cards/health-plans/.

Quality Improvement Program (QIP) - A quality improvement program with structure, 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, contracted health plans, and/or Members.

Quality Incentive – The portion of a Contractor's capitation payments at-risk in a given Contract period based on performance on quality metrics, population-based performance targets and VBP requirements as designated by the Department.

Quality Management Review (QMR) – An onsite visit and/or desk review of the Contractor conducted by the Department to assure the health and safety of waiver participants and compliance with Federal waiver assurances

Quality of Care Incident - Any incident that calls into question the competence or professional conduct of a healthcare provider in the course of providing medical services and has adversely affected, or could adversely affect, the health or welfare of a Member. These are incidents of a less critical nature than those defined as Sentinel Events.

Quarterly - For the purposes of contract reporting requirements, quarterly must be defined as within thirty (30) calendar days after the end of each calendar quarter.

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

Rate Cell - As defined in 42 CFR §438.2, a set of mutually exclusive categories of enrollees that is defined by one (1) 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 (1) of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating Period - A period of twelve (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 42 CFR §438.7(a).

Reassessment – For Members enrolled in a waiver or a Nursing Facility, the periodic (in accordance with waiver requirements), face-to-face review of a Member's condition and service needs.

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 Provider's request for review of an adverse action 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.

Registered Nurse (RN) – Person who is licensed or certified in Virginia as an RN or holds a RN/LPN license with multi-state privilege recognized by Virginia in accordance with §54.1-3040.1 et. seq., of the Code of Virginia.

Rehabilitation Services and Devices - Treatment the Member receives to help the Member recover from an illness, accident, or major operation.

Remand – The return of a case by the Department's hearing office to the Contractor for further review, evaluation, and action.

Residential Crisis Stabilization Unit (RCSU) – Serve as diversion facilities from inpatient hospitalization. Residential Crisis Stabilization Units provide short-term, twenty-four (24) hours a day, seven (7) days a week, facility-based psychiatric/substance-related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning.

Resource Utilization Groups (RUGS) – Based on information acquired from the Nursing Minimum Data Set, the RUGS score is developed. RUGS reflects the exclusive categories of a Nursing Facility resident's level of resource need (based on their functional and cognitive status) which are used to facilitate payment. For the purposes of this Contract, RUGS refers to the version in use by the Department on the date of service.

Respite Services - Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care. Respite services may refer to skilled nursing respite or unskilled respite.

Rural Area - A Census designated area outside of a metropolitan statistical area. The Department will follow definitions included in the CMS Medicare Advantage Network Adequacy Criteria Guidance. The Department defines "rural" as micro, rural, and counties with extreme access considerations (CEAC) areas.

Rural Health Clinic - A facility as defined in 42 CFR §491.2, as amended.

Safe Sleep 365 - Virginia Department of Social Services program designed to educate parents and caregivers regarding the steps they can take to prevent infant sleep-related death and to emphasize simple practices all Virginians can employ to provide a safe and healthy environment for infants during sleep.

Safety Net Providers - Providers that organize and deliver a significant level of health care and other related services to Medicaid, FAMIS, uninsured, and other vulnerable populations.

Screening - The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for screening for certain long-term services requiring Nursing Facility eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and, (iv)

provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home- and community-based care for those individuals who meet Nursing Facility level of care.

Screening Team - The Medicaid MLTSS Screening Team contracted with the Department that is responsible for performing screenings for Nursing Facilities or, if qualified, waiver services pursuant to the Code of Virginia § 32.1-330. Screening teams include: (1) "Community-based team" (CBT) means a nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, the Virginia Department of Health or the local Department of Social Services; (2) "Hospital Team" means persons designated by the hospital who are responsible for conducting and submitting the screenings for inpatients to the Department's automated system; and, (3) "Department or DMAS designee" means the public or private entity with an agreement with the Department to complete screenings.

Sentinel Event - A patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the Member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function that leads to permanent or severe temporary harm. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Serious Emotional Disturbance – Used to refer to children from birth through age seventeen (17) who have had a serious mental health problem diagnosed under the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one (1) year's time, problems that are significantly disabling based upon the social functioning of most children of the child's age, problems that have become more disabling over time, and service needs that require significant intervention by one (1) or more agency. See DBHDS website for more information.

Serious Mental Illness (SMI) – Used to refer to individuals ages eighteen (18) and older who have severe and persistent mental or emotional disorders that seriously impair their functioning in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals who are seriously mentally ill and who have also been diagnosed as having a substance ~~ab~~use disorder or developmental disability are included. The population is defined along three (3) dimensions: diagnosis, level of disability, and duration of illness. All three (3) dimensions must be met to meet the criteria for serious mental illness. (Mental Health Services Manual, Chapter IV).

Service Authorization (SA) - A type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that claim is billed and processed for payment. Pre-payment review is often focused on controlling utilization of specific services by a pre-determination that the service is medically necessary for an individual.

Service Authorization Contractor - An entity that is contracted to manage authorization of health and other covered benefits. The Department's Service Authorization Contractor is currently responsible for authorization of the Department's medical and behavioral health benefits for Medicaid and FAMIS Members enrolled in Fee-For-Service, including for Residential Treatment Services, and for carved-out behavioral health benefits including Therapeutic Group Home and Treatment Foster Care Case

Management services. The Department also contracts with a separate vendor to manage authorization and administration of carved-out dental services.

Service Authorization Request - A Managed Care member's request for the provision of a service.

Service Facilitator (SF) - Entity designated by the Managed Care Program MCO or one (1) who is employed or contracted by a Department-enrolled provider responsible for supporting the individual, individual's family/caregiver, or Employer of Record, as appropriate, by ensuring the development and monitoring of the CD services Plans of Care, providing employee management training, and completing ongoing review activities as required by the Department for CD personal care and respite services.

Significant Change - A change (decline or improvement) in a Member's status that: 1) will not normally resolve itself without intervention or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 2) impacts more than one (1) area of the individual's health status; and, 3) requires interdisciplinary review and/or revision of the ICP.

Skilled Private Duty Nursing Services ("Skilled PDN") – Skilled in-home nursing services listed in the person-centered Individualized Care Plan that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, respectively); and (iv) provided by a licensed RN, or by an LPN under the supervision of an RN, to CCC Plus Waiver Members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on Member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

Social Determinants of Health (SDOH) – Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.

Social Needs - Needs related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and informational supports, and personal goals (e.g., attend school, have a job).**Specialist -** A doctor who specializes in treating certain diseases, health problems, or conditions. For the purposes of this Contract, not a primary care or pediatric doctor.

Spread Pricing - The model of prescription drug pricing in which the pharmacy benefits manager charges a Managed Care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

Stabilized - As defined in 42 CFR §489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant individual who is having contractions, that the individual has delivered the child and the placenta.

State Fair Hearing – The Department's evidentiary hearing process for Member appeals. Any adverse 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 CFR §431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

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.

State Plan for Medical Assistance (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 or services in a setting 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 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). However, the Contractor must 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 twenty-one (21) through sixty-four (64) years of age, an Institution for Mental Disease (IMD) may be an "in lieu of" service, as further defined in this contract. Reference 42 CFR §§438.3 and 438.6(e).

Store-and-Forward – Used in Telehealth, when pre-recorded images, such as X-rays, video clips and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include teledermatology where digital pictures of a skin problem are transmitted and assessed by a dermatologist; teleradiology where x-ray images are sent to and read by a radiologist; and, teleretinal imaging where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

Subcontract - A written contract between the Contractor and a third party, under which the third party performs any one (1) 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 to perform part of the responsibilities under this Contract that relates directly or indirectly to the performance of the Contractor's obligations under its contract with the State. For subcontracts which require that the subcontractor be responsible for the provision of covered services, the subcontractor must be considered both a subcontractor and a network provider for the purposes of this Contract. A network provider is not a subcontractor by virtue of the network provider agreement with the Contractor.

Substance-Exposed Infants (SEIs) - Infants who experienced prenatal exposure to alcohol, tobacco, or other controlled substances. SEIs must include children born with Neonatal Abstinence Syndrome (NAS). SEIs/NAS infants require unique medical, behavioral health and care coordination services in order to reach optimum health outcomes.

Substance Abuse Case Management - Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs for the individuals assessed to have a substance-related disorder as defined in the current DSM. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Crisis Intervention - Immediate mental health care, available twenty-four (24) hours a day, seven (7) days a week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objective is to prevent exacerbation of a condition, to prevent injury to the Member or others, and to provide treatment in the context of the least restrictive setting. May also be referenced as a Substance Use Disorder Service.

Substance Use Disorder (SUD) – Per 12VAC30-130-5020, means a substance-related addictive disorder, as defined in the DSM-5 with the exception of tobacco-related disorders and non-substance-related disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems.

Target Amount - Means an amount equal to the total capitation payments for benefit costs for services allowed under 42 CFR §438.3(c)(1)(ii) paid by the Department for the contract year to the Contractor based on the actuarially determined projected benefit cost PMPM. The target amount will be determined by the Department and will not be affected by any service level agreement penalties described in Section 7.3, *Provider Network Management*.

Targeted Case Management (TCM) – Services that will assist individuals with specific conditions in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist social, educational, vocational, housing, and other services. TCM services include: ARTS, brain injury, mental health, developmental disabilities, early intervention, treatment foster care, and high-risk prenatal and infant case management services. Refer to the Cardinal Care Summary of Covered Benefits Chart. Also see Post-Adoption Case Management (PACM) Services.

Telehealth – The use of telecommunications and information technology to support remote or long-distance physical and behavioral health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision, and information across distance, and it is not restricted to modalities that involve real time, two (2)-way interaction (see "Telemedicine" below). Telehealth incorporates technologies such as telephone, facsimile machines, electronic, email systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Telemedicine – A service delivery model that uses real time two (2)-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the Member at an originating site to an enrolled provider approved to provide telemedicine services at a distant (remote) site.

Temporary Detention Order (TDO) – An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 CFR §441.150 and Code of Virginia § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults than for juveniles.

Therapeutic Group Home (TGH) – Means a congregate residential service providing twenty-four (24)-hour supervision in a community-based home having eight (8) or fewer residents.

Therapeutic Day Treatment (TDT) for Children and Adolescents – A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in treatment programs of two (2) or more hours per day.

Third Party Liability (TPL) – Any entity (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for injury, disease, or disability of a Medicaid Member.

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 action or 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.

Transition Services – Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. For the purposes of transition services, an institution means a NF, or a specialized care facility/hospital as defined at 42 CFR §435.1009. Transition services do not apply to an acute care admission to a hospital.

Transitional Care Management – Management of member needs during transitions between clinical settings (e.g., between a hospital and a rehabilitation facility) or between a clinical setting and home (e.g., from hospital to home) to prevent unplanned or unnecessary readmissions, emergency room visits or adverse outcomes.

Transportation Network Companies (TNC) – Provides prearranged rides for compensation using a digital platform that connects passengers with drivers using a personal vehicle. TNC drivers are referred to as TNC partners. For more information visit the DMV website.

Trauma-Informed Care – An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood

experiences (ACEs) have played in their lives. This approach also builds on Member resiliency and strengths to address both the overall physical and emotional wellbeing of the individual.

Triggering Events – Any occurrence that suggests a change in a member's condition or status that places the member at a higher risk of harm or jeopardizes their health, safety and welfare.

Treatment Foster Care (TFC) Case Management (CM) – Serves children under age twenty-one (21) in treatment foster care who have certain complex behavioral health needs or children with behavioral disorders who in the absence of such programs would be at-risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. TFC case management focuses on a continuity of services, is goal directed and results oriented.

Twenty-three (23) Hour Crisis Stabilization - Provides a period of up to twenty-three (23) hours in a community-based facility that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible twenty-four (24) hours a day, seven (7) days a week and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit setting is necessary.

Unable to Contact (UTC) for Initial HRA – The Contractor's reasonable efforts to contact the non-LTSS Member in-person, by telephone, or by mail immediately upon completion of the MCO Member Health Screening without success places the Member in the "UTC" category for the Initial HRA. "Reasonable efforts" are defined as at least three (3) documented attempts with more than one (1) method of contact being employed over more than one day, including a home visit. The Contractor is encouraged to reach out to the Member's PCP and other treating providers, supports or DSS Medicaid workers to establish contact with a Member for status updates. See Section 8.5.4, *Unable to Contact for HRA*.

Unable to Contact (UTC) for MMHS – The Contractor's reasonable efforts to contact the Member in-person, by telephone, or by mail in order to conduct the MMHS without success places the Member in the "UTC" category for the MMHS. "Reasonable efforts" are defined as at least three (3) attempts across more than one day, with more than one method of contact being employed. The Contractor must document each attempt, including what method was used on what date. If the Contractor is unable to reach the Member after reasonable efforts, the Contractor must place the Member in the Unable to Contact ("UTC") category for the MMHS. See Section 8.3.2.3., *Unable to Contact for MMHS*.

Urban Area – The Department will follow the CMS MA HSD reference guide. The Department defines urban as metro and large metro. 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 Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical/behavioral health condition, but that are the result of an unforeseen illness, injury, or condition for which medical/behavioral health services are immediately required. Urgent care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

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:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily function;
3. Serious dysfunction of any bodily organ or part; or
4. In the case of a pregnant individual, serious jeopardy to the health of the fetus.

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

Validation – As defined in 42 CFR §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 (VAN) – A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication.

Value-Based Payment (VBP) – includes a broad set of payment strategies intended to improve health care 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.

Virginia Administrative Code (VAC) – Contains regulations of all the Virginia State Agencies.

Virginia Department of Health Office of Emergency Medical Services (OEMS) – The governing state sister agency that ensures ambulance companies maintain employee, vehicle compliance, and licensing requirements. If OEMS finds the ambulance company out of compliance, OEMS is the governing authority that takes action.

Virginia Uniform Assessment Instrument (UAI) – The standardized multidimensional assessment instrument that is completed by the Screening Team that assesses an individual's physical health, mental health, psychosocial and functional abilities to determine if an individual meets the Nursing Facility level of care.

Volunteer Driver – A volunteer driver is an individual who transports Members in a personal vehicle that meets the driver, insurance, vehicle inspection and other safety requirements of a contracted driver, and who accepts occasional trips (e.g., long-distance trips or recovery trips) from the Contractor in exchange for gas and/or mileage reimbursement.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

Waste – The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified that the practice is inappropriate, may be considered fraud or abuse.

Will call – A call made to the Contractor by a Member or Member's representative stating the Member is ready for the return trip.

Withhold Arrangement – Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a compliance enforcement action and not a withhold arrangement.

23. ACRONYMS

AA – Adoption Assistance

AAA – Area Agencies on Aging

ABA – Applied Behavior Analysis

ABD – Aged, Blind, and Disabled Population

ACA – Patient Protection and Affordable Care Act

ACIP – Advisory Committee on Immunization Practice

ACT – Assertive Community Treatment

ADCC – Adult Day Care Center

ADHC – Adult Day Health Care

ADHD – Attention-Deficit/Hyperactivity Disorder

ADL – Activities of Daily Living

AHRQ – Agency for Healthcare Research and Quality

AI/AN – American Indian/Alaska Native

AIMS – Appeals Information Management System

ALS – Amyotrophic Lateral Sclerosis

ANSI – American National Standards Institute

APIN – Administrative Provider Identification Number

APM – Alternate Payment Model

ARTS – Addiction and Recovery Treatment Services

ASAM – American Society of Addiction Medicine

ASP – Application Service Provider

BAA – Business Associate Agreement

BBA – Balanced Budget Act of 1997

BHA – Behavioral Health Authority

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

CBO – Community-Based Organizations

CCC – Commonwealth Coordinated Care

CCM – Chronic Care Management

CD – Consumer-Directed

CDL – Coverage Decision Letter

CDSMP – Chronic Disease Self-Management Program

CFR – Code of Federal Regulations

CHF – Congestive Heart Failure

CHIPRA – Children's Health Insurance Program Reauthorization Act

CIL – Center for Independent Living

CLIA – Clinical Laboratory Improvement Amendments

CMR – Comprehensive Medication Review

CMS – Centers for Medicare and Medicaid Services

CMS 1500 – Standard Professional Paper Claim Form

CON – Certificate of Need

COPD – Chronic Obstructive Pulmonary Disease

CORFs – Comprehensive Outpatient Rehabilitation Facilities

CPT – Current Procedural Terminology

CQI – Continuous Quality Improvement

CSAC – Certified Substance Abuse Counselor

CSB – Community Service Board

CY – Calendar Year

CYSHCN -- Children and Youth with Special Health Care Needs

DARS – Virginia Department for Aging and Rehabilitative Services

DBA – Dental Benefits Administrator

DBHDS – Department of Behavioral Health and Developmental Services

DD – Developmental Disability

DESI – Drug Efficacy Study Implementation

DHHS – Department of Health and Human Services

DMAS – Department of Medical Assistance Services

DME – Durable Medical Equipment

DOB – Date of Birth

DOD – Date of Death

DRG – Diagnosis Relative Grouping

DSM – Diagnostic and Statistical Manual of Mental Disorders

DSMP – Diabetes Self-Management Program

D-SNP – Dual-Eligible Special Needs Plan

DSP – Data Security Plan

DSS – Department of Social Services

ECO – Emergency Custody Order

EDI – Electronic Data Interchange

EI – Early Intervention

EMR – Emergency Medical Record

EN – Enteral Nutrition

EOL – End-of-Life

EOM – End of Month

EOR – Employer of Record

EPA – Environmental Protection Agency

ePAS – Electronic Pre-Admission Screening

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

ESRD – End Stage Renal Disease

EVV – Electronic Visit Verification

FAMIS – Family Access to Medical Insurance Security

FC – Foster Care

FFC – Former Foster Care

F/EA – Fiscal/Employer Agent

FFS – Fee-for-Service

FFT – Functional Family Therapy

FIDE SNP – Fully Integrated Dual-Eligible Special Needs Plan

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

HCBS – Home- and Community-Based Care Services

HCPCS – Healthcare Common Procedure Coding System

HEDIS – Healthcare Effectiveness Data and Information Set

HIDE SNP – Highly Integrated Dual-Eligible Special Needs Plan

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

HPMS – Health Plan Management System

HRA – Health Risk Assessment

HRR – Hospital Referral Region

IADL – Instrumental Activities of Daily Living

IBNR – Incurred But Not Reported

ICF/ID – Intermediate Care Facility/Individuals with Intellectual Disabilities

ICP – Individualized Care Plan

ICT – Interdisciplinary Care Team

ID – Identification

ID – Intellectual Disability

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

IHCP – Indian Health Care Provider

IHS – Indian Health Services

IOP – Intensive Outpatient

I/T/U – Indian Tribe, Tribal Organization, or Urban Indian Organization

IMD – Institution for Mental Disease

ITOTS – Infant and Toddler Online Tracking System (Early Intervention tracking system)

LARC – Long Acting Reversible Contraceptive

LCSW – Licensed Clinical Social Worker

LDSS – Local Department of Social Services

LEIE – Listing of Excluded Individuals and Entities

LIFC – Low Income Families and Children

LOC – Level of Care

LOCERI – Level of Care Review Instrument

LSH – Long-Stay Hospital

LTAC – Long-term Acute Care

LTSS – Long-Term Services and Supports

MA – Medicare Advantage

MAO – Medicare Advantage Organization

MATE – Medical Assistance to Employment

MCHIP – Managed Care Health Insurance Plans

MCO – Managed Care Organization

MDS – Minimum Data Set

MES – Medicaid Enterprise System

MFCU – Medicaid Fraud Control Unit

MH-IOP – Mental Health Intensive Outpatient Program

MHPAEA – Mental Health Parity Addiction Equality Act

MH-PHP – Mental Health Partial Hospitalization Program

MHS – Mental Health Services

MLTSS – Managed Long-Term Services and Supports

MMHS – MCO Member Health Screening

MMIS – Medicaid Management Information System (also known as VAMMIS)

MMP – Medicare-Medicaid Plan

MOB – Matter of Balance

MOC – Model of Care

MOU – Memorandum of Understanding

MST – Multisystemic Therapy

MTM – Medication Therapy Management

MTR – Medical Transition Reports

NCPDP – National Council for Prescription Drug Programs

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NEMT – Non-Emergency Medical Transportation

NF – Nursing Facility

NIST – National Institute of Standards and Technology

NPDB – National Practitioner Data Bank

NPI – National Provider Identifier

OB/GYN – Obstetrician and Gynecologist

OIG – Office of Inspector General

OSR – Operational Systems Review

OT – Occupational Therapy

PACE – Program of All-Inclusive Care for the Elderly

PCP – Primary Care Provider

PHI – Protected Health Information

PIP – Physician Incentive Plan

PIRS – Patient Intensity Rating Survey

PDSA – Plan Do Study Act

PMV – Performance Measure Validation

POC – Plan of Care

PPE – Provider Preventable Event (refer to Provider Preventable Condition)

PRSS- Provider Services Solution

PRTF – Psychiatric Residential Treatment Facility

PSA – Prostate Specific Antigen

PT – Physical Therapy

PUMS – Patient Utilization Management and Safety Program

QI – Quality Improvement

QIP – Quality Improvement Program

RCSU – Residential Crisis Stabilization Unit

RFP – Request for Proposal

RHC – Rural Health Clinics

RN – Registered Nurse

RTF – Residential Treatment Facility

RUGS – Resource Utilization Groups

SA – Service Authorization (formally known as Prior Authorization)

SAMHSA – Substance Abuse and Mental Health Services Administration

SED – Serious Emotional Disturbance

SLP – Speech-Language Pathology

SMI – Serious Mental Illness

SPO – State Plan Options

SSI – Social Security Income

SSN – Social Security Number

SUD -- Substance Use Disorder

TB – Tuberculosis

TBI – Traumatic Brain Injury

TDO – Temporary Detention Order

TFCCM – Treatment Foster Care Case Management

TGH – Therapeutic Group Home

TMJ – Temporomandibular Joint (disorder)

TNC – Transportation Network Company

TPL – Third Party Liability

TPN – Total Parenteral Nutrition

TTY/TDD – Teletype/Telecommunication Device for the Deaf

UAI – Uniform Assessment Instrument

UB-92 – Universal Billing 1992 claim form

UM – Utilization Management

USC – United States Code

VAC – Virginia Administrative Code

VAMMIS – Virginia Medicaid Management Information System

VAN –Value Added Network

VBP – Value-Based Payment

VICAP – Virginia Independent Clinical Assessment Process

VPN – Virtual Private Network

VVFC – Virginia Vaccines for Children Program

XYZ – Any Named Entity

24. ATTACHMENTS

A. Managed Care Contractor Signature Page

B. Business Associate Agreement

C. Network Provider Agreement Requirements

D. FAMIS Program Exceptions

E. Cardinal Care Summary of Covered Benefits Chart

F. Certification of Data (Non-Encounter)

G. Managed Care Regions/Localities

H. MCO Member Health Screening

I. Model of Care Overview

J. Model of Care Policies, Procedures and Reports

K. Department of Medical Assistance Services Preenrollment / Revalidation Site Visit Checklist

L. Points Violations

M. Liquidated Damages

Attachment A –Managed Care Contractor Signature Page

Effective Dates: July 1, 2024 – June 30, 2025

Contract Name: Managed Care Contract

Issued By: Commonwealth of Virginia

Department of Medical Assistance Services

Contractor: <Health Plan>

The purpose of this renewal and amendment is to add necessary revisions to the Cardinal Care Managed Care Contract to which this Attachment A is incorporated by reference (collectively, with all other amendments, attachments, and exhibits thereto, the "Contract"). As a reminder, the Department is in the process of reprocuring the Cardinal Care Managed Care contract. You were notified on February 27, 2024 that the Department may terminate the current Contract for convenience prior to the end of the third 12-month renewal period to accommodate the transition to the new contracts. A subsequent notice will be issued with more details, including the anticipated timeframe.

This Contract will become effective on July 1, 2024 and will continue through June 30, 2025.

1. This Contract is contingent upon receipt of final approval from the Centers for Medicare and Medicaid Services (CMS), including all provisions of the Federal regulations in 42 CFR Part 438. Any revisions needed will be completed through a subsequent contract amendment.
2. By signature of this Contract, the Contractor agrees to adhere to all Cardinal Care program Contract provisions.
3. By signature of this Contract, the Contractor acknowledges that the CCMC rates in effect as of January 1, 2024, are in effect for the period of this renewal until such time as final Fiscal Year 2025 rates are available from the Department's actuary.

IN WITNESS HEREOF, the parties have caused this Contract to be duly executed intending to be bound thereby.

CONTRACTOR:	COMMONWEALTH OF VIRGINIA
<Health Plan Name>	Department of Medical Assistance Services
BY:_____	BY:_____
NAME: _____	NAME: _____
TITLE: _____	TITLE:_____
DATE: _____	DATE:_____

Attachment B – Business Associate Agreement

*This BAA is only required if there are changes from the original submission. The Contractor will highlight any changes to the BAA.

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 January 1, 2023 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 CFR §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") will 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 CFR §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:

1. Business Associate has the meaning given such term as defined in 45 CFR §160.103.
2. Covered Entity has the meaning given such term as defined in 45 CFR §160.103.
3. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid covered services.
4. 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.
5. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 CFR §160.103.
6. Breach has the meaning as that term is defined at 45 CFR §164.402.
7. Required by law will have the meaning as that term is defined at 45 CFR §160.103.
8. Unsecured Protected Health Information **has** the meaning as that term is defined at 45 CFR §164.402.

9. 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 will have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

Written Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate will be sent via email or general mail to the Department's Privacy Officer (with a copy to the Department's 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

2. Other written notices to the Covered Entity should be sent via email or general mail to Department's contract administrator at:

   Contact: DMAS Division of Health Care Services and Division of Integrated Care
   Department of Medical Assistance Services
   600 East Broad Street
   Richmond, Virginia 23219

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 (1) The Department's Business Associate is required to access Department PHI from another

Department Business Associate, the first Department Business Associate shall enter into a business associate agreement with the second Department 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 CFR §164.502. 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.
i. Shall comply with 45 CFR §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 CFR 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 CFR §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 CFR §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 Department's Privacy Officer.
i. Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within five (5) business days from the first (1st) 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 the Department's 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 the Department 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,
1. a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
2. a description of the types of unsecured PHI that were involved in the breach;
3. any steps the individuals should take to protect themselves from potential harm resulting from the breach;
4. 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,

5. 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 CFR §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 CFR §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 CFR §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 (1) 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.

(To be completed by Business Associate)

Department of Medical Assistance Services/<u>Contractor Name</u>

This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

1. The names and contact information for at least one (1) primary contact individual from each party to this Agreement.

   Contact: DMAS Integrated Care Division Director
   Department of Medical Assistance Services
   600 East Broad Street
   Richmond, Virginia 23219
   Phone Number : (804) 371-7983
   Email Address: CCCPlus@dmas.virginia.gov

   Contractor Contact:
   Address:
   Phone Number:
   Email Address:

2. Complete list of all individuals, whether employees or direct contactors, of Business Associate who shall be authorized to access Covered Entity's PHI.
3. List of the specific data elements required by Business Associate in order to carry out the purpose of this Agreement.
4. Purposes for which such data is required.
5. Description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Attachment C – Network Provider Agreement Requirements

Required Elements of Network Provider Agreement

The Contract between the Contractor and its intended network providers must comply with all applicable provisions of this Contract. The Department's review of the agreements will ensure that the Contractor has inserted the following standard language in-network provider agreements (except for specific provisions that are inapplicable in a specific Contractor management subcontract).

The following elements are required in all provider agreements (as applicable):

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. Provider must have a National Provider Identifier (NPI) number, and must be screened, enrolled (including signing a Department Medicaid provider participation agreement), and periodically revalidated in the Department's MES PRSS. This rule applies to all provider types and specialties. Per 42 CFR §438.608(b), this provision does not require the Contractor's network provider to render services to FFS beneficiaries. The Contractor's providers participating within an MCO's D-SNP network that only provide Medicare services are not required to enroll in PRSS.
3. Provider must meet the Contractor's standards for licensure, certification, and credentialing, and these must be included in the Contractor's provider network contracts.
4. Provider must comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, Section 1557 of the Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-171, Section 6085], and as explained in CMS SMD #06-010, Further, the Provider agrees to comply with all non-discrimination requirements in Medicaid Contract.
5. Provider must maintain records for ten (10) years from the date the provider contract terminates. For children under age twenty-one (21) enrolled in the CCC Plus Waiver, the Contractor must retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached twenty-one (21) years of age per 12VAC30-120-1730. Where applicable, the Contractor agrees to the special reporting requirements on sterilizations and hysterectomies stipulated in the Medicaid Contract.
6. 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.
7. Provider must provide copies of Member records and access to its premises to representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S.

Department of Health and Human Services, and the State Medicaid Fraud Unit. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the Medicaid Contract.

8. Provider must maintain and provide a copy of the Member's medical records, in accordance with 42 CFR §438.208(b)(5), to Members and their authorized representatives as required by the Contractor and within no more than ten (10) business days of the Member's request.
9. The Provider must forward to the Contractor medical records within ten (10) business days of the Contractor's request.
10. At the time of application, credentialing, and/or recredentialing, and/or upon request, provider must disclose required information, in accordance with 42 CFR §455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
11. Provider must screen their directors, officers, employees and contractors initially and on a monthly basis against the Exclusion Lists to determine whether any of its employees/contractors have been excluded from participating in Medicare, Medicaid, ~~S~~CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider must be required to immediately report to the Contractor any exclusion information discovered. The provider must be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Members.
12. Provider must submit utilization data for Members enrolled with the Contractor in the format specified by the Contractor, consistent with Contractor obligations to the Department as related to quality improvement and other assurance programs as required in this contract.
13. Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the Medicaid contract.
14. 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.
15. 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.
16. 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 provider is chosen or assigned.
17. The Provider agrees to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in the Medicaid Contract, to be stated in the network provider agreement.
18. The Providers will promptly provide or arrange for the provision of all services required under the provider agreement. This provision must 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.

19. Provider must comply with corrective action plans initiated by the Contractor.
20. The Contractor must follow service 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 pharmacy 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.
21. In accordance with 42 CFR §447.15, the provider must accept Contractor payment as payment in full except for patient pay liability amounts for LTSS services as established by the local Department of Social Services and must not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member's period of Contractor enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Cardinal Care recipient for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where the provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions.
22. Should an audit by the Contractor or an authorized state or federal official result in disallowance of amounts previously paid to the provider, the provider will reimburse the Contractor upon demand. The provider must not bill the member in these instances.
23. 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 must 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.
24. Any conflict in the interpretation of the Contractor's policies and MCO Network Provider contract must be resolved in accordance with Federal and Virginia laws and regulations. Provider must comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
25. Provider agreements must include claims processing and payment provisions as described in Section 12.1, *General Provider Payment Processes*.
26. The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a Member unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider except for timelines required for exceptional services as described in Section 12.2.4, *Nursing Facility (NF)/LTSS, ARTS, MHS, and Early Intervention, and Doula Payments* for the fourteen (14)-day processing language.
27. Pursuant to 42 CFR §434.6(a)(12)(i), the Contractor is prohibited from making a payment to the Provider for provider preventable conditions (PPC) that meet the criteria outlined in 42 CFR §447.26(b). The Provider must report to the Contractor all PPCs or health care-acquired

conditions (HCACs) associated with claims. No reduction in payment for a PPC must be imposed on the Provider when the condition defined as a PPC or that meets the definition of a HCAC for a particular covered member that existed prior to the initiation of treatment for that covered member by the Provider.

Special Provisions for Certain Provider Agreements

1. LTSS, ARTS, MHS and Early Intervention provider agreements must include provisions requiring the use of the Department established billing codes as described in the Cardinal Care Coverage Chart.
2. LTSS Providers that are considered HCBS Waiver Service Providers and are subject to 42 CFR §441.300 et al. must be required to comply with 42 CFR §441.301(c)(4)-(5).
3. Nursing Facility, LTSS, ARTS, and Early Intervention provider agreements must include special claim processing and payment provisions as described in 12.2.4 LTSS, ARTS, MHS and Early Intervention .
4. Provider agreements of MHS (private providers and Community Services Boards) - the MHS providers are enrolled as an agency and can bill with their agency NPI. General enrollment requirements can be found in the MHS Manual, Chapter II.
5. Provider agreements with Virginia Community Services Boards (CSBs) must include provisions that allow the CSBs to bill under the facility NPI for qualifying practitioners in accordance with Department guidelines. Such guidelines apply to:
    a. Outpatient Behavioral Health Services: In accordance with the Psychiatric Services Manual, Chapter II, CSBs can provide outpatient services in which qualifying providers bill under the facility NPI and are not required to operate under the physician-directed model for all services. CSBs can also bill as a mental health clinic in a physician-directed model. The specific requirements for physician-directed services are described in the Psychiatric Services Manual, Chapter II.

Network Provider Agreement Prohibitions

The following elements must not be included in any provider agreement:

1. Any terms which limit or terminate legal liability of the Contractor in the Cardinal Care Contract.
2. Any clause or terms of condition requiring as a condition of participation/contracting in the Cardinal Care program, that
    a. Limits or prohibits providers from contracting with other Cardinal Care program Managed Care Contractors;
    b. Any term or condition that providers enrolled in the Contractor's Cardinal Care program network must also participate in the Contractor's other lines of business (e.g., commercial Managed Care network). However, this provision would not preclude a Contractor from requiring their other Managed Care (commercial, Medicare, etc.) network providers to participate in their Cardinal Care provider network; and
3. In accordance with Va. Code § 32.1-4, contractual indemnification with a state or local government entity is an abrogation of sovereign immunity; therefore, the Contractor's

agreements with any state or local government provider must not contain an indemnity clause.

Network Provider Agreement Supplement

The Department recognizes that the Contractor may use a provider manual as a supplement to the Network Provider Contract. When doing so, the Network Provider Contract must state 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 Contract. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Network Provider Contract.

If the Contractor uses the Provider Manual as a supplement to the Network Provider Contract, 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.

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. The Contractor must have sixty (60) consecutive days to resubmit corrections when requested by the Department.

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 D – FAMIS Program Exceptions

This attachment specifies FAMIS program exceptions to select Cardinal Care program requirements.

FAMIS Appeals and Member Requested External Review

FAMIS Children, FAMIS MOMS, and FAMIS PC Members are excluded from 42 CFR §438.400(b)(6) in the definition of an adverse benefit determination pertaining to residents of rural areas with only one (1) MCO, the denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

FAMIS Children, FAMIS MOMS, and FAMIS PC Members must exhaust the MCO's member appeals process before the Member can request a State Fair Hearing. FAMIS Members may also request an external medical review by submitting a written request to:

KEPRO External Review
2810 N. Parham Road
Suite #305
Henrico, Virginia 23294

The Contractor's policies must be consistent with regulations pertaining to appeals for FAMIS Children at 12VAC30-141-40 through 12VAC30-141-70 and FAMIS MOMS at 12VAC30-141-700 through 12VAC30-141-730.

FAMIS Financial Exceptions

FAMIS Children, FAMIS MOMS, and FAMIS PC programs are not eligible for the uniform percentage increase described in Section 12.1.6, *Increased Payments to Ensure Access*.

Other Sections Not Applicable to FAMIS

1. Section 5.15.10, *Drug Rebates* is not applicable to FAMIS Children and FAMIS MOMS.

Attachment E – Cardinal Care Summary of Covered Benefits Chart

The Contractor must provide benefits as defined in this Contract within at least equal amount, duration, and scope as available under the State Medicaid fee- for-service program, and as further defined in the Medicaid State Plan, Department policy and guidance documents, and as described in the Coverage Chart below. Services listed as non-covered by Medicaid must be covered by the Contractor when medically necessary for children under age twenty-one (21) in accordance with Federal EPSDT requirements.

The Coverage Chart provides detailed information for covered benefits and includes information on how the Contractor can assist its Members in accessing services that are carved-out of this Contract and covered through fee-for-service or other Department Contractor. Services are presented in the chart in the following order:

1. Part 1 - Medical Benefits
2. Part 2 – Behavioral Health Services
    a. Part 2A - Inpatient and Outpatient Behavioral Health Services
    b. Part 2B – Mental Health Services (MHS) and Residential Treatment Services (RTS)
    c. Part 2C – Addiction and Recovery Treatment Services (ARTS)
3. Part 3A – EPSDT Services
4. Part 3B – Early Intervention Services
5. Part 4 – Long Term Services and Supports (LTSS)
    a. Part 4A – Facility-Based
    b. Part 4B - Community Based
    c. Part 4C – Community Based Developmental Disabilities (DD) Services
6. Part 5 – Preventive Services for Medicaid Adults
7. Part 6 – FAMIS Children Covered Services - *Individuals enrolled in FAMIS MOMS and FAMIS PC are exempt from cost sharing and receive coverage for Medical and Behavioral Health benefits as described in Parts 1, 2A, 2B, and 2C of the benefits chart.*

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Abortions, induced	42 CFR §§441.202, 441.203 and 441.206 12 VAC 30-50-100, 12 VAC 30-50-105, 12 VAC 30-50-110, 12 VAC 30-50-140, and 12 VAC 30-50-180. Also, See Hospital Manual Chapters IV and VI, and Exhibits for required forms.	Yes, limited	Yes, limited	The Contractor must provide coverage for induced abortions only in limited cases where a physician has found, and certified in writing, that on the basis of their professional judgment, the life of the mother would be substantially endangered if the fetus were carried to term. The certification must contain the name and address of the member. The Contractor is responsible for ensuring that payment and documentation of abortion services complies with State and Federal requirements.
Assisted Suicide	Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.)	No	No	The Contractor must 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.
Behavioral Health Services - See Part 2 of this Attachment				
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 except as medically necessary in accordance with EPSDT criteria.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Christian Science Sanatoria Facilities and Nurses	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from Managed Care participation when admitted to a Christian Science Sanatoria and services will be covered under the fee-for-service program per Department established criteria and guidelines. Christian Science Nursing Services are not covered.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor must cover all clinic services, which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Clinical Trials	SMD # 21-005	Yes	Yes	The Contractor must cover routine patient services furnished in connection with a Member's participation in a qualifying clinical trial, as defined in Section 22, *Definitions*, SMDL #21-005, and the Virginia Medicaid State Plan. Routine patient services include any item or service provided to the Member under the qualifying clinical trial that are needed to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that such items or services are otherwise covered outside the course of participation in the qualifying clinical trial. The Contractor is not required to provide coverage for any investigational item or service that is the subject of the qualifying clinical trial or for any service that is not otherwise covered under this Contract. The Contractor is not required to cover any items or service needed solely to satisfy data collection and analysis for the qualifying clinical trial, or for any services that are not used in the direct clinical management of the Member.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor must cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
				Society, for the ages, family histories and frequencies referenced in such recommendations.
Community Intellectual Disability Case Management (T1017)	12 VAC 30-50-440	Yes	No	The Contractor must provide information and referrals as appropriate to assist Members in accessing these services through the individual's local community services board. Also Part 4.C.
Court-Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor must cover all medically necessary court-ordered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.
Dental	12 VAC 30-50-190 See Dental Manual	Yes	Limited coverage	The Department's contracted dental benefits administrator (DBA) will cover routine dental services; therefore, these services are carved out of the Managed Care program. However, the Contractor is responsible for transportation and medications related to covered dental services. The Contractor must also cover medically necessary anesthesia and hospitalization services for its Members when determined to be medically necessary by the Department's Dental Benefits Administrator. Effective July 1, 2022 in accordance with Virginia Appropriations Act, Item 304 PPPP the Contractor must provide coverage for medically necessary general anesthesia and hospitalization or facility charges of a facility licensed to provide outpatient surgical procedures for dental care provided to a Medicaid enrollee who is determined by a licensed dentist in consultation with the enrollee's treating physician to require general anesthesia and admission to a hospital or outpatient surgery facility to effectively and safely provide dental care to an enrollee age ten or younger. Additionally, in accordance with the Code of Virginia,

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
				§ 38.2-3418.12, coverage for anesthesia is required for persons who are severely disabled, or 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. The Contractor's determination of medical necessity shall include but not be limited to a consideration of whether the age, physical condition or mental condition of the covered person requires the utilization of general anesthesia and the admission to a hospital or outpatient surgery facility to safely provide the underlying dental care. The Contractor must cover CPT codes billed by an MD as a result of an accident, and CPT and "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor must cover dental screenings and dental varnish under EPSDT. See Section 5.2.1 of this Contract for additional requirements.
Developmental Disability Support Coordination (T2023)	12 VAC 30-50-490	Yes	No	These services will be covered through Medicaid fee-for-service. The Contractor must provide information and referrals as appropriate to assist Members in accessing these services through the individual's local community services board. Also see Part 4.C.
Dietary Counseling	12VAC30-60-200 https://www.uspreventiveservicestaskforce.org/uspstf/	Yes	Limited Coverage	The Contractor must cover medically necessary dietary counseling services. f Coverage must be provided in accordance with U.S. Preventive Task Force recommendations, as described at: https://www.uspreventiveservicestaskforce.org/

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Doula Services		Yes	Yes	In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, the Contractor must cover certain services covered by certified Doulas. Services must include up to eight (8) prenatal/postpartum visits, and support during labor and delivery. The Contractor must also implement up to two (2) linkage-to-care incentive payments for postpartum and newborn care. Covered Services Include: 1. 99600-HD **Initial Prenatal Visit**; Maximum six (6) units of fifteen (15) minutes each (total max of 90 minutes). One (1) date of service only. 2. 59425-HD **Standard care, prenatal visit;** Maximum three (3) visits (initial prenatal (see above) and three prenatal visits). Bill in fifteen (15) minute increments for a total of sixty (60) minutes per visit. 3. 59409-HD **Labor support, Vaginal birth**; one (1) unit. 4. 59514-HD **Labor Support, C-section**; one (1) unit. 5. 59430-HD **Postpartum Care, Postpartum Visit**; Maximum four (4) visits. Bill in fifteen (15) minute increments for a total of sixty (60) minutes per visit. 6. 99199-HD **Incentive Mother Postpartum**; one (1) unit. 7. 99199-HD **Incentive Newborn Postpartum**; one(1) unit. Must be billed under the newborns Medicaid ID. All claims for Doula services must include diagnosis code Z32.2 (encounter for childbirth instruction).

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services - See Part 3A of this Attachment				
Early Intervention Services - See Part 3B of this Attachment				
Emergency Services	42 CFR §438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	The Contractor must cover all emergency services without service authorization. The Contractor must also cover services needed to ascertain whether an emergency exists. The Contractor must not restrict a Member's choice of provider for emergency services.
Emergency Services – Post-Stabilization Care	42 CFR §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 until AFTER an emergency condition has been stabilized.
Enhanced Services	Cardinal Care MCO Contract	No	Yes	Enhanced benefits are services offered by the Contractor to Members in excess of the Cardinal Care program covered services. Enhanced benefits do not have to be offered to individuals in every category of eligibility; however, must be available to all individuals if placed on the Cardinal Care health plan comparison chart. See Section 5.4, *Enhanced Benefits* for more information.
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	Experimental and investigational procedures as defined in 12 VAC 30-50-140 are not covered. For those Members < twenty-one (21), clinical trials are not always considered to be experimental or investigational and must be evaluated on a case-by-case basis, including using EPSDT criteria as appropriate. Also see Clinical Trials and EPSDT Services in Section 3B.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions. In

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
				accordance with 42 CFR §§438.10, 438.210, and 441.20, the Contractor is prohibited from restricting a Member's choice of provider (network or out-of-network) or method for family planning services or supplies. The Contractor cannot require an enrollee to obtain a referral before choosing a family planning provider.
Gender Dysphoria Treatment Services	Pending Manual Citation	Yes	Yes	In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, Item 313 (ZZZZZ),the Contractor must cover all Gender Dysphoria treatment services as outlined in the Department's coverage manuals and guidelines, including pharmacological, behavioral health, medical (hormonal), surgical, and procedural & therapeutic services. The Contractor is prohibited from imposing additional authorization criteria to access Gender Dysphoria treatment services and prohibited from imposing additional authorization criteria to access
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01. 12 VAC 30-50-510 Chapter IV of the Physician Manual	Yes	Yes	The Contractor must comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The Contractor must ensure that, as a routine component of prenatal care, every pregnant Member must be advised of the value of testing for HIV infection. Any pregnant Member must have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal must be maintained in the Member's Medical Record.
Home Health Services	12VAC30-10-220 12VAC30-50-160 12VAC30-50-200	Yes	Yes	The Contractor must cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits per year are allowed. Skilled home health visits are limited based upon medical necessity. The Contractor must manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
	12 VAC 30-60-70 42 CFR §440.70 41 CFR § 441.15			instances where the Member cannot perform the services; where there is no responsible party willing and able to perform the services; and where the service cannot be performed in the PCP office/outpatient clinic, etc. The Contractor may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. Medicaid home health services are provided in accordance with the requirements of 42 CFR §§440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services for Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving State and/or Federal assistance for those home health services. For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting. Services covered under Home Health include: 0550 Skilled Nursing Assessment 0551 Skilled Nursing Care, Follow-Up Care 0559 Skilled Nursing Care, Comprehensive Visit 0571 Home Health Aide Visit 0424 Physical Therapy, Home Health Assessment 0421 Physical Therapy, Home Health Follow-Up Visit 0434 Occupational Therapy, Home Health Assessment 0431 Occupational Therapy, Home Health Follow-Up Visit 0444 Speech-Language Services, Home Health Assessment

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				0441 Speech Language Services, Home Health Follow-Up Visit 0542 Non-Emergency Transportation, Per Mile Additional information can be found in the Home Health provider manual available on the Department's web portal at: www.virginiamedicaid.dmas.virginia.gov
Hospice Services - See Part 4 (LTSS) of this Attachment.				
Hysterectomies	42 CFR Part 441 Subpart F as amended. See Hospital Manual Chapter IV, Exhibits For required forms.	Yes, limited.	Yes, limited.	The Contractor may not impose a thirty (30)-day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor must 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 must comply with State and Federal 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 upon request.
ID/DD/DS Waivers (known Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver) See Part 4C of this Attachment.				
Immunizations	12 VAC 30-50-130 Physician Manual, Chapter IV.	Yes	Yes	The Contractor must cover immunizations within the most current Advisory Committee on Immunization Practices (ACIP) guidelines, without cost sharing for children under age twenty-one (21) (through the EPSDT benefit), Medicaid adults

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	Provider Manual Supplement B -EPSDT Supplement			(including Expansion), and Medicaid Works, who are required to receive all essential health benefits (EHB). The Contractor is also required to provide coverage for the COVID-19 vaccine for all populations and for the flu and pneumonia immunizations for "at-risk" populations within the Center for Disease Control (CDC) guidelines. The Contractor must educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. See EPSDT in part 3B for immunizations for children, and Section 5.11, *Covered Services for MAGI Adult Medicaid Expansion Population*.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 12 VAC 30-50-225 12 VAC 30-60-20 12 VAC 30-60-120 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor must cover inpatient stays in general acute care and rehabilitation hospitals for all Members within at least equal amount, duration and scope as available under the Medicaid State Plan for all individuals and the EPSDT benefit for children under age twenty-one (21). Contractor coverage must include, but not be limited to, all of the following: maternity length of stay requirements; radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and an early discharge follow-up visit in maternity cases where the Member is discharged earlier than forty-eight (48) hours after the day of delivery. 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.
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private. - See Part 4 of this Attachment.				

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Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	The Contractor must cover all medically necessary laboratory, radiology and anesthesia services directed and performed within the scope of the license of the practitioner. In accordance with 42 CFR §§493.1 and 493.3, all laboratory testing sites providing services under this Contract are required to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)	12VAC30-50-220	Yes	Yes	Screenings will be covered for Members who meet all of the following criteria: fifty-five through eighty (55-80) years of age; asymptomatic (no signs or symptoms of lung cancer); tobacco smoking history of at least one (1) pack per day for thirty (30) or more years; current smoker or former smoker who has quit smoking within the last fifteen (15) years; and, receive a written order furnished by a licensed provider or a qualified non-physician practitioner for lung cancer screening with LDCT that meets the requirements described above. Prior authorization may be required.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor must cover low-dose screening mammograms for determining presence of occult breast cancer. Screening mammograms for age forty (40) and over must be covered consistent with the guidelines published by the American Cancer Society.
Medical Supplies and Equipment	12 VAC 30-50-165 12 VAC 30-60-75 12 VAC 30-80-30	Yes	Yes	The Contractor must cover medical supplies and equipment at least to the extent covered by the Department. The Contractor's DME benefits must be limited based upon medical necessity. There are no maximum benefit limits on DME. The Contractor must cover nutritional supplements and supplies (enteral nutrition) for children and adults. The Contractor must cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements

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				specified in the DME supplies manual. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the Member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the Member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Contractor must use the valid preauthorization begin date as the invoice date. The MCOs must work with the Member to receive/replace DME supplies that have been lost or destroyed, or the current DME provider is not available, as a result of a disaster or emergency in accordance with Code of Virginia § 44.146.16. Additional information can be found in the Durable Medical Equipment & Supplies provider manual available on the Department's web portal at: www.virginiamedicaid.dmas.virginia.gov
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor must cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation	12 VAC 30-50-540 12 VAC 30-50-550 12-VAC 30-50-560 12 VAC 30-50-580, 12 VAC 30-10-280 12 VAC 30-50-100G	Yes	Yes	The Contractor must cover organ transplants for children and adults in accordance with 12 VAC 30-10-280, 12 VAC 30-50-540, VAC 30-50-550, VAC 30-50-560, 12 VAC 30-50-580, and Section 1903(i) of the Social Security Act within at least equal amount, duration, and scope as Medicaid fee-for-service. The Contractor must provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the

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	12 VAC 30-50-105K			accessibility of high quality care to enrollees. Transplant services for kidneys, corneas, hearts, lungs, livers (from living or cadaver donors), and bone marrow/stem cell must be covered for all eligible persons as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. Contractor must cover necessary procurement/donor related services. Transplant services must be covered for children (under twenty-one (21) years of age) per EPSDT guidelines.
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	The Contractor must cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services must 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. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor must cover annual pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care; EPSDT	https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library 42 CFR §441.50	Yes	Yes	The Contractor must cover medically necessary personal care services for children under age twenty-one (21) consistent with the Department's criteria described in the EPSDT Supplement, available on the Department's website at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library

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	1905(a) of Social Security Act			Individuals have the choice to receive personal care through an agency-directed or consumer-directed delivery model. The delivery model is to be chosen by the adult individual or the caregiver if the individual is under age eighteen (18) or is not able to make a choice. This is not a State Plan covered benefit for Adults. Coverage is available for children under age twenty-one (21) under EPSDT. Personal care coverage is also available for Members through HCBS waiver programs. See Part 4 of this coverage chart.
Personal Care Medicaid Works See CCC Plus Waiver services in Part 4b.	12VAC30-60-200 12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor must provide coverage for personal care services for Medicaid works individuals using the same coverage criteria as the personal care coverage criteria under the CCC Plus HCBS Waiver, however, Medicaid Works individuals are not required to have a Medicaid LTSS screening. In order to receive personal care services, Medicaid Works individuals who meet coverage criteria must be enrolled with the Medicaid Works (MW) exception indicator. Medicaid Works individuals also have no patient pay responsibility for the personal care services. Criteria information regarding personal care can be found in the Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapter IV, beginning on page 10. The manual is available on the web portal at www.virginiamedicaid.dmas.virginia.gov under the Provider Resources; Provider Manuals link.

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor must cover physical therapy, occupational therapy, speech pathology, and audiology services that are provided as an inpatient, outpatient hospital service, outpatient rehabilitation agencies, or home health service. The Contractor's benefits must include coverage for acute and non-acute conditions and maybe limited based upon medical necessity. There are no maximum benefit limits on PT, OT, SLP, and audiology services. These services are covered regardless of where they are provided, the plan must also cover all Medically Necessary, intensive physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130 42 CFR §438.206	Yes	Yes	The Contractor must cover all symptomatic visits to physicians or physician extenders, Collaborative Care Management (99492, 99493 and 99494), and routine physicals for children up to age twenty-one (21) under EPSDT. The Contractor must 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.

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				The Contractor must provide for a second opinion from a network provider, or arrange for the Member to obtain one (1) outside the network, at no cost to the Member.
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor must cover podiatry services including 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.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280 12 VAC 30-50-290	Yes	Yes	The Contractor must cover prenatal and postpartum services to pregnant enrollees. The Contractor must cover case management services for its high-risk pregnant women. The Contractor must provide to qualified Members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor must cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled Members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan must cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit must be provided to all mothers who meet the Department's criteria and the follow-up visit must be provided within forty-eight (48) hours of discharge and meet minimum requirements.

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Prescription Drugs	12 VAC 30-50-210 Chapter IV of the Pharmacy Manual	Yes	Yes	The Contractor must cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Behavioral Health visits. Refer to Section 5.15, *Pharmacy Services*.
Private Duty Nursing (PDN) under EPSDT	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR §441.50 1905(a) of Social Security Act	Yes	Yes	The Contractor must cover medically necessary private duty nursing services for children under age twenty-one (21) consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the Department's website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Program in Part 4 of this Attachment) Not a State Plan covered benefit for Adults. Coverage is available for children under age twenty-one (21) under EPSDT. PDN Coverage is also available for Members in the Technology Assisted Program.
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor must cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male Members for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual	Yes	Yes	The Contractor must 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 twenty-one (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 must cover breast prostheses following medically necessary removal of a breast for any medical reason.

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covered?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	The Contractor must cover reconstructive breast surgery.
Local Education Agency-Based Services	12 VAC 30-50-130	Yes	No	State plan-approved Local Education Agency-Based Services (see Section 22, *Definitions* and Section 23, *Acronyms*) rendered to member students in the school setting by qualified providers that are employed or contracted by a Department-enrolled Local Education Agency Provider are billed using FFS and reimbursed using a reconciled cost-based methodology. These services are carved-out of the Managed Care contracts. Services rendered in a school setting that are not part of Local Education Agency-Based Services must be covered by the Contractor in accordance with the Department's established criteria and guidelines. The Contractor may not deny medically necessary covered services rendered in a non-school setting based on the fact that the child is receiving the same covered services as part of a local education agency school-based services program. Private duty nursing and personal care services provided through EPSDT, Technology Assisted Program, Community Living Waiver, or Family and Individual Supports Waiver are not considered Local Education Agency-based services, including when provided in the school setting or provided before or after school by personnel not employed by or contracted by the Local Education Agency.
Skilled Nursing Facility Care - See Part 4A (LTC Facility Services) of this Attachment.				
Sterilizations	42 CFR§ 441, Subpart F, as amended Code of Virginia § 54.1-2974	Yes, limited.	Yes, limited.	The Contractor must not perform sterilization for a Member under age twenty-one (21). The Contractor must comply with State and Federal requirements and must comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia § 54.1-2976. The Contractor must ensure that the consent form DMAS-3004 of 42 CFR §441.258 is both obtained and documented

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				prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the Member being informed, the Member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor must comply with State and Federal 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 upon request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor must provide coverage for telemedicine services. Telemedicine is defined as the real time or near real time two(2)-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, certified nurse-midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one (1) of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and state laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities must be compliant with HIPAA requirements.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 CFR §440.170(a)	Yes	Yes	The Contractor must provide urgent and emergency transportation as well as non-emergency transportation to all Medicaid covered services, including those Medicaid services covered by Medicare or another third party payer and to services provided by subcontractors as described here and as further detailed in

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	Chapter IV of the Transportation Manual			Section 5.14, *Non-Emergency Medical Transportation Services (NEMT).* These modes must include, but must 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 must cover air travel for critical needs. The Contractor must cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in CFR §440.170(a). The Contractor must 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. The Contractor must cover transportation to and from Medicaid covered behavioral health services. Community Living, Family and Individual Supports, and Building Independence Waiver Members must receive acute and primary medical services via the Contractor and must receive waiver services and related medical transportation to waiver services via the fee-for-service program.
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4 2021 Virginia Acts of Assembly, Chapter 552.	Yes	Yes	The Contractor must cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy for all Medicaid Members. The EPSDT benefit includes the provision of anticipatory guidance and risk reduction counseling with regard to vaping or tobacco use during routine well-child visits. In addition to routine visits, additional counseling and Nicotine Replacement Therapy must be provided when medically necessary for individuals under age twenty-one (21).
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor must cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists,

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	Chapter IV of the Vision Services Manual			optometrists, and opticians. The Contractor must also cover eyeglasses for children under age twenty-one (21). The Contractor's benefit limit for routine refractions must not be less than once every twenty-four (24) months. Service Codes: S0620 - Routine ophthalmological examination including refraction; new patient. 92004 - Comprehensive eye exam for a new patient. Does not include refraction.
Brain Injury Services Case Management	*New Service-Regulations Pending Brain Injury Services Manual (Pending)	Yes	Yes	The Contractor must cover medically necessary Brain Injury Services Case Management. Brain Injury Services Case Management is defined as a service to assist individuals, eligible under the State Plan who reside in a community or institutional setting, in gaining access to needed medical, social, educational, and other services as planned upon discharge from a facility setting or while residing in the community. Case management does not include the provision of direct clinical or treatment services. Service Code: Pending
Waiver Services (Home- and Community-Based) - See Part 4 B (LTSS) of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See Section 5.6, Mental Health Parity and Addiction Equity Requirements (MHPAEA) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
INPATIENT BEHAVIORAL HEALTH TREATMENT SERVICES				
Inpatient Psychiatric Hospitalization in Free-standing Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 12VAC30-50-130 12VAC30-50-100 12VAC30-50-105 Manual-Psychiatric Services Chapter 4 Final Rule: 42 CFR Part 438.6 page 27861 and pages 27557 and 27558 Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions (FAQs) – Section 438.6(e)	Yes	Yes	The Contractor must cover medically necessary inpatient psychiatric hospital stays in free-standing psychiatric hospitals for covered Members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a free-standing psychiatric hospital "in lieu of" inpatient psychiatric hospitalization in a general hospital (per below) for Medicaid Members between the ages of twenty-one (21) and sixty-four (64). Coverage must comply with Federal Mental Health Parity law and Federal provisions for IMDs. Where the length of stay exceeds fifteen (15) days in a calendar month, the Contractor is required to refund the capitation payment, consistent with the Federal regulations described in 42 CFR §438.6, 42 CFR §438.3(e)(2) and Section 5.5.1.2, *IMD Enhanced and State Plan Substituted (In Lieu Of) Services of for Certain Medicaid Members*. Exception: FAMIS MOMS and FAMIS PC are not eligible for services furnished in a state or private free-standing psychiatric mental hospital/IMD setting; however, managed care plans may elect to cover as an additional benefit for their FAMIS MOMS and FAMIS PC enrolled members.

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Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
Inpatient Psychiatric Hospitalization in General Hospital	12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 Manual-Psychiatric Services, Chapter 4	Yes	Yes	The Contractor must provide coverage for medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital for all Members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
State Geriatric Hospital Placements (Piedmont, Hiram Davis, and Hancock)		Yes	No	Individuals in Piedmont, Hiram Davis, and Hancock state geriatric facilities are excluded from Managed Care program participation.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO) (Revenue Codes for TDOs and Service Code 0450 for ECOs)	Code of Virginia § 16.1-340 and 340.1 and §§ 37.2-808 through 810 Appendix B of the Hospital Manual	Yes	Yes	Pursuant to 42 CFR §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 must 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 twenty-one (21) through sixty-four (64) and admitted to a free-standing facility. The Contractor 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

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See Section 5.6, Mental Health Parity and Addiction Equity Requirements (MHPAEA) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				based on a diagnosis while the Member is under TDO for Mental Health Services. The duration of temporary detention must be in accordance with §16.1-335 et seq. of the Code of Virginia for individuals under age eighteen (18) and §37.2-800 et. seq. for adults age eighteen (18) and over. 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. Exception: FAMIS MOMS and FAMIS PC coverage does not include TDO treatment in a state or private free-standing psychiatric hospital/IMD setting. Managed care plans may elect to cover as an additional benefit for their FAMIS MOMS and FAMIS PC enrolled members. Coverage is also available through the State TDO fund.
OUTPATIENT BEHAVIORAL HEALTH SERVICES – Psychiatric Services Manual for All				
Electroconvulsive Therapy	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	The Contractor must cover medically necessary electroconvulsive therapy services. Coverage must comply with Federal Mental Health Parity law.
Pharmacological Management, including prescription and review of medication, when	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary pharmacological management services. (CPT 90863)

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See Section 5.6, Mental Health Parity and Addiction Equity Requirements (MHPAEA) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
performed with psychotherapy services				
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Psychiatric Diagnostic Evaluation ; with Medical Service (CPT 90792 alone or GT)
Psychological/ Neuropsychological Testing	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law. The former psychological testing CPT codes (96101-96103) and neuropsychological testing CPT codes (96118-96120) are retired, and have been replaced with the following codes, effective Jan. 1, 2019: Psychological Testing administered by Computer (CPT: computer:96146) Neurobehavioral Status Exam (CPT: 96116 and 96121 for Each additional Hour) Neuropsychological Testing Administered by Psychologist/Physician

SUMMARY OF COVERED SERVICES - PART 2A –INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See Section 5.6, Mental Health Parity and Addiction Equity Requirements (MHPAEA) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive the Medicaid benefits as described in this table and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				(CPT: 96132 and 96133 for Each additional Hour; 96136 and 96137 for Each additional thirty (30) minutes) Neuropsychological Testing Administered by Technician (CPT: 96138 and 96139 for Each additional thirty (30) minutes) Neuropsychological Testing Administered by Computer(CPT: 96146)
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	The Contractor must cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy. 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).
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor must cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Use the most up-to-date version of the CPT codes.

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
Applied Behavior Analysis	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 [excluding C.4, D.2(d) and E(i)] Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D	Yes	Yes	The Contractor is required to provide coverage for Applied Behavior Analysis (ABA). ABA means the practice of behavioral analysis by the Virginia Board of Medicine in §54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. See the DMAS Mental Health Services Provider Manual, Intensive Community Based Support – Youth Appendix D, for service codes, available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal
Assertive Community Treatment	Mental Health Services Manual (formerly CMHRS)	Yes	Yes	Assertive Community Treatment (ACT) is a highly coordinated set of services offered by a group of medical, behavioral health, and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	Chapters 2, 4 & 6 and Appendix E			ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals' needs, and oriented around individuals' personal goals. A fundamental charge of ACT is for the team to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Community Based Support Appendix E for assessment requirements, including billing codes. Treatment Service Code: H0040 U2 – Contracted as Base Small Team U1 – Contracted as Base Medium Team none – Contracted as Base Large Team

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				U5 Contracted as High Fidelity Small Team U4 Contracted as High Fidelity Medium Team U3 Contracted as High Fidelity Large Team
Community Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall provide Community Stabilization services which are short-term and designed to support an individual and their natural support system following contact with an initial crisis response service or as a diversion to a higher level of care. Providers deliver community stabilization services in an individual's natural environment and provide referral and linkage to other community-based services at the appropriate level of care. Interventions may include: brief therapeutic and skill building interventions, engagement of natural supports, interventions to integrate natural supports in the de-escalation and stabilization of the crisis, and coordination of follow-up services. Coordination of specialized services to address the needs of co-occurring intellectual/developmental disabilities and substance use are also available through this service. The goal of Community Stabilization services is to continue to stabilize the individual within their community and support the individual and/or support system during the period between either 1) an initial Mobile Crisis Response and entry in to an established follow-up service at the appropriate level of care or 2) transitional step-

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<tr><td></td><td></td><td></td><td></td><td>down from a higher level of care if the next level of care service is identified but not immediately available for access.

Treatment Service Code: S9482

<table><tr><th>Modifier</th><th>Modifier Meaning</th></tr><tr><td>HN</td><td>1 QMHP-A or QMHP-C or 1 CSAC[x]</td></tr><tr><td>HO</td><td>1 Licensed[x]</td></tr><tr><td>HT, HM</td><td>1 Licensed[x] <u>and</u> 1 Peer or
1 Licensed[x] <u>and</u> 1 CSAC-A</td></tr><tr><td>HT</td><td>1 Licensed[x] <u>and</u> 1 QMHP-E or QMHP-C or QMHP-A or
1 Licensed[x] <u>and</u> 1 CSAC[x]
[x] = Includes supervisees and residents</td></tr></table></td></tr>
<tr><td>Functional Family Therapy (FFT)</td><td>Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D</td><td>Yes</td><td>Yes</td><td>The Contractor shall cover Functional Family Therapy (FFT) which is a short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT is a primarily home-based service that addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

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<tr><td></td><td></td><td></td><td></td><td>a family. The FFT model is a rehabilitative service that serves as a step-down and diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community.

Treatment Service Code: H0036

<table>
<tr><td>HN</td><td>Bachelor's Established Team</td><td>One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
<tr><td>HO</td><td>Master's/Licensed Established Team</td><td>One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.</td></tr>
<tr><td>HK, HN</td><td>Bachelor's New Team</td><td>One FFT Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee</td></tr>
</table>
</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**

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<table>
<tr><td></td><td></td><td>All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
<tr><td>HK, HO</td><td>Master's/Licensed New Team</td><td>One FFT Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP</td></tr>
</table>
</td></tr>
<tr><td>Intensive In-Home Assessment and Services</td><td>12 VAC 30-50-130
12 VAC 30-60-61
12 VAC 30-60-143
12 VAC 30-130-2000
12 VAC 30-60-5
Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6</td><td>Yes</td><td>Yes</td><td>The Contractor must cover medically necessary Intensive In-Home Assessment Services. Intensive in-home services (IIH) for youth under age 21 are intensive therapeutic interventions provided in the youth's residence (or other community settings as medically necessary and documented in the Comprehensive Needs Assessment and ISP), to improve family functioning, and significant functional impairments in major life activities that have occurred due to the youth's mental, behavioral or emotional illness in order to prevent an out of home placement, stabilize the youth, and gradually transition the youth to less restrictive levels of care and supports. All IIH services shall be designed to specifically improve family dynamics, provide modeling, and include clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the</td></tr>
</table>

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The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				home. IIH services are designed to promote benefits of psychoeducation in the home setting of a youth who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the youth. Comprehensive Needs Assessment Service Code: H0031 Treatment Service Code: H2012
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Mental Health Services Manual	Yes	Yes	The Contractor must cover medically necessary Mental Health Case Management services. Mental health Case Management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services. Service Code: H0023

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The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
	(formerly CMHRS) Manual Chapters 2, 4 & 6			
Mental Health Intensive Outpatient	Mental Health Services Manual Chapters 2, 4, and 6, and Appendix F	Yes	Yes	The Contractor shall cover Mental Health Intensive Outpatient Services (MH-IOP) which are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time limited treatment programs that integrate evidence-based practices for youth (ages six (6) – seventeen (17) years) and adults (eighteen (18) years and older). MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care. MH-IOP services are appropriate when an individual requires at least six (6) hours of clinical services a week (for youth ages six (6) – seventeen (17)), or nine (9)

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The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of nineteen (19) hours per week. A MH-IOP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-IOP tapers in intensity as an individual's symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements. Treatment Service Code: S9480/ S9480 GO (Occupational Therapy)
Mental Health – Partial Hospitalization Program	Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services which are similar to an inpatient program, but available on a less than twenty-four (24)-hour basis. MH-PHP are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth six to seventeen (6-17 years old) and adults (eighteen (18) years +). The average length of stay may be four (4) to six (6) weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				down option following an inpatient hospitalization. MH-PHP can serve as a diversion for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs services may occur in either a hospital- or community-based location. MH-PHP services are appropriate when an individual requires at least four (4) hours of clinical services a day, over several days a week and totaling a minimum of twenty (20) hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-PHP tapers in intensity and frequency as an individual's symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are appropriate to participate in a lower level of care. Assessment Service Code: See Mental Health Services Provider Manual, Intensive Clinic Based Support Appendix for assessment billing requirements. Treatment Service Code: H0035

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The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
Mental Health Peer Recovery Support Services	Regulations: 12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160 through 12 VAC 30-130-5210 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Manual: Mental Health Services Manual – Peer Recovery Support Services Supplement	Yes	Yes	The Contractor must cover medically necessary MH Peer Support Services for adults and MH Family Support Partners for youth under 21. MH Peer Support Services and MH Family Support Partners are peer recovery support services as defined in 12VAC35-250-10. Collaborative, nonclinical, peer-to-peer services that engage, educate, and support a member's self-help efforts to improve his health, recovery, resiliency, and wellness to assist members in achieving sustained recovery from the effects of mental illness, addiction or both. Service Code H0024 (Individual) H0025 (Group)
Mental Health Skill-building Assessment and Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130	Yes	Yes	The Contractor must cover medically necessary Mental Health Skill-building Assessment and Services. Mental Health Skill-building Services (MHSS) are defined as goal directed training and supports to enable restoration of an individual to the highest level of

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	12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6			baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS services must provide face to face activities, instruction, interventions, and goal directed trainings that are designed to restore functioning and that are defined in the ISP in order to be reimbursed by Medicaid. MHSS must include goal directed training in the following areas: (i) functional skills and appropriate behavior related to the individual's health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities. Comprehensive Needs Assessment Service Code: H0032-U8 Treatment Service Code: H0046
Mobile Crisis Response	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall cover Mobile Crisis Response which provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. This service is provided twenty-four (24) hours a day, seven (7) days a week. The purpose of this service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care. Mobile Crisis Response is also the

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
				mechanism by which pre-admission screenings for hospitalization may be performed by DBHDS pre-admission screening clinicians, when clinically necessary. Treatment Service Code: H2011

Modifier	Modifier Meaning
HO	1 Licensed[x]
32	Emergency Custody Order 1 Licensed[x]
HT, HM	1 QMHP-A/QMHP-C/CSAC[x] **and** 1 PRS **or** 1 QMHP-A/QMHP-C/CSAC[x] **and** 1 CSAC-A
HT, HO	1 Licensed[x] **and** 1 PRS **or** 1 Licensed[x] **and** 1 CSAC-A **or**
HT, HN	2 QMHPs (QMHP-A, QMHP-C and/or QMHP-E) /CSACs[x] **or** 1 QMHP-A/QMHP-C **and** 1 CSAC[x]
HT	1 Licensed[x] **and** 1 QMHP(QMHP-A, QMHP-C or QMHP-E) **or** 1 Licensed[x] **and** 1 CSAC[x] [x] = Includes supervisees and residents

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**

<table>
<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th>Contractor Responsibilities</th></tr>
<tr><td>Multisystemic Therapy (MST)</td><td>Mental Health Services Manual Chapters 2, 4, and 6, and Appendix D</td><td>Yes</td><td>Yes</td><td>The Contractor shall cover Multi-systemic therapy (MST) which is an intensive, evidence-based treatment program provided in home and community settings for youth (eleven (11) – seventeen (17) years of age) who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes an emphasis on engagement with the youth's family, caregivers and natural supports and professionals delivering interventions in the recovery environment. MST is a short-term and rehabilitative service that may serve as a step-down and diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.

Treatment Service Code: H2033

<table>
<tr><td>HN</td><td>Bachelor's Established Team</td><td>One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
</table>
</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

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<table>
<tr><th>Service</th><th>State Plan Reference or Other Relevant Reference</th><th>Medicaid Covered?</th><th>MCO Covers?</th><th colspan="3">Contractor Responsibilities</th></tr>
<tr><td></td><td></td><td></td><td></td><td>HO</td><td>Master's/ Licensed Established Team</td><td>One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.</td></tr>
<tr><td></td><td></td><td></td><td></td><td>HK, HN</td><td>Bachelor's New Team</td><td>One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
<tr><td></td><td></td><td></td><td></td><td>HK, HO</td><td>Master's/ Licensed New Team</td><td>One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP</td></tr>
<tr><td>Psychiatric Residential Treatment Facility –</td><td>12 VAC 30-10-540 12 VAC 30-60-61 12 VAC 30-50-130</td><td>Yes</td><td>No</td><td colspan="3">The Contractor is not responsible for covering Psychiatric Residential Treatment Facility (PRTF) services for Medicaid children under age 21.</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
(PRTF) for children under age twenty-one (21) years – (Formerly known as Level C)	12 VAC 30-60-5 Residential Treatment Services; Manual			Psychiatric residential treatment (level C) is not a covered service for FAMIS MOMS and FAMIS PC. The Contractor may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit. **Note: Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled with the Contractor and who are admitted to a Residential Treatment Center for Substance Use Disorder are not excluded and will remain enrolled with the Contractor. See Part 2C for RTC coverage through ARTS benefits.** Department authorization for Medicaid children under age 21 into a PRTF program will result in disenrollment of the Medicaid Member from the managed care program. The PRTF provider must contact the Department's Service Authorization Contractor for authorization and payment through the fee-for-service program. The Contractor must work closely with the Department's Service Authorization Contractor to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. The Contractor must collaborate with the Department's Service Authorization Contractor to ensure physician engagement occurs on behalf of the

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
				Member during the independent certification of need process as required prior to any residential treatment service authorization.
Psychosocial Rehabilitation Assessment and Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-5 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-143 Mental Health Services Manual (formerly CMHRS) Chapters 2, 4 & 6	Yes	Yes	The Contractor must cover medically necessary Intensive Psychosocial Rehabilitation Assessment and Services. Includes services for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a non-residential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually. Comprehensive Needs Assessment Service Code: H0032-U6. Service Code: H2017 Not an excluded service for Members in one (1) of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation.

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
Residential Crisis Stabilization Unit	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall provide access to and cover services provided in Residential Crisis Stabilization Units which serve as diversion facilities from inpatient hospitalization. Residential Crisis Stabilization Units provide short-term, twenty-four (24) hours a day, seven (7) days a week, residential psychiatric/substance related crisis evaluation and brief intervention services. The service supports individuals experiencing abrupt and substantial changes in behavior noted by severe impairment or acute decompensation in functioning. Treatment Service Code: H2018 32 – Emergency Custody Order (ECO) HK – Temporary Detention Order (TDO)
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-50-226	Yes	Yes	The Contractor must cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. TDT provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses as evidenced by diagnoses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities such that they need the structured treatment interventions offered by TDT. TDT treatment interventions are provided during the school day or to supplement the school day or

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
	12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Mental Health Services Manual Chapters 2, 4 & 6			year. This service shall include assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. These services shall be provided for two or more hours per day Comprehensive Needs Assessment Service Code: H0032 Service Code: H2016 Modifiers: School Based TDT must be billed as H2016 (none) After School TDT must be billed as H2016 UG Summer TDT must be billed as H2016 U7
Therapeutic Group Home Children and Adolescents under twenty-one (21) – Group Home	12 VAC 30-50-130 and 12 VAC 30-60-61 VAC 30-60-5	Yes	No	The Contractor is not responsible for covering Therapeutic Group Home (TGH) services Any youth admitted to a TGH participants will not be excluded from the Cardinal Care Managed Care Program; however, the TGH per diem service is carved out of the Cardinal Care Managed Care Contract and will be administered through the Department's Service Authorization Contractor. Covered services rendered to individuals in the TGH that are allowed to be billed outside the TGH per diem will be

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS) Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
(Formerly known as Levels A&B)	12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Residential Treatment Services Manual			the responsibility of the Contractor. (See Chapter V of the DMAS Residential Treatment Services Manual). The Contractor must collaborate with the Department's Service Authorization Contractor to: facilitate Independent Assessment Certification and Coordination Team (IACCT) activities on behalf of the Member, to ensure coordination of Medical, ARTS, and mental health services for its Members, and to provide coverage for transportation and pharmacy services necessary for the provision of, and as related to, TGH carved out services. TGH Service Code: H2020 HW or HK EPSDT TGH Code: H0019
Treatment Foster Care (TFC) Case Management (CM) for children under age twenty-one (21) years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111 Mental Health Services Manual	Yes	Yes	The Contractor must cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age twenty-one (21) years. Treatment Foster Care - Case Management is a service that assists Medicaid eligible individuals in gaining and coordinating access to necessary care and services appropriate to their needs.

SUMMARY OF COVERED SERVICES - PART 2B –MENTAL HEALTH SERVICES (MHS) & RESIDENTIAL TREATMENT SERVICES (RTS)

Individuals enrolled in Medicaid, FAMIS MOMS and FAMIS PC receive MHS and PRTS services as described below and are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.

The Contractor must provide coverage for MHS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. MHS Providers must have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations**. Exceptions are noted below.**

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities
	(formerly CMHRS) Chapters 2, 4 & 6			Service Code T1016.
Twenty-three (23) hour Crisis Stabilization	Mental Health Services Manual Chapters 2, 4, and 6 and Appendix G	Yes	Yes	The Contractor shall cover Twenty-three (23)-Hour Crisis Stabilization which provides a period of up to twenty-three (23) hours in a community-based crisis stabilization clinic that provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis. This service should be accessible twenty-four (24) hours a day, seven (7) days a week, and is indicated for those situations wherein an individual is in an acute crisis and requires a safe environment for observation and assessment prior to determination of whether admission to an inpatient or crisis stabilization unit setting is necessary. This service allows for an opportunity for thorough assessment of crisis and psychosocial needs and supports throughout the full twenty-three (23) hours of service to determine the best resources available to for the individual to prevent unnecessary hospitalization. Treatment Service Code: S9485 32 Emergency Custody Order (ECO) HK Temporary Detention Order (TDO)

SUMMARY OF COVERED SERVICES - Part 2C - 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) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - The Contractor must provide coverage in IMD settings for Medicaid, FAMIS MOMS, and FAMIS PC, as appropriate based on the ASAM Criteria, including for children and adults, regardless of age. Effective July 1, 2021, FAMIS MOMS and FAMIS PC enrollees are eligible for coverage for medically necessary services in an IMD, equivalent to such benefits offered to pregnant women under the Medicaid state plan and Medicaid Section 1115 demonstration waiver. This coverage includes the following settings: ASAM Levels 3.3, 3.5, 3.7 and 4.0 in residential treatment settings, psychiatric units and free-standing psychiatric hospitals.				
Medically Managed Intensive Inpatient	ASAM Level 4.0 12VAC30-130-5000 to 5040 12VAC30-130-5150	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7 12VAC30-130-5000 to 5040 12VAC30-130-5140	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed High Intensity Residential Services	ASAM Level 3.5 12VAC30-130-5000 to 5040 12VAC30-130-5130	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3 12VAC30-130-5000 to 5040 12VAC30-130-5120	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier TG

SUMMARY OF COVERED SERVICES - Part 2C - 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) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1 12VAC30-130-5000 to 5040 12VAC30-130-5150	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H2034
OUTPATIENT WITHDRAWAL MANAGEMENT				
ARTS Partial Hospitalization	ASAM Level 2.5 12VAC30-130-5000 to 5040 12VAC30-130-5110	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes S0201 Rev 0913 and S0201
ARTS Intensive Outpatient	ASAM Level 2.1 12VAC30-130-5000 to 5040 12VAC30-130-5090	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. Service Codes H0015 Rev 0906 and H0015
Ambulatory Withdrawal Management With Extended On- Site Monitoring	ASAM Level 2WM	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. CPT codes
Ambulatory Withdrawal Management	ASAM Level 1 WM	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. CPT codes

SUMMARY OF COVERED SERVICES - Part 2C - 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) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.					
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**	
Without Extended On- Site Monitoring					
Medication Assisted Treatment (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs 12VAC30-130-5000 to 5040 12VAC30-130-5050	Yes	Yes	Counseling Medication Medication Administration Care Coordination Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance	H0004 – individual and family counseling H0005 - group counseling S0109 Methadone five (5) mg oral billed by provider H0020 G9012 Substance Use Care Coordination H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone and Naltrexone in Opioid Treatment Program (DBHDS-Licensed CSB and	ASAM Opioid Treatment Programs 12VAC30-130-5000 to 5040 12VAC30-130-5050	Yes	Yes	Counseling Medication	H0004 – individual and family counseling H0005 - group counseling J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider

SUMMARY OF COVERED SERVICES - Part 2C - 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) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.					
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**	
Private Methadone Clinics)					J2315 Naltrexone, Injection, depot form, billed by provider
					G9012 Substance Use Care Coordination
				Medication Administration	H0020
				Care Coordination	
				Physician Visit – Induction Day 1	H0014
				Urine Drug Screen	80305 to 80307 and G0480- G0483
				Labs	CPT codes
				Physician Visit – Maintenance	Use CPT E&M Established patient
Buprenorphine/Naloxone and Naltrexone in ASAM Office Based Addiction Treatment and ASAM Level 1.0	ASAM Office Based Opioid Treatment 12VAC30-130-5000 to 5040 12VAC30-130-5160	Yes	Yes	Counseling and Medication Oversight	H0004 – individual and family counseling H0005 - group counseling
				Care Coordination	G9012 Substance Use Care Coordination
				Physician Visit – Induction Day 1	H0014
				Drug Screen	80305 to 80307 and G0480- G0483
				Labs	CPT codes
				Physician Visit – Maintenance	Use CPT E&M Established patient

SUMMARY OF COVERED SERVICES - Part 2C - 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) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts Individuals enrolled in FAMIS MOMS and FAMIS PC receive the same comprehensive Addiction and Recovery Treatment Services (ARTS) benefits as Medicaid. Medicaid, FAMIS MOMS, and FAMIS PC Members enrolled in Managed Care are exempt from cost sharing. See Part 6 for FAMIS Children Covered Services.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities**
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Use Case Management	12 VAC 30-60-185 12 VAC 30-50-491	Yes	Yes	The Contractor must cover SUD services within ASAM criteria. (H0006)
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0 12VAC30-130-5000 to 5040 12VAC30-130-5080	Yes	Yes	The Contractor must cover SUD services within ASAM criteria (CPT Codes)
ARTS Peer Recovery Support Services	Regulations: 12VAC30-50-226 12VAC30-50-130 12VAC30-130-5160 through 12VAC30-130-5210 Manual: ARTS - Peer Services Manual Supplement	Yes	Yes	The Contractor must cover ARTS Peer Support Services for Adults and ARTS Family Support Partners for youth under twenty-one (21). Group – S9445 Individual – T1012
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-130-5000 to 5040 12VAC30-130-5070	Yes	Yes	The Contractor must cover SUD services within ASAM criteria (99408/99409)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
EPSDT Benefit Global Coverage Guidelines	12 VAC 30-50-130 42 CFR §440.40(b)(2) and 42 CFR §441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act http://www.dmas.virginia.gov/files/links/914/EPSDT%20Specialized%20Services%20-%20Guide%20to%20Providers.pdf https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	Yes	Yes	EPSDT includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under twenty-one (21) years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. For individuals under twenty-one (21) years of age EPSDT services will be provided before Technology Assisted Program services are offered. The Contractor must cover dental screenings and dental varnish under EPSDT. The Contractor must screen and assess all children; cover immunizations; educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal to increase immunization rates.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				EPSDT Assistive Technology (T5999) is a covered EPSDT benefit. The Contractor must provide assistive technology as specified in the EPSDT Manual, Supplement B Chapter.
Assistive Technology	Same as EPSDT Global Coverage Guidelines	Yes	Yes	To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for Assistive Technology services. Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia State Plan for Medical Assistance. Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable. See EPSDT Supplement B for specific coverage criteria. For children under age twenty-one (21) on the CCC Plus Waiver, assistive technology is covered through EPSDT.
Case Management for High-risk Infants (up to age two (2))	12 VAC 30-50-410	Yes	Yes	The Contractor must reimburse case management services for high-risk Medicaid-eligible children up to age two (2).
Clinical Trials	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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.
Dental Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				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 one(1)-year 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, referral must be made for needed dental services. The Contractor is not required to cover testing of fluoridation levels in well water.
Dental Varnish	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form must be covered.
Hearing Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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 must include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening must mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment must be part of each preventive visit for an older child.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Immunizations	Same as EPSDT Global Coverage Guidelines	Yes	Yes	According to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines, immunizations must be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Coverage must also be within CDC guidelines. The Contractor must coordinate coverage within the Virginia Vaccines for Children (VVFC) program. See the EPSDT Supplement Manual and the VVFC website at: http://www.vdh.virginia.gov/immunization/vvfc
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	The following recommended sequence of screening laboratory examinations must be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and must be obtained as necessary: 1. Hemoglobin/hematocrit 2. Tuberculin test (for high-risk groups) 3. Blood lead testing (see row below on Lead Testing)
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	The Contractor must provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the Member's local health department to see if a Member qualifies for a risk assessment. More information is available at http://www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for-public-health/elevated-blood-lead-levels-in-children Payments for environmental investigations must be limited to no more than two (2) visits per residence.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	All Medicaid children are required to receive a blood lead test at twelve (12) months and twenty-four (24) months of age. In addition, any child between twenty-four (24) and seventy-two (72) months with no record of a previous blood lead screening test must receive one (1). Testing may be performed by venipuncture or capillary. Filter paper methods are also acceptable and can be performed at the provider's office. Tests of venous blood are considered confirmatory. The providers need to use the code 83655 for Lead blood testing and one (1) of the following: 1. 36416 for the collection of capillary blood specimen (finger, heel, ear stick) 2. 36415 for the collection of venous blood by venipuncture. A blood lead test result equal to or greater than 5 ug/dL (or consistent with the most current CDC guidelines) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing must be done through a blood lead level determination. Results of lead testing, both positive and negative results, must be reported to the Virginia Department of Health, Office of Epidemiology.
Personal Care	Same as EPSDT Benefit Global Coverage Guidelines	Yes	Yes	EPSDT Personal Care Services are designed to assist children under the age of twenty-one (21) who meet the criteria for EPSDT Personal Care as defined in the EPSDT Personal Care Services Supplement with activities of daily living (ADLs), instrumental activities of daily living (IADLs), medically necessary supervision and monitoring of self-administered medications. The child's need for assistance with ADLs due to a health condition must be documented by the child's primary care provider on the EPSDT Functional Status Assessment Form (DMAS-7). The form must be completed and signed by a physician, physician's assistant or nurse practitioner and updated every

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				year. EPSDT Personal Care criteria is utilized for children not enrolled in CCC Plus Waiver. For members enrolled in CCC Plus Waiver, including those members under twenty-one (21) years old, personal care will be provided under the waiver. As such CCC Plus Waiver criteria and forms are used to determine personal care hours for these members. See Section 5.12.2, *Commonwealth Coordinated Care Plus Waiver*.
Private Duty Nursing	42 CFR §§441.50, 440.80, Social Security Act §1905(a) and 1905(r) l.	Yes	Yes	The Contractor must 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. The Contractor must 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. Skilled PDN is also covered for Members who are enrolled in Technology Assisted Program who require continuous nursing that cannot be met through home health. Technology Assisted Program uses form 108& 109 to determine the hours of service needed. Under EPSDT or Skilled PDN, the Member's condition warrants continuous nursing care including but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT and Skilled PDN differ 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

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				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. Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT or Skilled Private Duty Nursing must be reimbursed no less than the Department's fee-for-service rate.
Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Comprehensive, periodic health assessments (or screenings) from birth through age twenty (20) at intervals specified by the American Academy of Pediatrics (AAP). AAP 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 must not require any SA associated with the appropriate billing of these developmental screening services (e.g., CPT96110) in accordance with AAP recommendations. The medical screening must include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including reimbursement for developmental screens rendered by providers other than the primary care provider; and, (2) a comprehensive unclothed physical examination The medical screening must include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including reimbursement for developmental screens rendered by providers other than the primary care provider; and, (2) a comprehensive unclothed physical examination including vision and hearing screening, dental inspection, nutritional assessment, height/weight, and BMI assessment.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Vision Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	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 must include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant must mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity must be done. Effective September 1, 2022, vision assessments and eyeglasses are covered when provided in a school setting by a mobile vision provider.
Other Medically Necessary Services,	Same as EPSDT Global Coverage Guidelines	Yes	Yes	EPSDT includes medically necessary health care, diagnostic services, treatment, and measures as needed to correct or ameliorate defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's (under twenty-one (21) years of age) current level of functioning or to prevent the child's medical condition from getting worse. CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf NHeLP - http://www.healthlaw.org/ State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES Medical necessity for Early Intervention services must be defined by the Member's IFSP, approved by a physician, physician's assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Early Intervention Services	20USC § 1471 34 CFR §303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor must provide coverage for Early Intervention services as defined in 12 VAC 30-50-131, 12 VAC 30-50-415, and 12VAC35-225 et. seq., and within the Department's coverage criteria and guidelines. The Department's Early Intervention billing codes, reimbursement methodology, and coverage criteria must be used and are described in the Department's Early Intervention Program Manual, on the Department's website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Medical necessity for Early Intervention services must be defined by the Member's IFSP, including in terms of amount, duration, and scope. Service authorization must not be required. The Contractor must also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate. For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for: 1. Those services federally required to be provided at public expense as is the case for a. assessment/EI evaluation,

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member's IFSP, approved by a physician, physician's assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				b. development or review of the Individual Family Service Plan (IFSP); and, c. targeted case management/service coordination; 2. Developmental services; and, 3. Any covered early intervention services where the family has declined access to their private health/medical insurance. See Section 13.4.4, *Comprehensive Health Coverage*.
Early Intervention Targeted Case Management/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor must provide coverage for EI Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child's Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and ongoing supportive communication with the family. The Service Coordinator can serve in a "blended" role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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<tr><td></td><td></td><td></td><td></td><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td></td><td></td><td></td><td></td><td>T2022</td><td>Service Coordination</td><td>one (1) charge/child/month</td></tr>
<tr><td rowspan="3">Early Intervention Initial Assessments for Service Planning and Development and Annual Review of the Individual Family Services Plan (IFSP)</td><td rowspan="3">12VAC30-50-131
12VAC30-50-415
12 VAC 35-225 120</td><td rowspan="3">Yes</td><td rowspan="3">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention initial and subsequent assessments for service planning in the child's natural environment or in a center based program.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>T1023 (RC 2)
T1023 U1(RC 1)</td><td>Initial assessment, development of initial IFSP, Annual IFSP</td><td>twenty-four (24) units/day and thirty-six (36) units/year</td></tr>
<tr><td>IFSP Team Treatment Activities (more than one (1) professional providing services during same session</td><td>12VAC30-50-131
12 VAC 35-225-120 – 12VAC35-225-160</td><td>Yes</td><td>Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention team treatment activities where more than one (1) professional is providing services during same session for an individual child/family. These services may be provided in the child's natural environments for team treatment activities; or the natural environment or center for IFSP reviews and assessment.</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member's IFSP, approved by a physician, physician's assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
for an individual child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning				**Billing Code** T1024* (RC 2) T1024 U1* (RC 1)	**Description** 1. Team Treatment activities (more than one (1) professional providing services during same session for an individual child/family 2. IFSP Review Meetings (must be in-person) 3. Assessments that are done after the initial Assessment for Service Planning	**Limits** The maximum daily units/per child/ per (service) code/ per individual practitioner is **six (6) units** with a maximum of **eighteen (18) units** per day per child for all agency/providers combined. Applies to all codes in this Section with "*".
Developmental Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention developmental services for an individual child or for more than one (1) child, in a group (congregate) in the child's natural environment.		

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				Billing Code	**Description**	**Limits**
				T1027* (RC 2)	Developmental Services and other early intervention services provided for more than one (1) child, in a group (congregate).	RC 2 only. See above for limits *.
				Billing Code	**Description**	**Limits**
				T1027 U1* (RC 2)	Developmental Services and other early intervention services provided for one (1) child	RC 2 only. See above for limits *.
Center-Based Early Intervention Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention center-based individual and group (congregate) services.		
				Billing Code	**Description**	**Limits**
				T1026* (RC 1)	Center-based group (congregate) early intervention services	See above for limits*.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td>T1026 U1* (RC 1)</td><td>Center-based individual early intervention services</td><td rowspan="3"></td></tr>
<tr><td>T1015*
(RC 2)</td><td>Center-based group (congregate) early intervention services</td></tr>
<tr><td>T1015 U1*
(RC 2)</td><td>Center-based individual early intervention services</td></tr>
<tr><td rowspan="4">Early Intervention Physical Therapy; individual and/or group</td><td rowspan="4">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child's natural environment.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0151*
(RC 1)</td><td>Group (congregate) PT</td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0151 U1*
(RC 1)</td><td>Individual PT</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member's IFSP, approved by a physician, physician's assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

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<tr><td rowspan="4">Early Intervention Occupational Therapy; individual and/or group</td><td rowspan="4">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child's natural environment.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0152*
(RC 1)</td><td>Group (congregate) OT</td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0152 U1*
(RC 1)</td><td>Individual OT</td></tr>
<tr><td rowspan="3">Early Intervention Speech Language Pathology; individual and/or group</td><td rowspan="3">12VAC30-50-131
12 VAC 35-225-120</td><td rowspan="3">Yes</td><td rowspan="3">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child's natural environment.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0153</td><td>Group (congregate) SLP</td><td></td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services must be defined by the Member's IFSP, approved by a physician, physician's assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization must not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

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<tr><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td><td>(RC 1)</td><td></td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0153 U1
(RC 1)</td><td>Individual SLP</td></tr>
<tr><td rowspan="4">Developmental Nursing; individual and/or group</td><td rowspan="4">12VAC30-50-13112
VAC 35-225-120</td><td rowspan="4">Yes</td><td rowspan="4">Yes</td><td colspan="3">The Contractor is required to provide coverage for Early Intervention individual and group (congregate) Nursing Services or Developmental Services provided by a nurse, in the child's natural environment.</td></tr>
<tr><td>Billing Code</td><td>Description</td><td>Limits</td></tr>
<tr><td>G0495*
(RC 1)</td><td>Group (congregate) RN Training and Education Services;</td><td rowspan="2">See above for limits*.</td></tr>
<tr><td>G0495 U1*
(RC 1)</td><td>RN Individual Training and Education Services.</td></tr>
</table>

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor must cover this service. The Contractor must also be responsible for non-nursing facility services and must work with the NF on discharge planning if appropriate. The Contractor must establish strong relationships with NFs to ensure that Members in NFs receive high quality care, maintain good health, and to reduce avoidable hospital admissions among NF residents. Contractors must help facilitate Members returning to community settings when possible and desired by the Member. The Contractor may provide 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 by Members.
Long-stay Hospital State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be found in the Nursing Facility provider manual available on the Department's web portal at: www.virginiamedic	Yes	Yes	The Contractor must provide information and referrals as appropriate to assist Members in accessing services. The Contractor must cover all services associated with the provision of long-stay hospital services. Long-stay Hospital services are a state plan only service which covers individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services. The Contractor must make provisions for the collection and distribution of the individual Member's monthly patient pay for long-stay hospital services. Hospitals recognized as LSH are Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
	aid.dmas.virginia.gov			
Specialized Care State Plan Only Service	12 VAC 30-60-40; 12 VAC 30-60-320 (ADULTS) 12 VAC 30-60-340 (CHILDREN) Additional information can be found in the Nursing Facility provider manual available on the Department's web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor must cover all services associated with the provision of specialized care services for adults and children. Specialized care services are a state plan only service which covers complex trach and ventilator-dependent nursing facility residents at a higher reimbursement rate. The Contractor must make provisions for the collection and distribution of the individual Member's monthly patient pay for specialized care services. Transition services are covered for those individuals seeking services in the community through the Contractor.
Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)	http://www.dbhds.virginia.gov/library/developmental%20services/ods-	Yes	No	The Contractor is not required to cover ICF-IID services. Individuals receiving services in an ICF-ID will be excluded from MLTSS participation.

SUMMARY OF COVERED SERVICES - PART 4A – LONG-TERM SERVICES AND SUPPORTS (LTSS) FACILITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
	voluntaryadmission 2011.pdf http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/training-centers			

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
CCC Plus HCBS Waiver (formerly Elderly or Disabled with Consumer-Directed Services EDCD and	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC	Yes	Yes	The Contractor must provide care coordination, information and referrals as appropriate to assist Members in accessing these services. The Contractor must cover personal care, respite care, adult day health care, personal emergency response systems, skilled private duty nursing, assistive technology, environmental modifications, services facilitation, and transition services. The Contractor must cover both agency-directed and consumer- directed services as a service delivery model for personal care and respite care services. Personal emergency response systems may

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
Technology Assisted Waivers) General Requirements	Plus Program provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library			include medication monitoring as well. Transition services are covered for those individuals seeking services in the community after transition from a qualified institution. The Contractor must make provisions for the collection and distribution of the Member's monthly patient pay for Program services (if appropriate). The Contractor must cover transportation services for the CCC Plus Waiver program Members. Rates for all CCC Plus Waiver services have both a Northern Virginia and Rest of State rate structure with the exceptions of Assistive Technology and Environmental Modifications. Rates are paid based upon the Member FIPS except for Adult Day Health Care. (See additional details below for specifics regarding AT and EM.)
CCC Plus Waiver Personal Care	Same as General Requirements	Yes	Yes	Agency-or consumer-directed personal care services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Personal Care** A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long-Stay Hospital and which includes assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home- and community

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized. Personal care must not be a replacement for private duty nursing services performed by a RN. Service Codes AD = T1019 CD = S5126 Services are billed as hourly.
CCC Plus Waiver Respite Care	Same as General Requirements	Yes	Yes	Respite is for the relief of the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the Member. Agency- or consumer-directed respite care services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. Respite coverage in children's residential facilities. A. Individuals with special needs who are enrolled in the CCC Plus Waiver and who have a diagnosis of developmental disability (DD) will be eligible to receive respite

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				services in children's residential facilities that are licensed for respite services for children with DD. B. These respite services are covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery. **Service Definition - Respite Care** Respite services are unskilled services (agency-directed or consumer-directed) or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual. **Skilled Private Duty Nursing Respite Care (Agency-Directed Only)** Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services. **Congregate Private Duty Nursing Respite Care (Agency-Directed Only)** Congregate respite nursing provided to three (3) or fewer Program individuals who reside in the same primary residence.

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				Service Codes AD = T1005 CD = S5150 PDN RN Respite Services = S9125 TD PDN LPN Respite Services = S9125 TE Congregate Respite RN Nursing Services = T1030 TD Congregate Respite LPN Nursing Services = T1031 TE Services are billed as hourly Respite is limited to four hundred and eighty (480) hours per fiscal year – regardless of the number of providers or whether the individual receives agency and consumer-directed respite services.
CCC Plus Waiver Adult Day Health Care ADHC	Same as General Requirements	Yes	Yes	Adult Day Health Care (ADHC) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Adult Day Health Care** Long-Term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who have been determined eligible for waiver services and who also require the level of care provided in either a nursing facility, specialized care nursing facility, or long-stay hospital. The

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				program must be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). ADHC may be offered either as the sole home- and community-based care service or in conjunction with other CCC Plus Waiver services. ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.
CCC Plus Waiver Personal Emergency Response System (PERS) PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.	Same as General Requirements	Yes	Yes	Personal Emergency Response Systems (PERS) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Personal Emergency Response System (PERS)** Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual's safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two(2)-way voice communication system that dials a twenty-four (24)-hour response or monitoring center upon activation via the individual's home telephone line or other two(2)-way voice communication system. When appropriate, PERS may also include medication monitoring devices.

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				PERS is not a stand-alone service. It must be authorized in conjunction with at least one (1) qualifying CCC Plus Waiver service. Service Codes PERS nursing = H2021 TD (RN) PERS nursing = H2021 TE (LPN) PERS installation = S5160 Person installation + medication monitoring = S5160 U1 PERS monitoring = S5161 PERS medication monitoring = S5185 PERS nursing services are billed in thirty (30) minute increments. PERS installation (w/ or w/out medication monitoring) is billed as per visit.
CCC Plus Waiver Services Facilitation	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/	Yes	Yes	Services Facilitation must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Services Facilitation** During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
	manuals/provider-manuals-library			service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. The SF is responsible for completion of the following tasks related to service facilitation: 1. Service Facilitation Comprehensive Visit: 2. Consumer (Individual) Training: 3. Management Training 4. Routine Onsite Visits 5. Reassessment Visit Service Codes SF Initial Comprehensive Visit = H2000 (billed as visit). SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit). SF Routine Visit = 99509 (billed as visit). SF Reassessment Visit = T1028 (billed as a visit).
CCC Plus Waiver Transition Services	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver	Yes	Yes	Transition Services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Transition Services**

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
	provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library			Services that are "set-up" expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. Transition services do not apply to an acute care admission to a hospital. Transition Services Code T2038 (limited with a total cost regardless of the number of items to $5,000 per lifetime
CCC Plus Waiver Assistive Technology and Assistive Technology Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/	Yes	Yes	Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT must not be authorized as a standalone service. Assistive technology devices, as defined in 12VAC30-120-924, must be portable and must be authorized per fiscal year. AT = T1999 (limited to per item with a set limit of $5,000.00 per fiscal year) AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per fiscal year)

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
	manuals/provider-manuals-library			AT and AT maintenance combined costs cannot exceed the $5,000.00 limit. Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461
CCC Plus Waiver Environmental Modifications and Environmental Modification Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library	Yes	Yes	Service Definition – Environmental Modifications (EMs) Physical adaptations to an individual's primary residence or primary vehicle which are necessary to ensure the individual's health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization. EM = S5165 (limited to per item with a set limit of $5,000.00 per fiscal year) EM Maintenance = 99199 U4 (limited to per item with a set limit of $5,000.00 per fiscal year) EM must be provided in conjunction with at least one (1) other qualifying CCC Plus Waiver service. EM and EM maintenance combined costs cannot exceed the $5,000.00 limit Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
CCC Plus Waiver Skilled Private Duty Nursing	Same as General Requirements	Yes	Yes	Private Duty Nursing (PDN) services must be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services must be provided within at least equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. **Service Definition – Skilled Private Duty Nursing (Skilled PDN)** In-home nursing services provided for individuals enrolled in the CCC Plus Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. **Service Definition – Congregate Skilled PDN** Skilled in-home nursing provided to three (3) or fewer CCC Plus Waiver individuals who reside in the same primary residence. Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances where individuals attend school or must be out of the home for part of the authorized PDN hours. Congregate skilled PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form. Coverage Limits – Up to sixteen (16) hours a day; one hundred and twelve (112) hours per week Service Codes

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				PDN RN Nursing Services = T1002 (billed hourly) PDN LPN Nursing Services = T1003 (billed hourly) Congregate RN Nursing Services = T1000 U1 (billed hourly). Congregate LPN Nursing Services = T1001 U1 (billed hourly).
Hospice Services	12 VAC 30-50-270 and 12 VAC 30-60-130 Additional information can be found in the Hospice provider manual available on the Department's web portal at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library	Yes	Yes*	*Individuals receiving Hospice at time of enrollment will be excluded from Managed Care participation and will not be auto-enrolled. Managed care enrolled Members who elect hospice will remain enrolled in Managed Care. A Member may be in a waiver and also be receiving hospice services. The Contractor must provide information and referrals as appropriate to assist Members in accessing services. The Contractor must cover all services associated with the provision of hospice services. The Contractor must ensure that children under twenty-one (21) years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. Non-institutional Hospice Services must be paid by the Contractor based on the member FIPS. The Department's hospice revenue codes and rates for non-institutional claims are available at: http://www.dmas.virginia.gov/#/ratesetting. Categories of Care: 0651- Routine Home Care: In-home care that is not continuous (less than eight (8) hours per day). (One (1) unit = one (1) day) Note: As of January 1, 2016 a higher base payment for the first sixty (60) days of hospice care and a reduced base payment rate for days sixty-one (61) and thereafter.

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				0652 - Continuous Home Care: In-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight (8) hours of care per day must be provided to qualify as continuous home care. (one (1) unit = one (1) hour) 0655 - Inpatient Respite Care: Short-term inpatient care provided in an approved facility (free-standing hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five (5) consecutive days of respite care will be allowed (one (1) unit = one (1) day). Payment for the sixth (6^{th}) day and any subsequent days of respite care is made at the routine home care rate. 0656 - General Inpatient Care: May be provided in an approved free-standing hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one (1) unit = one (1) day) 0658 - Nursing Facility: Beginning July 1, 2019, for Members who reside in a nursing facility and are enrolled in a Medicaid approved hospice program, the Contractor must pay the nursing facilities their share of payment directly rather than paying the hospice provider. Payments made to the nursing facility must be the full amount that would be paid to the nursing facility if the Member was not receiving hospice services. 0551 - Skilled Nursing Visit – Used when submitting charges representative of a visit by a Registered Nurse within the Member's last seven (7) days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one (1) unit = fifteen (15) minutes, max sixteen (16) per day). Note: a corresponding 0651 - Routine Home Care

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				charge for the same date of service must also be submitted for consideration of SIA payment. 0561 - Medical Social Service Visit – Used to be used when submitting charges representative of a visit by a Clinical Social Worker within the Member's last seven (7) days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one (1) unit = fifteen (15) minutes, max sixteen (16) per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_atchs/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	Individuals in PACE will be excluded from managed care program participation. Individuals in managed care have the right to transition from the managed care program to PACE, including outside of their annual open enrollment. The Contractor must ensure that Members are aware of PACE. PACE provides qualifying Members a fully integrated community alternative to nursing home care, and provides care/services covered by Medicare/Medicaid, and may include enhanced services not covered by Medicare/Medicaid. PACE coverage includes prescription medications, doctor care, transportation, home care, hospital visits, adult day services, respite care, restorative therapies, and nursing home stays, when necessary. In order to qualify for PACE, an individual must be fifty-five (55)+ years of age, live within a PACE service area, and be able to reside safely within the community at the time of enrollment. When a Member requests additional information about PACE, the contractor must assist the Member with obtaining information and related referrals. This includes checking to see if there is a PACE site in the Member's service area. This information is available via the Department's website:

SUMMARY OF COVERED SERVICES - PART 4B – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities and Service Codes as Applicable**
				http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx (based upon the member's zip code). The Contractor must refer Members interested in enrolling in PACE to their Local Department of Social Services (LDSS) to request a Medicaid LTSS Screening. Meeting the functional criteria for nursing home level of care is a requirement for PACE enrollment and screening must be coordinated through the Member's LDSS.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES				
Waiver Services for Individuals in the 3 Developmental Disabilities (DD) Waivers The Contractor is not required to cover DD Waiver Services **(including when covered under EPSDT)**, DD targeted case management (T1017 & T2023), or transportation to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Coverage Details**
Building Independence Waiver formerly Day Support (DS) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Day Support Waiver** will become the **Building Independence Waiver** which will include supports for adults eighteen (18+) who live independently in their own homes. Services may be complemented by non-waiver funded rent subsidies and/or other types of support.
Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Individual and Family Developmental Disabilities Support (DD) Waiver** will become the **Family and Individual Supports Waiver** which will include supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.
Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Intellectual Disability (ID) Waiver** will become the **Community Living Waiver**, which will include residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs.
A description of all waiver services and a comparison of the services covered under each DD Waiver is available below				

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES See full list of services available here: https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/view
Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)
Shared Living = T1020 (billed as either full month or partial month) This is a new service and is available under all three (3) DD waivers.

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES See full list of services available here: https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/view
Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)
An individual would live in an apartment, condominium, townhome, or other home in the community with a roommate of the Member's choice. The roommate acts as the individual's live-in companion. Individuals must be eighteen (18) years old or older and must be directly responsible for the residence (i.e., the individual must either rent or own it). Individuals will be responsible for all expense associated with their housing, utilities and food as well as those for the live-in companion. Those expenses incurred by the individual and determined to be usual, reasonable and within the location's maximum reimbursement amount will be reimbursed by Medicaid consistent with the service authorization. These expenses may be covered when the live-in companion provides companionship supports, including fellowship and enhanced feelings of security, and may include limited Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) supports as long as these account for no more than twenty percent (20%) of the anticipated companionship time on a weekly basis. The individual is responsible for his own living expenses. Designated Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive payment for administering this service. After retention of an allowable amount for administrative expenses, the provider will distribute payments to the individual to reimburse for expenses incurred per the service authorization. Tiers do not apply to this service. Size does not apply to this service.
Community Engagement = T2021 (billed as hourly) This service applies to all three (3) of the DD the waiver(s): This is a new service that provides the individual with a wide variety of opportunities to build relationships and natural support systems, while utilizing the community as a learning environment. It supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). These services are provided to the individual at no more than a 1:3 staff to individual ratio. Tiers 1-4 do apply to this service. Size does not apply to this service.
Community Coaching = 97127 (billed as hourly) This service applies to all three (3) of the DD waivers

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES See full list of services available here: https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfclIEB1uUHAR_/view
Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)
This is a new service designed to engage the individual in the community and to help the individual be supported to minimize a barrier from participating in activities of community engagement. This is a one-on-one service that occurs in a community setting. Tiers do not apply to this service. Size does not apply to this service.
Group Day Services = 97150 (billed as hourly) This service applies to all three (3) of the DD waivers This includes skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, enhancement of social networks and assurance of an individual's health and safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services are delivered in a group setting of no more than 1:7 staff to individual ratio. Tiers 1-4 do apply to this service and are stand-alone tiers. Size does not apply to this service.
Individual Supported Employment = H2023 (billed as hourly) This service applies to all three (3) of the DD waivers: This is a service that is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment. Tiers do not apply to this service. Size does not apply to this service.
Group Supported Employment = H2024 (billed as hourly using the modifier related to the size.) This service applies to all three (3) of the DD waivers This is a service that provides continuous staff support in a naturally occurring place of employment to groups of two (2) to eight (8) individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing

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Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

small groups of workers with disabilities in the community. Group Supported Employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. These supports enable an individual to obtain and maintain a job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

1. 2 or Fewer Individuals/Staff = Size 1 = UA
2. 2+ TO 4 Individuals/Staff = Size 2 = U2
3. 4+ Individuals/Staff = Size 3 = U3

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Electronic-Based Home Supports = A9279 (limited to $5,000.00 per year)

This service applies to all three (3) of the DD waiver

This is a new service designed to give individuals support to gain more independence and freedom at home by using electronic equipment. Electronic devices can be purchased and installed in the individual's home to help monitor and support greater autonomy. To qualify for reimbursement, purchases must substitute for other Medicaid services, promote integration into the community and increase the individual's safety in the home. Providers that bill and receive payment for this service are responsible for providing emergency assistance twenty-four (24) hours a day and three hundred and sixty-five (365) or three hundred and sixty-six (366) days a year as well as furnishing, installing, maintaining, testing and providing user training of the services. Members receiving per diem residential services will not qualify to receive this service.

Tiers do not apply to this service.
Size does not apply to this service.

Assistive Technology (AT) = T1999 (limited to per item with a set limit of $5,000.00 per year)
AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per year)

This service applies to all 3 of the DD waivers.

AT and AT maintenance costs cannot exceed the $5,000.00 limit.
This means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the

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State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment. Tiers do not apply to this service. Size does not apply to this service.
Environmental Modifications (EM) = S5165 limited to per item with a set limit of $5,000.00 per year) EM Maintenance = 99199 U4 (limited to per item with a set limit of $5,000.00 per year) This service applies to all three (3) of the DD waiver. EM and EM maintenance costs cannot exceed the $5,000.00 limit. This means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. Tiers do not apply to this service. Size does not apply to this service.
Personal Emergency Response System (PERS) This service applies to all three (3) of the DD waivers. PERS NURSING = H2021 TD (RN) PERS NURSING = H2021 TE (LPN) PERS INSTALLATION = S5160 PERSON INSTALLATION + MEDICATION MONITORING = S5160 U1 PERS MONITORING = S5161 PERS MEDICATION MONITORING = S5185 PERS nursing services are billed in thirty (30) minute increments.

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Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)
PERS installation (w/ or w/out medication monitoring) is billed as per visit. PERS monitoring (w/ or w/out medication monitoring) is billed as monthly. Personal emergency response systems (PERS): an electronic device and monitoring service that enables certain individuals at high-risk of institutionalization to secure help in an emergency. PERS services must be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.
Transition Services = T2038 (limited to per item with a total cost regardless of the number of items is a set limit of $5,000.00) This service applies to all three (3) of the DD waivers. This means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Tiers do not apply to this service. Size does not apply to this service.
Peer Mentoring = H0038 This service applies to all three (3) of the DD waivers. Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual receiving CL, FIS, or BI waiver supports. This service is delivered by individuals with developmental disabilities who are or have received services, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience. Peer mentors share their successful strategies and experiences in navigating a broad range of community resources with waiver participants. Waiver participants become better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life. Peer mentoring is intended to assist with empowering the individual receiving the service. This service is provided based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be a short-term, periodically intermittent, intense service associated with a specific outcome. Peer Mentor Supports may be authorized for up to six (6) consecutive months, and the cumulative total across that timeframe may be no more than sixty (60) hours in a plan year. For allowable activities, refer to Medicaid Memo located at https://vamedicaid.dmas.virginia.gov/memo/three-new-services-added-developmental-disabilities-dd-waivers
Community Guide = H2015

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This service applies to all three (3)of the DD waivers. Community Guide Services include direct assistance to promote individuals' self-determination through brokering community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation. Includes the following components: General Community Guide services: Utilizes an individual's existing assessment information regarding the individual's general interests in order to determine specific activities and venues that are available in the community (e.g., clubs, special interest groups, physical activities/sports teams, etc.) to promote inclusion and independent participation in community life. Community Housing Guide services: Supports an individual's move to independent housing by helping with transition and tenancy sustaining activities. The community housing guide collaborates with the support coordinator, regional housing specialist, and others to enable the individual to achieve and sustain integrated, independent living.
Benefits Planning = T1023 (billed as hourly) This service applies to all 3 of the DD waivers. Benefits planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. This service includes education and analysis about current benefits status and implementation and management of state and federal work incentives as appropriate. For allowable activities, refer to Medicaid Memo issued on 9/4/2018 located at https://vamedicaid.dmas.virginia.gov/memo/three-new-services-added-developmental-disabilities-dd-waivers
Employment & Community Transportation = A0080, A0090, A0110, A0120This service applies to all 3 of the DD waivers. This service is offered in order to enable individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his/her community. Use of this services must be related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them.

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Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Crisis Support Services = T2034 (billed as hourly)

This service applies to all 3 of the DD waivers.

Includes the following components:

Crisis Prevention: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis prevention may be authorized for up to sixty (60) days per ISP year.

Crisis Intervention: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis intervention may be authorized in increments of no more than fifteen (15) days at a time for up to ninety (90) days per ISP year.

Crisis Stabilization: unit of service = one (1) hour and billing may occur up to twenty-four (24) hours per day if necessary. Medically necessary crisis stabilization may be authorized in increments of no more than fifteen (15) days at a time for up to sixty (60) days per ISP year.

Services may be authorized for an individual who has a history of at least one (1) of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) previous residential/day placement or placements were terminated; or (iv) behaviors that have significantly jeopardized placement.

Services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

Tiers do not apply to this service.
Size does not apply to this service.

Center-Based Crisis Supports = H2019 UA and H2019 U1 (billed as hourly)

This service applies to the following waiver(s):

1. Building Independence Waiver formerly Day Support (DS) Waiver
2. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
3. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

The service includes crisis prevention and stabilization services in a residential setting (a crisis therapeutic home) using plan and emergency admissions. Services are approved for those individuals who will need ongoing crisis supports for long-term. Services may be authorized for individuals who are at-risk of at least one (1) of the following: 1) psychiatric hospitalization; 2) emergency ICF/IID placement; 3) immediate threat of loss of community service due to severe situational reaction; or 4) causing harm to himself or others.

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Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Tiers do not apply to this service.
Size does not apply to this service.

Community-Based Crisis Supports = S9484 U1 (billed as hourly for up to six (6) months per year in thirty (30) day increments)

This service applies to the following waiver(s):

1. Building Independence Waiver formerly Day Support (DS) Waiver
2. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
3. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

In order to be approved to receive this service, the individual must:

1. have a history of at least one (1) of the following:
    a. previous psychiatric hospitalization or hospitalizations;
    b. previous incarceration;
    c. lost previous residential/day placement or placements; or
    d. behavior or behaviors have jeopardized his/her community placement.
2. meet at least one (1) of the following:
    a. is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
    b. is experiencing an increase in extreme emotional distress;
    c. needs continuous intervention to maintain stability; or
    d. is actually causing harm to himself or others.
3. also:
    a. be at-risk of psychiatric hospitalization;
    b. be at-risk of emergency ICF/IID placement;
    c. be at immediate threat of loss of community service due to a severe situational reaction; or
    d. is actually causing harm to himself or others.

The service provides ongoing supports to individuals in their homes and community settings or both.

Tiers do not apply to this service.
Size does not apply to this service.

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Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Supported Living Residential (formerly part of Congregate Residential Supports) = H0043 (billed as per diem with a maximum of three hundred and forty-four (344) days/year)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This service provides access to twenty-four (24) hour supports in an apartment setting operated by a DBHDS licensed provider. Services are provided to the individual in the form of 'round the clock availability of paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one (1) individual living in the apartment, depending on the required support. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. The unit of service billed will be "daily" when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

In-Home Supports (formerly In-home Residential Supports) = H2014 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is a supplemental service that take place in an individual's home, family's home or community setting. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Usually, In-home supports involve one (1) staff person to one (1) individual, but now may include 1:2 or 1:3 as appropriate. The latter is a change from previous allowances. The unit of service billed remains "hourly."

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

1. 2 or Fewer Individuals/Staff = Size 1 = UA
2. 2+ TO 4 Individuals/Staff =Size 2 = U2
3. 4+ Individuals/Staff = Size 3 = U3

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Skilled Nursing:
RN = S9123 (TD)
LPN = S9124 (TE)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Services are billed as 15 minute increments.

This is an existing service that will not change as part of the waiver redesign; however, individuals receiving this service may be assessed to determine whether private duty nursing is now the appropriate service.

Skilled nursing services: means both skilled and hands-on care, as rendered by either licensed RN or LPN, of either a supportive or health-related nature nursing services ordered by a physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver.

Tiers do not apply to this service.
Size does not apply to this service.

Private Duty Nursing:
RN = T1002 (TD)
LPN = T1003 (TE)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Services are billed as fifteen (15) minute increments.

This is a new service that is designed to provide individual and continuous medically necessary care as certified by a physician, physician assistant or nurse practitioner to individuals with a serious medical condition and/or complex health care need. It allows individuals to remain at home to receive care instead of in a nursing facility, hospital or ICF-IID. This service is provided to an individual at his place of residence or other community setting.

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Tiers do not apply to this service.
Size does not apply to this service.

Therapeutic Consultation - Therapists/Behavior Analysts/Rehab Engineer = 97139 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.
Size does not apply to this service.

Therapeutic Consultation - Psychologist/Psychiatrist = H2017* (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.
Size does not apply to this service.

In the absence of a service authorization, billing is likely for Therapeutic Consultation (billed with procedure type I or M) and is excluded. Not an excluded MHS service for Members in one (1) of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation H2017. Refer to Coverage Chart Part 2B.

Therapeutic Consultation - Other Professionals = 97530 (billed as hourly)

This service applies to the following waiver(s):

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1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three (3) distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.
Size does not apply to this service.

Personal Assistance
AD = T1019 (billed as hourly)
CD = S5126 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Personal assistance: means assistance with ADL's, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.
Size does not apply to this service.

Respite Services
AD = T1005 (billed as hourly)
CD = S5150 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Respite: means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. These services may be agency-directed or consumer-directed.

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Tiers do not apply to this service.
Size does not apply to this service.

Workplace Assistance Services = H2025 (billed as hourly). Cannot exceed forty (40) hours/week. Cannot exceed sixty-six (66) hours/week alone or in combination with 97150, T2021, H2023, H2024, 97127, and/or H2025.

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Workplace Assistance Services: supports provided to someone who has completed job development and completed or nearly completed and job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment. Workplace Assistance services are supplementary to the services rendered by the job coach services; the job coach still provides professional oversight and job coaching intervention. The provider provides onsite habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

In order for an activity to qualify under Workplace Assistance services it must include all three (3) of the following:

1. The activity must not be work skill training related which would normally be provided by a job coach
2. Services are delivered in their natural setting (where and when they are needed)
2. Services must facilitate the maintenance of and inclusion in an employment situation
3. The ratio is 1:1

Allowable activities include:

1. Skill building and supports around non-work skills necessary for the individual to maintain employment
2. Skill building and supports in the home, community, or workplace of employment maintenance related skills
3. Support to make and strengthen community connections
4. Safety supports to ensure the individual's health and safety.

Tiers do not apply to this service.
Size does not apply to this service.

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Individual & Family Caregiver Training = S5111 (billed as hourly). Limited to eighty (80) hours per ISP year.

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Individual & Family Caregiver Training: service that provides training and counseling services to individuals, families, or caregivers of individuals receiving waiver services. All individual and family/caregiver training must be included in the individual's written person-centered plan. "Family" does not include people who are employed to care for the individual.

Allowable activities:

1. Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support.
2. Participation in educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self-determination / self-advocacy abilities.
3. Travel expenses and room and board expenses are not covered.

Tiers do not apply to this service.
Size does not apply to this service.

Companion Services:
AD Companion = S5135 (billed as hourly)
CD Companion = S5136 (billed as hourly)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Companion: means non-medical care, or support and socialization provided to an adult (ages eighteen (18) years and over). The provision of companion services does not entail (routine) hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature. Companions may assist or support the individual (enrolled in the waiver) with such tasks as meal preparation, community access and activities, laundry, and shopping but companions do not perform these activities as discrete services. Companions may also perform light housekeeping, tasks (such as bed-making, dusting, and vacuuming, laundry, grocery shopping, etc.) which such services are specified in the individual's Plan for Supports and

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

essential to the individual's health and welfare in the context of providing non-medical care, socialization or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.
Size does not apply to this service.

Services Facilitation (SF)

This service applies to the following waiver(s):

1. Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
2. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

SF Initial Comprehensive Visit = H2000 (billed as visit).
SF Consumer Training Visit = S5109 (billed as visit).
SF Management Training Visit = S5116 (billed as visit).
SF Routine Visit = 99509 (billed as visit).
SF Reassessment Visit = T1028 (billed as a visit).
Service Definition – Services Facilitation

During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan.

The SF is responsible for completion of the following tasks related to service facilitation:

1. Service Facilitation Comprehensive Visit:
2. Consumer (Individual) Training:
3. Routine Onsite Visits
4. Reassessment Visit
5. Management Training

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Tiers do not apply to this service.
Size does not apply to this service.

Group Home Residential (formerly part of Congregate Residential Supports) = H2022 (billed as per diem with a maximum of three hundred and forty-four (344) days/year)

This service applies to the following waiver(s):

1. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Provides services in a home in which an individual lives with other individuals with developmental disabilities receiving supports from paid staff. These supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Providers must be licensed by DBHDS and follow state and federal guidelines to participate in the service. The unit of service billed will be “daily” when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size applies to this service. Size is defined as:

1. Four (4) or Fewer Individuals/Staff = Size one (1) = UA
2. Five (5) individuals/staff = Size two (2) = U2
3. Six (6) individuals/staff = Size three (3) = U3
4. Seven (7) individuals/staff = Size four (4) = U4
5. Eight (8) individuals/staff = Size five (5) = U5
6. Nine (9) individuals/staff = Size six (6) = U6
7. Ten (10) individuals/staff = Size seven (7) = U7
8. Eleven (11) individuals/staff = Size eight (8) = U8
9. Twelve (12) individuals/staff = Size nine (9) = U9

Sponsored Residential (formerly part of Congregate Residential Supports) = T2033 (billed as per diem)

This service applies to the following waiver(s):

1. Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

SUMMARY OF COVERED SERVICES - PART 4C – LONG-TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY-BASED DD SERVICES
See full list of services available here: https://drive.google.com/file/d/1LrbJAArPyynLT40Wq8hfcllEB1uUHAR_/view

Services Available Under the DD Waivers (Carved out of this Contract and covered through fee-for-service.)

Effective January 1, 2017:

Provides individuals the ability to live with a family or single "sponsor" in the community. No more than two (2) individuals can live in the sponsor's home. The supports provided by the sponsor may include skill building, supports with ADLs and IADLs, community access and recreation/social supports, as well as general supports. Sponsors are generally not related to the individual unless all other alternatives were investigated and found not to be appropriate for the individual. Sponsors are affiliated with a DBHDS licensed agency.

Tiers 1-4 do apply to this service and are stand-alone tiers.
Size does not apply to this service.

Independent Living = T2032 (full month)
T2032 U1 (partial month)

This service applies to the following waiver(s):

1. Building Independence Waiver formerly Day Support (DS) Waiver

This is a new service provided to adults (eighteen (18) and older) that offers skill building and supports necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with a roommate in their own homes or apartments. The roommate may be paid (see Shared Living above) or unpaid. The unit of service billed is "monthly" or "partial month."
Monthly services = no modifier
Partial Month services = U1 modifier

Tiers do apply to this services
There are only two (2) Tiers for this service.
Tier 1 (stand-alone)
Tiers 2-4 (combined together)
Size does not apply to this service.

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
Annual Adult Wellness Exams	CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg–13	No	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: 1. 99385 (New patient, eighteen to thirty-nine (18-39 years)); one (1) per calendar year 2. 99386 (New patient, forty to sixty-four (40-64 years)); one (1) per calendar year 3. 99387 (New patient, sixty-five years and older (65+)); one (1) per calendar year 4. 99395 (Established patient, eighteen to thirty-nine (18-39 years)); one (1) per calendar year 5. 99396 (Established patient, forty to sixty-four (40-64 years)); one (1) per calendar year 6. 99397 (Established patient, forty to sixty-five (> 65 years)); one (1) per calendar year *CPT Code descriptions above subject to change
Individual and Group Smoking Cessation Counseling	https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf 42 U.S.C. § 300gg–13	Limited	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: 2. 99406 (Individual counseling visit, three through ten (3-10) minutes); six (6) units per calendar year; no preauthorization) 3. 99407 (Individual counseling visit, > ten (10) minutes); six (6) units per calendar year; no preauthorization

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
				S9446 (Group patient education, not otherwise classified, non-physician provider); six (6) units per calendar year; no preauthorization *CPT Code descriptions above subject to change
Nutritional Counseling for Individuals With Obesity or Chronic Disease	CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg–13	Limited	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: 1. 97802 (Medical Nutrition Therapy, Initial Assessment and Intervention, Indiv., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no prior authorization 2. 97803 (Medical Nutrition Therapy Reassessment and Intervention, Indiv., Face-to-Face with the patient, each fifteen (15) minutes; twelve (12) units per calendar year; no preauthorization 3. 97804 (Medical Nutrition Therapy, Group (two (2) or more individual(s), each thirty (30) minutes; four (4) units per calendar year; no preauthorization 4. G0270 (Medical Nutrition Therapy; Reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each fifteen (15) minutes; eight (8) units per calendar year; no prior authorization 5. G0271 (Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (two (2) or more

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
				individuals), each thirty (30) minutes; four (4) units per calendar year; no prior authorization 6. S9470 (Nutritional Counseling, Dietician visit, eight (8) units per calendar year; no preauthorization *CPT Code Descriptions above subject to change
ACIP Recommended Adult Vaccines	2023 Appropriations Act, Chapter 1, Item 304. EEEE. CMS Bulletin 1/28/16 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf CDC Adult Immunization Schedule https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html	Yes	Yes	Coverage in accordance with Centers for Disease Control and Prevention. Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

SUMMARY OF COVERED SERVICES – PART 5 – ADULT PREVENTIVE SERVICES FOR MEDICAID ADULTS				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid Covered?**	**MCO Covers?**	**Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable**
	42 U.S.C. § 300gg–13			

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
FAMIS COVERED MEDICAL SERVICES			
Abortion	$0	$0	The Department will be responsible for payment of abortion services under the fee for service program in accordance with FAMIS State Plan and Federal SCHIP requirements. Coverage for induced abortions is only available in limited circumstances where a physician has found and certified in writing, that, on the basis of his professional judgement, the abortion is necessary to save the life of the mother (her life is substantially endangered). The Contractor is prohibited from covering services for induced abortion. The Contractor must 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.
Case Management Services	N/A	N/A	The Contractor shall cover an alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.
Chiropractic Services	$0	$0	The Contractor shall provide up to $500 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.
Clinic Services Well-Child Visits Preventive Care Behavioral Health Maternity Services	$0 $0	$0 $0	The Contractor shall cover clinic services that 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. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician or a dentist. Renal dialysis clinic visits are also covered.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Dental Services (Covered through DBA; limited coverage provided by Contractor)	For services covered by the Contractor, $0 per visit Outpatient/ Emergency; $0 per admission Inpatient	For services covered by the Contractor, $0 per visit Outpatient/ Emergency; $0 per admission Inpatient	Pediatric dental services for FAMIS Children are covered through the Smiles for Children Program through the Department's Dental Benefit Administrator (DBA). No copayment is due for dental services through the DBA. For more information regarding SFC benefits, call 1-888-912-3456. The Contractor shall cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care.
Durable Medical Equipment	$0 per item for equipment	$0 per item for equipment	The Contractor shall cover medically necessary durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). The Contractor is responsible for payment of any specially manufactured DME equipment that was authorized by the Contractor. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition.
Early Intervention Services	$0	$0	The Contractor is 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 health plan 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 Department's 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. Cost sharing provisions shall not apply to EI services received by FAMIS members enrolled in EI.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Family Planning Services	$0	$0	The Contractor shall cover family planning services, which are defined as those services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. Family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage, or make direct referrals for abortions. FAMIS covered services include drugs and devices provided under the supervision of a physician. In accordance with 42 CFR §§438.10, 438.210, and 441.20, the Contractor is prohibited from restricting a Member's choice of provider (network or out-of-network) or method for family planning services or supplies. The Contractor cannot require an enrollee to obtain a referral before choosing a family planning provider. Code of Virginia § 54.1-2969 (D), 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.
Gender Dysphoria Treatment Services	0	0	In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, Item 313 (ZZZZZ), the Contractor must cover all Gender Dysphoria treatment services as outlined in the Department's coverage manuals and guidelines, including pharmacological, behavioral health, medical (hormonal), surgical, and procedural & therapeutic services. The Contractor is prohibited from imposing additional authorization criteria to access Gender Dysphoria treatment services and from imposing additional authorization criteria to access Gender Dysphoria treatment services.
Hearing Aids	$0	$0	The Contractor shall cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five (5) years.
Home Health Services	$0 per visit	$0 per visit	The Contractor shall cover home health services, including medically necessary nursing and personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to ninety (90) visits per calendar year. Personal care means assistance with walking, taking a bath, dressing; giving medicine; teaching self-help skills; and performing a few essential housekeeping tasks.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
			The Contractor is not required to cover the following home health services: medical social services, services that would not be paid for by FAMIS 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).
Hospice Services	$0	$0	The Contractor shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a provider licensed to do so; furnished and billed by a licensed hospice; and medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six (6) months or fewer. Hospice care is available concurrently with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.
Hospital Services (Inpatient)	$0 per confinement	$0 per confinement	The Contractor shall cover inpatient stays in general acute care hospitals up to three hundred and sixty-five (365) days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy (includes medically necessary ancillary services).
Hospital Services (Outpatient)	$0 per visit (waived if admitted)	$0 per visit (waived if admitted)	The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. 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. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Immunizations	$0	$0	The Contractor shall cover immunizations. The Contractor shall ensure that providers render immunizations in accordance with the most current Advisory Committee on Immunization Practices (ACIP) standards. The Contractor shall work with the Department to achieve its goals related to increased immunization rates. The Contractor is responsible for educating providers, parents and guardians of members about immunization services, and coordinating information regarding member immunizations. **FAMIS Children do not qualify for the free Virginia Vaccines for Children (VVFC) program.**
Laboratory and X-Ray Services	$0, or covered as part of the visit or hospital admission	$0, or covered as part of the visit or hospital admission	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 in appropriate settings, including physician office, hospital, independent and clinical reference labs. No copay shall be charged for laboratory or x-ray services that are performed as part of an encounter with a physician.
Lead Testing	$0	$0	The Contractor shall cover blood lead testing as part of well-baby and well-child care.
Medical Transportation	$0	$0	Professional ambulance services when medically necessary are covered when used locally to or from a covered facility or provider office. Ambulance services may be covered when prearranged by the Primary Care Physician and authorized by the Contractor if, because of the member's medical condition, the member cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the member's condition suddenly becomes worse and s/he must go to a local hospital's emergency room, or for transportation between local hospitals when medically necessary. For coverage of ambulance services, the trip to the facility or office must be to the nearest one (1) recognized by the Contractor as having services adequate to treat the member's condition; the services received in that facility or provider's office must be covered services; and if the Contractor or the Department requests it, the attending provider must explain why the member could not have been transported in a private car or by any other less expensive means.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Organ Transplantation Services	$0 per confinement and $0 per outpatient visit	$0 per confinement and $0 per outpatient visit	The Contractor shall cover organ transplantation services as medically necessary and per industry treatment standards for all eligible individuals, including but not limited to transplants of tissues, autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children with conditions including but not limited to lymphoma, myeloma, or a diagnosis of Aplastic Anemia, Heritable Bone Marrow Syndrome, Paroxysmal Nocturnal Hemoglobinuria, Beta Thalassemia major, or Sickle Cell Disease when a member meets medical necessity criteria. The Contractor shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, pancreas, and single lung transplants. The Contractor shall cover reasonable and necessary procurement/donor related services. Services to identify donor limited to $25,000 per member. In accordance with Section 1903(i) of the Social Security Act, the Contractor must provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees. 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.
Pap Smears	$0	$0	The Contractor shall cover annual pap smears and other preventive services for reproductive health.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	$0 per visit	$0 per visit	The Contractor shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, speech therapy, occupational therapy, inhalation therapy, and intravenous therapy.
Pregnancy-Related Services	$0	$0	The Contractor shall cover prenatal services for pregnant FAMIS Children. There is no copay for pregnancy-related services.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Prescription Drugs Retail up to 34-day supply Retail 35-to-90-day supply Mail service up to 90-day supply	$0 per prescription $0 per prescription $0 per prescription	$0 per prescription $0 per prescription $0 per prescription	The Contractor shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions. If a generic is available, member pays one hundred percent (100%) of the difference between the allowable charge of the generic drug and the brand name drug, except in cases where the prescribing provider requires the brand name drug. Note that there is no cost sharing for oral contraceptives or other birth control prescriptions (see "Family Planning Services" above).
Private Duty Nursing (PDN) Services	$0 per visit	$0 per visit	The Contractor shall cover medically necessary private duty nursing services for FAMIS Children only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Private duty nursing services must be authorized. The nurse may not be a relative or member of the member's family; the member's provider must explain why the services are required; and the member's provider must describe the medically skilled service provided.
Prosthetics/ Orthotics	$0 per item	$0 per item	The Contractor shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all members. At a minimum, the Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for members when recommended as part of an approved intensive rehabilitation program.
Screening, Diagnostic, and Preventive Services	$0	$0	The Contractor shall cover preventive services and all routine well baby and well-child care recommended by the American Academy of Pediatrics Advisory Committee and according to AAP's recommended periodicity schedule, including routine office visits with screenings; health assessments; physical exams; routine lab work; and age-appropriate immunizations. Well-child visits are covered at birth and at specified months and years of age, according to the American Academy of Pediatrics recommended periodicity schedule.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
(Well-Baby and Well-child Care)			Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.
Second Opinions	$0 per visit	$0 per visit	The Contractor shall provide coverage for second opinions 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 second opinions from a qualified health care professional within the network, or arrange for the member to obtain one (1) outside the network, at no cost to the member. The Contractor may require an authorization for the member to receive specialty care from an appropriate provider; however, the Contractor cannot deny a second opinion request as a non-covered service.
Skilled Nursing Facility Care	$0 per confinement	$0 per confinement	The Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to one hundred and eighty (180) days per confinement.
Telemedicine Services	$0 per visit	$0 per visit	The Contractor shall provide coverage for medically necessary telemedicine services. Telemedicine is defined as the real time or near real time two (2)-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.
Therapy Services	$0 per confinement if inpatient $0 per visit outpatient	$0 per confinement if inpatient $0 per visit outpatient	The Contractor shall cover the costs of renal dialysis, chemotherapy and radiation therapy, and intravenous and inhalation therapy.
Vision Services Routine eye exam	$0 Member Payment	$0 Member Payment	The Contractor shall cover vision services that 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 shall be allowed at least once every two (2) years.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Eyeglass frames (one (1) pair) Eyeglass lenses (one (1) pair) Single vision Bifocal Trifocal Contacts	$0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan	$0Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan $0 Reimbursed by Plan	The Contractor shall cover eyeglasses (one (1) pair of frames and one (1) pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist. Effective September 1, 2022 vision assessments and eyeglasses are covered when provided in a school setting by a mobile vision provider.
FAMIS COVERED BEHAVIORAL HEALTH SERVICES			
Inpatient Mental Health Services	$0	$0	Medically necessary hospitalization and inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members. Inpatient mental health services are

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
			covered for three hundred and sixty-five (365) days per confinement. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission. FAMIS Children's benefits do not include services furnished by IMDs, services furnished in free-standing psychiatric hospitals or state psychiatric hospitals. Psychiatric residential treatment facility (PRTF) services are not a covered service under FAMIS. The Contractor may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit. See MHS covered services, including Residential Crisis Stabilization Unit, below.
Inpatient Substance Use Disorder Treatment Services*	$0	$0	Medically necessary inpatient substance use disorder treatment services are covered for three hundred and sixty-five (365) days per confinement. This coverage for FAMIS children does not include services furnished in a state-operated mental hospital, or in an IMD, residential services, or other twenty-four (24)-hour therapeutically planned structural services. See Part 2C above for coverage information on FAMIS MOMS and FAMIS PC.
Mental Health Services (MHS)	$0	$0	The mental health services (MHS) listed below are covered under the Cardinal Care Program for FAMIS Children, in accordance with the coverage criteria and guidelines described in the DMAS MHS Provider Manual, and as described in Part 2b above. 1. Applied Behavior Analysis 2. Assertive Community Treatment 3. Community Stabilization 4. Functional Family Therapy 5. Intensive In-home Services 6. Mental Health Case Management Services 7. Mental Health Intensive Outpatient 8. Mental Health Partial Hospitalization Program 9. Mobile Crisis Response

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
			10. Multisystemic Therapy 11. Peer Recovery Support Services 12. Residential Crisis Stabilization Unit 13. Therapeutic Day Treatment 14. Twenty-Three (23) Hour Crisis Stabilization
Outpatient Mental Health and Substance Use Disorder Treatment Services*	$0	$0	The Contractor is responsible for covering medically necessary outpatient individual, family, and group psychotherapy and counseling for treatment of mental health conditions and substance use disorders. Outpatient substance use disorder treatment services for FAMIS Children include outpatient (ASAM Level 0.5 and 1.0), intensive outpatient (ASAM Level 2.1), partial hospitalization (ASAM Level 2.5), medication-assisted treatment, case management, and peer recovery support services per 12VAC30-130-5000 through 12VAC30-130-5100, 12VAC30-50-491, and 12VAC30-130-5160 through 12VAC30-130-5210.
Tobacco Dependence Treatment (i.e., Tobacco or Smoking Cessation)*	$0	$0	The Contractor shall provide coverage for smoking cessation in accordance with SUPPORT Act requirements.
FAMIS COVERED EMERGENCY SERVICES			
Emergency Services Physician Care	$0 per visit	$0 per visit	Members who present to the emergency room shall pay the Emergency Services copayment ($2/$5). The Contractor shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist. The Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
			The Contractor shall cover all emergency services provided by out-of-network providers. The Contractor may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that a member seeks in an emergency.
Non-Emergency Use of the Emergency Room	$0 per visit	$0 per visit	If it is determined, using prudent layperson standards for access, that the visit was a non-emergency, the hospital may bill the member only for the difference between the emergency room and non-emergency copayments, i.e. $8 for members with household incomes at or below one hundred fifty percent (150%) FPL and $20 for members with household incomes above one hundred fifty percent (150%) FPL. The hospital may not bill for additional charges.
Post-Stabilization Care Following Emergency Services			The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized. The Contractor must cover post-stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's network.
FAMIS CARVED-OUT SERVICES			
Local Education Agency (LEA) Services	N/A	N/A	The Contractor is not required to cover school-based services rendered by and billed by an LEA. LEA-based services that meet the Department's criteria will continue to be covered by the Department on a fee-for-service basis as a carve-out service. However, the Contractor shall not deny medically necessary services or therapies in the outpatient, home, or school setting based on the fact that the child is also receiving LEA-based services.
FAMIS NON-COVERED SERVICES			
Cosmetic Services	N/A	N/A	Cosmetic services are not covered except to correct deformity resulting from disease, trauma or congenital abnormalities, which cause functional impairment, or complete a therapeutic treatment as a result of such deformity.

SUMMARY OF COVERED SERVICES – PART 6 – BENEFITS FOR FAMIS CHILDREN **NOTE:** FAMIS MOMS and FAMIS PC members have the Medicaid benefit package and do not have cost sharing requirements.			
SERVICE	**NETWORK COST SHARING AND BENEFIT REQUIREMENTS**		**CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE**
Court-Ordered Services	N/A	N/A	The Contractor is not required to cover a court-ordered service unless the service is (1) medically necessary and (2) a FAMIS covered service.
EPSDT	N/A	N/A	The Contractor is not required to cover EPSDT for FAMIS, including EPSDT Clinical Trials. The Contractor is required to cover well baby and well-child services without cost sharing, as described in this table.
Experimental and Investigational Procedures	N/A	N/A	The Contractor is not required to cover this service.
NEMT	N/A	N/A	Transportation services are not provided for routine access to and from providers of covered services.
Psychiatric Residential Treatment Services	N/A	N/A	This service is non-covered under FAMIS.
Temporary Detention Orders (TDOs)	N/A	N/A	The Contractor is not required to cover inpatient psychiatric treatment as a result of a TDO outside of the coverage guidelines described in the Cardinal Care Managed Care Services Agreement for inpatient behavioral health services. Coverage for TDO admissions are available through the State TDO fund per authority: §16.1-335 et seq. of the Code of Virginia.

*Contractor's coverage of mental health and substance use disorder treatment services shall comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 and the SUPPORT Act Section 5022.

Attachment F – 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 CFR §§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 CFR §§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 if it complies with Va. Code § 2.2-4342(F), 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

_____

(INDICATE HEALTH PLAN NAME)

Attachment G – Managed Care Regions/Localities

CENTRAL REGION					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLES CITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
49	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		
TIDEWATER REGION					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK
NORTHERN & WINCHESTER REGION					
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
CHARLOTTESVILLE WESTERN REGION					
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					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	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
063	FLOYD	141	PATRICK		
SOUTHWEST REGION					
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 H – MCO Member Health Screening

Document Header Fields

Member Last Name: _____

Unable to Contact Member	
Member Refused to Answer	
Member Complexity Attestation Completed (Maintained by MCO)	

Member First Name: _____

*Member Medicaid ID #: _____

Member ID # (plan): _____

Member Contact/Phone: _____

Member Primary Care Provider: _____

Member Primary Care Provider NPI: _____

*Date Screening Completed: _____

(*fields will be validated and errors returned to plan for correction)

PART 1 - Medically Complex Classification Questions:

Question 1: Has a doctor, nurse, or health care provider told you that you had/have any of the following (**please check all applicable boxes**):

	Cancer (Active)
	COPD or Emphysema
	Diabetes
	Heart Disease, heart attack, heart failure (weak heart)
	HIV or AIDS
	Kidney Failure or End Stage Renal Disease (ESRD)
	Parkinson's Disease
	Sickle Cell Disease
	Stroke, Brain Injury or Spinal Injury
	Transplant or on a transplant wait list
	Other chronic (long-term) disabling condition – **IF YES, Member Complexity Attestation must be completed**

Question 2: Do any of the chronic conditions you checked above impact your ability to do everyday things **AND** require you to receive assistance with any of the following (**please check all applicable boxes**):

	Bathing
	Dressing
	Eating
	Using the bathroom
	Walking

Question 3: Has a doctor, nurse or health care provider told you that you had/have any of the following (please check all applicable boxes):

	Alcoholism
	Bipolar Disorder or Mania
	Depression
	Panic Disorder
	Post-Traumatic Stress Disorder (PTSD)
	Psychotic Disorder
	Schizophrenia or Schizoaffective Disorder
	Substance Use Disorder or Addiction
	Other chronic (long-term) mental health condition – **IF YES, Member Complexity Attestation must be completed**

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

☐ **Yes** ☐ **No**

Question 5: Do you have an intellectual or developmental disability and require help with any of the following: (**please check all applicable boxes**):

	Learning or Problem-Solving
	Listening or Speaking
	Living on your own
	Making decisions about your health or wellbeing
	Self-Care (bathing, grooming, eating)
	Travel/Transportation (driving, taking the bus)

PART 2 - Social Determinants of Health and Health Risk Assessment Triage Questions:

QUESTION 1: What is your housing situation today?

	I have housing

	Yes	No	I am worried about losing my housing
	I do not have housing (**check all that apply**)		
			Staying with others
			Living in a hotel
			Living in a shelter
			Living outside (on the street, on a beach, in a car, or in a park)
			I choose not to answer this question

QUESTION 2(a): In the past **three (3) months**, did you worry whether your food would run out before you got money to buy more?

Yes	No

QUESTION 2(b): In the past **thirty (30) days**, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? **Select all that apply.**

Yes	No	Prescription Drugs or Medicine
Yes	No	Utilities
Yes	No	Clothing
Yes	No	Child Care
Yes	No	Phone
Yes	No	Health Care (doctor appointment, mental health services, addiction treatment)
		I choose not to answer this question

QUESTION 3: How many times have you been in the Emergency Room or a hospital in the last ninety (90) days for one (1) of the conditions you listed earlier? _____ (enter number from 0-99)

QUESTION 4: How many times have you had a fall in the last ninety (90) days and needed to visit a doctor, Emergency Room, or hospital because of the fall? _____ (enter number from 0-99)

(Adult Population Question)

QUESTION 5: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

	Yes it has kept me from medical appointment or from getting my medications
	Yes it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

QUESTION 6: Caregiver Status (**Adult Population Question)**

Yes	No	Do you live with at least one (1) child under the age of nineteen (19), AND are you the main person taking care of this child?
Yes	No	Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?

QUESTION 7: What is the highest level of school that you have finished? **(Adult Population Question)**

	Some high school but no diploma
	High school diploma or equivalency (GED)
	Some college but no degree
	Workforce Credential or Industry Certification after High School
	Associate's Degree
	Bachelor's Degree or higher
	I choose not to answer this question

QUESTION 8: Do you have a job? **(Adult Population Question)**

	I have a part time or temporary job
	I have a full time job
	I do not have a job and am looking for one
	I do not have a job and I am not looking for one
	I choose not to answer this question

QUESTION 9: Do you like your current job? **(Adult Population Question)**

Yes	No	Yes, I like my job
Yes	No	I must work more than one job because I can't find a full time job
Yes	No	I work more than forty (40) hours per week at two (2) or more part time jobs

Yes	No	I have been looking for a job for more than three (3) months and I have not been offered a job
Yes	No	I would like help finding a job that I like more or pays more money

QUESTION 10: In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

	Yes
	No
	Unsure
	I choose not to answer this question

QUESTION 11: Do you have other important health issues or needs that you would like to discuss with someone?

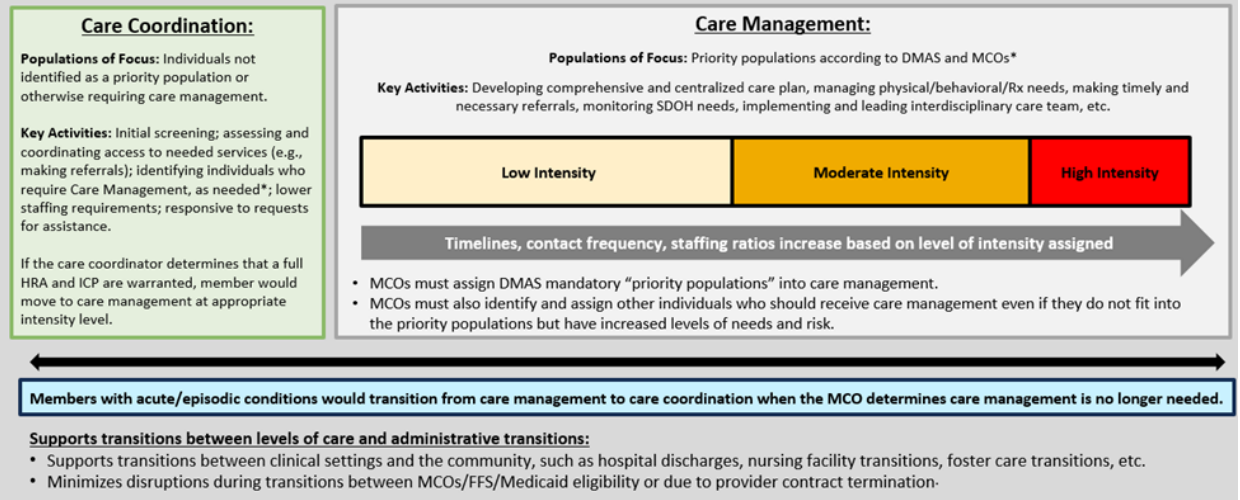
	Yes
	No

QUESTION 12: How soon do you want to be contacted by someone to discuss your health issues or needs?

	1-30 Days
	31-60 Days
	61-90 Days
	91-120 Days
	Do not contact me

Attachment I – Model of Care Overview

Overview of Cardinal Care Model of Care, including Care Coordination and three tiers of Care Management intensity levels:



Overview of Care Management requirements for Members in Low, Moderate or High Intensity Care Management:

	Low Intensity CM	Moderate Intensity CM	High Intensity CM
Populations of Focus	**Mandatory Priority Populations + other individuals needing care management, as identified by the MCO**		**Mandatory High Priority**
Initial MMHS Screening Completion Timeline	**90 calendar days from enrollment** (***30 calendar days for Members who are ventilator dependent and receiving private duty nursing services***)		
Initial HRA Timeline	60 calendar days from MMHS completion/identification as requiring care management (*or sooner, as needed*)		
Initial ICP Timeline	60 calendar days from HRA completion (or enrollment if HRA was previously completed)	30 calendar days from HRA completion (or enrollment if HRA was previously completed)	7 calendar days from HRA completion (or enrollment if HRA was previously completed)
ICT Meeting/ Communications Timeframe	As needed or at Member request *NF and Waiver Members in Low/Moderate Intensity should receive ICT Meetings aligned with requirements for Members in High Intensity Care Management*		Initial: 30 calendar days from ICP completion Ongoing: Following HRA reassessment, triggering events, readmissions, upon member request
Minimum Contact Requirements/Format [2]	1 contact per 6 months **in-person, telephone or videoconference** *NF and Waiver Members: initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference*	1 contact per 3 months **in-person, telephone or videoconference** *NF and Waiver Members: initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference*	1 contact per month **Initial meeting and at least one contact every 6 months must be in-person** *NF and Waiver Members: Initial HRA and annual level of care review must be in-person; interim contacts may be via telephone or videoconference unless otherwise required to be in-person*
Caseload Ratios	1:500	1:175	1:70

1. Maintains face to face for certain LTSS populations; allows for interim / subsequent contacts to be in person, telephone, or video conference.
2. DMAS will allow for ICTs to move forward without every team member always being present. The Care Manager must provide a summary of the meeting to all ICT Members (including those who were unable to attend) within 30 calendar days of the meeting.
3. Care managers will be required to meet with members as expeditiously and frequently as their care conditions require but will be held to these minimum contact requirements. Minimum timeframes or contacts do not allay the MCO from its responsibility to make contacts as clinically necessary to ensure the health, safety and welfare of a member.

Summary of required credentials and experience for Care Manager positions:

Care Manager Position	Required Credentials*	Required Experience
Care Managers serving: • Members in Low or Moderate Intensity Care Management	Bachelor's degree in a health or	One year of experience working directly with individuals who meet

• Members in High Intensity Care Management other than populations listed in the two rows below	human services field, LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	the Cardinal Care priority population criteria.
Care Managers serving Members in High Intensity Care Management with the following conditions: • Members receiving private duty nursing services; • Life-sustaining Ventilator-dependent members; • Vulnerable infant members, including those diagnosed with neonatal abstinence syndrome, classified as substance-exposed, or admitted to the NICU Level 3.	RN	One year of experience working directly with Members who meet the conditions listed in this row.
Care Managers serving Members in High Intensity Care Management who are in Foster Care	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW	One year of experience working directly with individuals involved in the foster care/Child Protective Services system and/or former foster youth.
ARTS Care Manager	LMHP, RN/LPN, QMHP, LMSW, LBSW, MSW or BSW, CSAC, CSAC-Assistant	One year of experience working directly with individuals with SUD.
Care Manager Supervisor	LMHP or RN	Two years of experience working directly with individuals who meet the Cardinal Care priority population criteria

*****Credentials that require licensure or certification must be current/active in Virginia. RN/LPNs must be licensed in Virginia or hold an RN/LPN license with multi-state privilege recognized by Virginia.

REVISED 5/9/23 - Cardinal Care Priority Populations; Person Centered Care Management

1) Mandatory High Priority Populations; members must receive high intensity Care Management

- **CCC Plus Waiver members receiving PDN**
- **Children receiving PDN through EPSDT**
- **Ventilator-dependent members**
- **Members transitioning from a NF to the community** (for a minimum of 3 months prior to the transition and 6 months after the transition, or longer if determined necessary by the MCO)
- **Foster Care / Former Foster Youth**:
  - Members in foster care or former foster youth for 3 months after enrollment into the Medicaid program, the child welfare system or a new foster care home
  - **Members in foster care 3 months prior to aging out of the child welfare system**
  - Former foster youth for the first 3 months after aging out of the child welfare system
- **Very Vulnerable Infants:**
  - Substance-exposed infants for first 3 months of Medicaid enrollment;
  - Neonatal abstinence syndrome infants(following diagnosis or identification as part of this population, whichever is later) for first 3 months of Medicaid enrollment
  - Infants admitted to the NICU Level 3 for first 3 months of Medicaid enrollment

2) Mandatory Priority Populations; members must receive care management, MCO determines intensity (high, moderate, low)

Members Enrolled in Waivers or with I/DD
- CCC Plus Waiver members (not receiving PDN)
- Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers)
- Members with intellectual/developmental disabilities (I/DD)

Members in Hospice, Nursing Facilities or with Dementia
- Members receiving hospice benefits
- Nursing facility members (except for members in the "Mandatory High Priority Population")
- Members with cognitive or memory problems (e.g., dementia)

Members with brain injuries

Members with SMI or SED
- Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
- Members who receive Mental Health Services, as reflected in the Cardinal Care Summary of Covered Benefits Chart
- **Individuals in foster care and former foster youth who are not in the "Mandatory High Priority Population"**

3) MCO-Determined Priority Populations; MCO Determines Care Management and appropriate intensity (high, moderate, low)

Pregnant Women and Children with High Needs/Risk
- Members with a high-risk pregnancy, as defined by the Contractor
- Children and Youth with Special Health Care Needs
- Children identified as at risk for developing developmental disabilities or delays (early intervention program)

Members with Other Complex/Chronic Conditions
- Members with other complex or multiple chronic conditions (e.g., respiratory conditions, heart disease/heart failure, diabetes, cancer, etc.)
- Members with end stage renal disease
- Members with physical or sensory disabilities

Members Meeting Utilization-Based Criteria
- Patient Utilization Management and Safety (PUMS) Program Members
- Members with 3 or more ED visits or hospitalizations related to their chronic medical, physical health condition in the past 90 calendar days
- Members with 1 or more ED visits or hospitalizations related to their behavioral health or substance use condition in the past 3 months;
- Members 18 years of age or older who have had 2 or more falls resulting in an ED visit, hospitalization, or physician office visit within the past 90 calendar days

Members with Behavioral Health (BH/SUD)
- Members with behavioral health and substance use disorders

Members with High Social Needs
- Members who are experiencing homelessnes
- Justice-involved populations (includes individuals who have a history of incarceration, probation or parole supervision)
- Members who have other, high social needs that pose a significant risk to their health, safety and welfare

Other Populations Based on MCO Determination

1

DMAS

Attachment J – Model of Care Policies, Procedures and Reports

The Contractor must submit to the Department for review and approval prior to implementation, upon revision, or upon request, the policies and procedures as specified herein. All policies and procedures must include how the Contractor will meet all requirements as stated throughout Section 8, *Model of Care*. The Contractor must submit consolidated policy and procedures no later than three (3) months from when Model of Care requirements are implemented.

Care Coordination

The Contractor's Care Coordination policies and procedures must describe how all Members must have access to the following supports:

1. A single, toll-free point of contact for assistance;
2. Assurance that referrals result in timely appointments;
3. Communication and education regarding available services and community resources in a mode and manner that is culturally, developmentally appropriate and that considers the Member's physical and cognitive abilities and level of literacy;
4. Assistance with developing self-management skills to effectively access and use services; and
5. Assessment of needs that potentially require a referral to Care Management for more intensive assistance to the Member.

Care Management

The Contractor must submit policies and procedures to describe:

1. Methods to identify Priority populations. This must include, but is not limited to, the Contractor's approach to defining "high-risk pregnancy";
2. Risk stratification (and restratification) methods (including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information) to assign Members to the appropriate Care Management intensity. The Contractor must indicate whether any data elements are consistently not used in the risk stratification method and explain why the Contractor consistently does not have access to this information;
3. Processes to comply with requirements for maintaining minimum caseload ratios and complying with contact requirements;
4. How the Contractor notifies Members of their assigned Care Manager's name(s) and how to contact them;
5. If the Care Manager is not available to the Member, how the Care Manager will be notified by the next business day of any issues/changes/concerns of the Member (this includes contacts from the Member or the Member's authorized representative or caregiver made through a Member support line, 24-hour clinical triage line that offers nurse advice and behavioral health crisis response);
6. Processes to ensure that referrals result in timely appointments;
7. How the Contractor will provide education available services and community resources in a mode and manner that is culturally, developmentally appropriate and that considers the Member's physical and cognitive abilities and level of literacy;

8. How the Contractor will help Members develop self-management skills to effectively access and use services;
9. How the Contractor will ensure continuity of care when Care Manager changes are made whether initiated by the Member or by the Contractor;
10. How Care Managers will work with all Members to ensure their ongoing Care Management needs are identified and met, using a person-centered planning approach, beyond complying with HRA, reassessment, ICP and ICT requirements. The policy and procedures must also describe how the Contractor will incorporate disease management into the Care Management approach for all Members;
11. How the Care Manager is made aware of grievances and appeals filed by Members or by providers (when providers file an appeal based on a denial of service);
12. How providers, including nursing facilities, are notified of the name and contact information of their clients' or residents' assigned Care Managers and any changes to this assignment;
13. Strategies to: (1) outreach to and engage Members who are hard to contact/locate (e.g., incorrect address information, missing or incorrect phone number, Members who are experiencing homelessness); and (2) reengage Members who previously refused to engage in Care Management;
14. Strategies the Contractor uses to document attempted contacts. Upon request, the Contractor must provide the Department with detailed documentation of efforts taken (dates, times, type of attempts made, etc.) to reach specific Members and with an explanation of the reason why they were unable to successfully reach Members and complete contract deliverables (including HRAs, ICPs, etc.);
15. Strategies the Contractor uses to assist Members who are determined to have high-risk behaviors;
16. Safety plans for Members and Contractor staff;
17. How training of Care Managers is confirmed and verifying that training or any certifications remain current;
18. How the Contractor will address noncompliance with training by Care Managers;
19. Types of training, including the frequency and modes of training the Contractor will provide to its Care Managers. The Contractor must resubmit this policy at any time the Contractor revises its training plan for Care Managers;
20. How the ICP will be developed and how the ICT will engage the Member in Care Management;
21. How the Contractor will interface with the Department's Service Authorization Contractor and ensure open communication and collaboration in the best interest of the Member's integrated care needs; and
22. Strategies to ensure that Members do not receive duplicative Care Management from multiple sources.

The Contractor is required to maintain data that identifies Members' current assignment at each level of Care Management. This data must be made available to the Department upon request.

On a monthly basis, the Contractor must provide the Department with:

1. A Care Management staffing report that demonstrates its level of compliance with the Department's caseload ratio requirements as required by the Cardinal Care Technical Manual.

The report must include caseload ratios on a proportionate full time equivalent (FTE) basis, providing the FTE percentage for each subpopulation with whom a Care Manager has been assigned. The Department may require the Contractor to provide a regional breakdown of Care Manager staffing.

2. A report providing the number and percentage of Members assigned to:
    a. Care Management (including Low, Moderate and High Intensity Care Management)
    b. Low Intensity Care Management
    c. Moderate Intensity Care Management
    d. High Intensity Care Management

HRA and Reassessments

The Contractor must submit its policies and procedures related to HRAs, reassessments, and tools used in these processes. The Contractor's HRA and reassessment processes and procedures must describe all of the following required elements:

1. The Contractor's approach to conducting the HRA and reassessments, including a copy of specific tools;
2. The Contractor's approach to administering the HRA to different populations, including methods of administration (e.g., face-to-face, videoconferencing, telephone) and timeframes. This should include a description of how the Contractor will administer HRAs to Members residing in NFs and those enrolled in the Commonwealth Coordinated Care Plus Waiver and what constitutes "reasonable efforts" for Members living in the community;
3. The Contractor's approach to 1) timely completion of the HRA reassessment following a triggering event and 2) determining when the HRA must be completed within ten (10) calendar days or longer, as appropriate;
4. How the Contractor involves Members, authorized representatives, family Members and caregivers in the HRA process, including the Contractor's efforts to obtain documentation, including signatures, to signify that Members, authorized representatives, and family Members and caregivers understand and consent to the HRA process;
5. How the Contractor will provide Communication/Interpreter Services as described in Section 4.1.2, *Communication and Interpreter Assistance*; and
6. How to ensure timely reassessment, including following triggering events.

MCO Member Health Screening

The Contractor's MMHS policies and procedures must describe all of the following required elements:

1. Key components of the MMHS and approach for administering the MMHS;
2. The qualifications of the personnel conducting the MMHS;
3. How the Contractor determines if Members are capable of participating in the MMHS process and how authorized representatives, family Members and caregivers are involved in the MMHS process when appropriate;
4. Protocols for when the Contractor cannot reach the Member to complete the MMHS; and
5. How the Contractor will provide Communication/Interpreter Services as described in Section 4.1.2, *Communication and Interpreter Assistanc*e.

The Contractor must submit a report to the Department on the Commonwealth Coordinated Care Plus Waiver and NF Members who are unable to be reached due to a lack of response to outreach attempts, using outreach strategies outlined in Section 8.3.2.3, *Unable to Contact for MMHS* and as specified in the Cardinal Care Technical Manual.

Individualized Care Plan

The Contractor's ICP policies and procedures must describe all of the following required elements:

1. The person-centered and culturally competent ICP development process and how the ICP development process will incorporate and not duplicate Targeted Case Management (if applicable);
2. How the Contractor will ensure the Member and their family/preferred support system are engaged in the initial and ongoing development of their ICP and receives any assistance and accommodations to prepare for and fully participate in the care planning process and ICP development;
3. How the Care Manager will obtain the Member's signature on the initial ICP and any subsequent updates and revisions by the ICT or during other contacts with the Member;
4. How the ICT will be involved in the ICP's ongoing development and how the Care Manager leads the development of the comprehensive, person-centered, culturally competent, individualized ICP that is tailored to the Member's needs and preferences;
5. The personnel who review the person-centered ICP and how frequently the ICP is reviewed and revised (e.g., initially developed by the Member and Care Manager and reviewed/revised by the ICT, including the Member and family/preferred support system whenever feasible, and other pertinent specialists required by the Member's health needs; reviewed and revised at least annually and as otherwise required, etc.);
6. How the person-centered ICP is documented; how the documentation is maintained, preserved from destruction, and secured for privacy and confidentiality; and how it is made accessible to the Member's ICT, provider network, and Member either in original form or copies;
7. How services included during the continuity of care period are incorporated into the ICP and how medically necessary services will be continued after the continuity of care period is over;
8. How information from the LTSS Screening, when available, will be incorporated into the ICP for individuals in the Commonwealth Coordinated Care Plus Waiver;
9. How information from the MMHS will be incorporated in the ICP;
10. The Contractor's process for obtaining NF MDS data and how it will be incorporated into the ICP;
11. How the Contractor will incorporate and leverage external existing plans of care (e.g. NF, Personal Care, ADHC, TCM, etc.); and
12. How the ICP is developed, maintained, and monitored to ensure all treatment needs are met and that all changes and updates are reflected accurately and timely.

Interdisciplinary Care Team

The Contractor's ICT policies and procedures must describe all of the following required elements:

1. The method used to facilitate the participation of the Member, the Member's authorized representative, and other required participants whenever feasible;

2. How the Contractor will accommodate the Member's needs and preferences related to location of ICT meetings (e.g., in the home/facility for LTSS Members, transportation to other locations, etc.);
3. How the Contractor will coordinate with other existing ICT meetings, including but not limited to, those held in NFs, ADHC, CSB, etc. Include provider outreach and education regarding ICT requirements and expectations;
4. How the scheduled ICTs will operate, document, and communicate (e.g., frequency of meetings, process for documenting proceedings in a Member's medical records and retention of records, notifications and invitations about ICT meetings, dissemination of ICT reports to all ICT participants and invitees, etc.);
5. Description of the advanced notice that will be provided to the Member and other required attendees in order to maximize participation (for planned ICT meetings, reasonable and sufficient notice must be provided) and how documentation will be maintained if an invitee cannot attend;
6. Description of how the ICT will solicit input from required participants who are unable to participate in the ICT meeting and how these participants will be informed of information discussed and outcomes of the ICT meeting;
7. The communication mechanism the Contractor institutes to notify the ICT, provider network, Members, etc. about the HRA and stratification results (e.g., written notification, secure electronic record, etc.);
8. Description how the provider network coordinates with the ICT and the Member, the member's primary insurance, and care team providers to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the Member in a timely and quality way, how reports on services delivered are shared with the Contractor and ICT for maintenance of a complete Member record and incorporation into the care plan, how services are delivered across care settings and providers, etc.);
9. How the ICT process will be used to empower and support the ICT in proactively recognizing signs of emerging issues (e.g., depression, fall risk, etc.) and mechanism for follow-up on identified risks; and
10. Description how the ICT process will interface with the ongoing development of a comprehensive ICP.

Transitional Care Management

The Contractor must maintain and submit policies and procedures that reflect how the Contractor will meet the Contract requirements related to transitional Care Management and timely discharge planning, including coordinating with nursing facilities and facility-based care coordinators, care managers, and/or case managers, how discharge plans will be documented, how the Member will be involved, and how discharge planning will be triggered.

Administrative Transitions/Continuity of Care Policy and Procedures

The Contractor must maintain and submit Administrative Transitions/Continuity of Care policies and procedures must describe all of the following required elements:

1. How the Contractor will automatically generate SAs for continuity of care for Members whose authorization information is included in the MTR file received from the Department prior to enrollment and how this information is disseminated internally and to whom;
2. How the Contractor will notify Members and providers in writing of the continuity of care authorization, including the service or item, name of the provider, authorized units or amounts, and authorized dates of service;
3. How the Contractor will ensure medically necessary services are continued without gaps in care at the end of the continuity of care period and the role of the Care Manager in ensuring services needed on an ongoing basis do not lapse; and
4. Outreach efforts to non-participating providers and pharmacies to ensure services are not discontinued during the continuity of care period.

Foster Care Care Management

The Contractor must report monthly to the Department any barriers identified in contacting and/or providing care to foster care children. The Department will use the Barrier Report to assist the Contractor in resolving the barriers reported. Refer to the Cardinal Care Technical Manual for Barrier Report specifications.

The Contractor agrees to adhere to all additional reporting requirements related to the foster care population, as outlined in the Cardinal Care Technical Manual.

Care Management Partnerships

The Contractor must maintain and submit policies and procedures that reflect how the partnerships with Care Management entities, such as community-based organizations, work within the framework of the Contractor's systems to ensure non-duplication of services according to 42 CFR § 431.301(c)(1)(v-vi). The policies and procedures must address monitoring and oversight of the activities performed by community partners, how information will be imported into the Contractor's systems, and the tracking of Care Manager assignments.

Coordination with the Member's Medicare Plan

The Contractor must maintain and submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract related to coordinating with Medicare Services for Dual-Eligible individuals when the Member is:

1. Enrolled in the Contractor's D-SNP plan;
2. Enrolled in or Medicare Advantage; or
3. Receiving Medicare via the traditional FFS model of service delivery.

Members Experiencing Homelessness

The Contractor must submit a report to the Department within one hundred twenty (120) days of the effective date of this Contract and annually thereafter that identifies community-based homeless support services by city/county, details of the formal referral relationships established, and how the Contractor will make face-to-face contact with its Members experiencing homelessness. Refer to the Cardinal Care Technical Manual for details.

Electronic Care Coordination System

The Contractor must submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures of its electronic system and other tools Care Managers will use to integrate care for Members, including integrating Medicare services for dual-eligible individuals. The policies and procedures should place emphasis on how the system facilitates communication so that the Contractor, providers, helpline, Member, subcontractors and Care Managers can receive real time or near real time data (e.g., utilization management, claims data, appeals and grievances, experience with the Contractor, subcontractors, etc.) to better coordinate care, follow Members through episodes of care, and streamline care transitions to ensure positive health outcomes for Members. In the policies and procedures, the Contractor must describe:

1. The types of data stored in the electronic Care Coordination system;
2. How information is fed into the system (e.g., real time, manual entry, etc.), how frequently (e.g., daily, weekly, etc.), and from what sources(s) (e.g., subcontractors);
3. Which providers and staff have access to the data, how they access the data, and for what purposes; and
4. The Contractor's ability to capture (send/receive) relevant information to report to the Department for Care Coordination and monitoring purposes.

Disease Management Programs

The Contractor must submit to the Department, on September 30th of each contract year, a document outlining the approach taken to work with individuals with the conditions listed above. The Disease Management Program Plan must include the following elements:

1. A description of how the Contractor identifies the Members with the identified focus conditions;
2. A description of any predictive modeling techniques that support the Disease Management Programs employed by the Contractor;
3. 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.;
4. A description of how and why the program has or has not been successful under that definition; and,
5. A description of any successful focus condition specific measures employed by the Contractor in other product lines or state (Commercial or Medicaid lines of business), and a brief justification as to whether these measures could be successfully utilized by the Commonwealth.

Social Determinants of Health

The Contractor must submit an annual report detailing how it is identifying, addressing (i.e. via programs and partnerships), and tracking each of the five (5) key areas of SDOH described above in Section 8.17, *Social Determinants of Health* and as specified in the Cardinal Care Technical Manual.

The Department has the discretion to expand the SDOH reporting criteria throughout future Contract years, to include specific data for the five key areas noted above or additional areas as necessary.

Services for Justice-Involved Members

The Contractor must collaborate with the Department to develop policies and procedures for the screening and provision of care for Medicaid Members who have been identified as recently released from a correctional facility or local/regional jail. These policies and procedures should address the following:

1. Coordinating with case managers and Probation/Parole/Public Defenders offices who are working with the Member prior to release and in the community;
2. Assessing current medical needs and functional status;
3. Assisting the Member with accessing care and/or community supports as needed;
4. Partnering with community resources to facilitate referral networks; and,
5. Developing reports that include methods for identifying and removing barriers to care and addressing additional needs expressed by the Member.

Attachment K – Department of Medical Assistance Services Preenrollment / Revalidation Site Visit Checklist

NPI:

Provider Name:

OFFICE USE ONLY: PASS☐FAIL☐

Preenrollment/Revalidation Site List Checklist

Per Federal Regulation 42 CFR §455.432, the State Medicaid agency—

1. Must conduct reenrollment and post-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.
2. Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced onsite inspections of any and all provider locations.

Date:

Time:

Attempt:

Site Visit Performed by:

Provider Information

Instructions: From the provider application and most recent provider maintenance (if any), complete the information below. The type of services provided by the enrolling provider will determine necessary observations during the tour of the facility.

Name:

NPI:

Business Name:

Business Telephone:

Servicing Address:

Provider Type:

Specialty:

Revalidation or New Enrollment:

Contact Name:

Title:

Phone:

Correspondence Email:

Onsite

Instructions: The site visit to the servicing location of the enrolling/revalidating provider will be unannounced. Upon arrival at the location, verify physical address. Upon entering the business, introduce yourself, provide business card, letter of authorization and DMAS photo ID; ask to speak with provider. Explain the purpose of your visit. Complete the following information.

1. Presented photo ID? YES☐ NO☐
2. Provided Letter of Authorization? YES☐ NO☐
3. Is the servicing location address correct? YES☐ NO☐
4. Picture taken of the exterior of the business? YES☐ NO☐
5. Business signage present? YES☐ NO☐
6. Hours of operation posted? YES☐ NO☐
7. Is the site/office open? YES☐ NO☐
8. Type of facility?
    a. Store Front☐
    b. Office Suite☐
    c. Warehouse☐
    d. Private Residence☐
    e. Multi-Office Building☐
    f. Other: ☐

    Do you have additional servicing locations? YES☐ NO☐ If yes, please list below.
9. Is the site operational?
    a. Working phones? YES☐ NO☐ Verify phone#:
    b. Working Computers YES☐ NO☐ Verify email:
    c. Customers at site? YES☐ NO☐
10. Tour:
    a. Picture of interior? YES ☐ NO☐

b. Reception area? YES☐ NO☐

c. License Displayed? YES☐ NO☐

Licenses held:

Business license

11. Are you accepting patients/clients at this time? YES☐ NO☐

a. If not, when do you expect to be open for business?

Owner Background

Instructions: If the contact person is not the owner, ask who the owner is and match names to those documented in the provider application. If no answers are provided, please document that the information is not available.

12. Name of Owner(s)?

13. Does the owner have interest in any other medical related business? YES☐ NO☐

a. If yes, what percentage? _____

Provider Education

14. Web portal registration

15. EFT

16. EDI

17. Provider Training website.

18. Process for updating license

19. Accessing online manuals that's applicable to PCTs and memos

20. Process for revalidations

21. PPM functions

22. Blast email

23. Was provider education provided? YES☐ NO☐

NOTES:

ACKNOWLEDGEMENT

By signing below, I verify that the information given on this site visit is accurate and that it was performed at the address given for this enrollment and or revalidation.

_____

Signature of the Provider

By signing below, I verify that I have personally performed this site visit at the location and on the date and time listed above and that the observations I have recorded are correct.

_____

Signature of individual Performing Site Visit

PASS___ FAIL___