COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

July 17, 2017

Dear Prospective Offeror:

The Department of Medical Assistance Services (DMAS or the Department) is soliciting proposals for Offerors to enter into fully capitated, risk-based contracts to administer a coordinated delivery system for Medicaid (Title XIX) and FAMIS (Title XXI) under the Department's new MEDALLION 4.0 Program. MEDALLION 4.0 is the next iteration of the Department's long-standing Medallion II and Medallion 3.0 Medicaid and FAMIS Managed Care Programs and will focus on improving quality, access and efficiency.

Medallion II was Virginia's first mandatory managed care program. As the program expanded wide (statewide) and deep (additional populations), Medallion II was rebranded Medallion 3.0 with a renewed focus on the areas of systems integration, contract and quality monitoring, compliance, and program integrity. Virginia seeks to strengthen and reinvigorate this model by adjusting the included populations and services.

As detailed in the RFP, selected Contractors shall arrange for the provision of services for approximately 737,000 Medicaid and FAMIS eligible members including infants, children and adults in the low income families with children (LIFC) group, pregnant women, FAMIS MOMS, foster care and adoption assistance, children with special health care needs, and teens.

DMAS will implement the new MEDALLION 4.0 Program on a regional basis beginning in August 2018. DMAS anticipates that it will enter into annual contracts with at least three (3) Contractors per region. Offerors may propose to cover one or more MEDALLION 4.0 region(s), however, Offerors do not need to submit a separate proposal for each region. Offerors must cover all eligible individuals in all localities within the region(s) in which it proposes to cover. Regions are "all or nothing" and no individual FIPS codes within a region may be selected.

Specific details about the RFP process are included in the enclosed RFP.

Offerors are encouraged to review the 2017-2018 Medallion 3.0 and FAMIS Contracts available under Program Information on the Medallion 3.0 section of the DMAS website at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx. Prospective Offerors must check eVA Virginia Business Opportunities (VBO) at http://www.eva.virginia.gov for all official addenda and notices regarding this RFP. While DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx, eVA is the official and controlling posting site. The Commonwealth will not pay any costs that any Offeror incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Prospective Offerors are requested not to call the Department with questions. Instead all questions related to this RFP should be submitted in writing in MS Word format by email to the attention of Adrienne T. Fegans at RFP2017-03@dmas.virginia.gov. All questions must be submitted by 10:00 a.m. Eastern Time on July 31, 2017. Responses to questions will be posted in a RFP addendum on the eVA and DMAS websites.

MANDATORY PREPROPOSAL CONFERENCE: A mandatory preproposal conference will be held on July 28, 2017, 1:00 p.m. Eastern Time at the Department of Medical Assistance Service, 600 E. Broad Street, Conference Room 7B, Richmond, VA 23219. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. Due to the importance of all Offerors having a clear understanding of the specifications/scope of work and requirements of this RFP, in person attendance at this conference will be a prerequisite for submitting a proposal.

Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be permitted to sign the register after 1:15 p.m. on day of conference. Due to space limitations, Offerors are limited to two (2) representatives each at the preproposal conference. To ensure adequate accommodations, Offerors must pre-register with Adrienne T. Fegans by sending an email to RFP2017-03@dmas.virginia.gov stating the name of Offeror and Offeror's participating representatives. For planning purposes, Offerors must pre-register with Adrienne T. Fegans no later than 2:00 p.m. Eastern Time on July 26, 2017. Offerors should bring a copy of the RFP to the conference. Any changes resulting from this conference will be issued in a written addendum to the RFP.

Sincerely,

Christopher Banaszak

Christopher Banaszak
DMAS Contract Manager

Enclosure

REQUEST FOR PROPOSALS
RFP 2017-03

Issue Date: July 17, 2017

Title: MEDALLION 4.0 Medicaid/FAMIS Managed Care

Period of Contract: An annual contract with provisions for six (6) twelve-month renewal options.

Commodity Code: 95856

All inquiries should be directed in writing via email in MS Word format to the attention of Adrienne T. Fegans at RFP2017-03@dmas.virginia.gov

Mandatory Preproposal Conference: **July 28, 2017 1:00 p.m.**

Deadline for Submitting Inquiries: **July 31, 2017 10:00 a.m.**

Proposal Due Date: Proposals will be accepted until **10:00 AM E.T. on September 8, 2017**

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

"RFP2017-03 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: Christopher Banaszak

Facsimile Transmission of the proposal is not acceptable.

Note: This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, § 2.2-4343.1 or against a bidder or Offeror because of race, religion, color, sex, national origin, age, disability, sexual orientation, gender identity, political affiliation, or veteran status or any other basis prohibited by state law relating to discrimination in employment. Faith-based organizations may request that the issuing agency not include subparagraph 7.3.1, e in General Terms and Condition 7.3. Such a request shall be in writing and explain why an exception should be made in that invitation to bid or request for proposal.

In compliance with this Request for Proposal (RFP) and pursuant to all conditions imposed herein or incorporated by reference, the undersigned proposes and agrees, if awarded a contract, to furnish the services contained in its proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone:	Date Signed
Fax Number:	Email:
eVA Registration Vendor Number **(Required):**	eVA #:
State Corporation Commission ID Number **(Required):** (See Special Terms and Conditions)	SCC ID#:
Dun & Bradstreet D-U-N-S Number (**Required):**	DUNS#:
Check Applicable Status: Corporation: _____ Partnership:_____ Proprietorship:_____ Individual:_____ Woman Owned: _____ Minority Owned: _____ Small Business: _____ If Department of Minority Business Enterprises (DMBE) certified, provide certification number: _____	

Submit this completed form with Technical Proposal under Required Forms

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

MEDALLION 4.0 MEDICAID/FAMIS MANAGED CARE

RFP 2017-03

ISSUED: JULY 17, 2017

Table of Contents

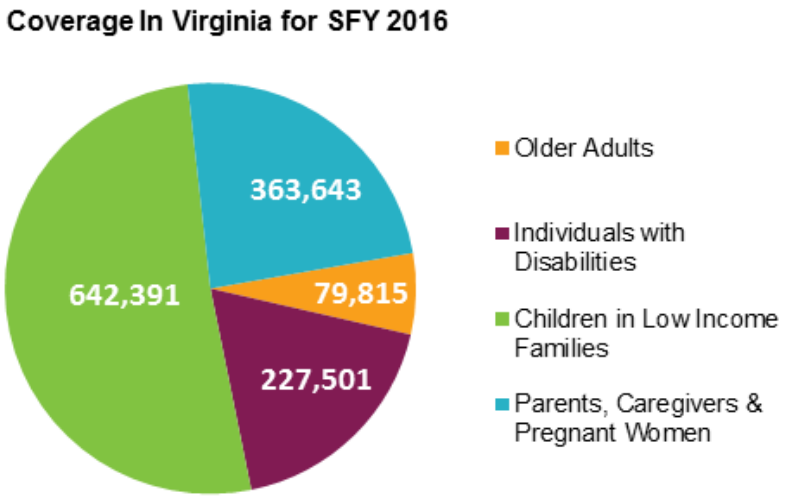
RFP 2017-03
MEDALLION 4.0 Medicaid/FAMIS Managed Care

SECTION 1.0 INTRODUCTION

1.1 MEDICAID/FAMIS BACKGROUND

The Department of Medical Assistance Services (DMAS) hereinafter referred to as the Department or DMAS, is 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. These programs are financed by both Federal and State funds and are administered by the State according to Federal guidelines. Both programs provide a system of high quality and cost effective health care services to qualifying Virginians and their families.

Coverage is primarily available to Virginians who meet specific income thresholds and other eligibility criteria, including: children, pregnant women, parents, older adults, and individuals with disabilities.

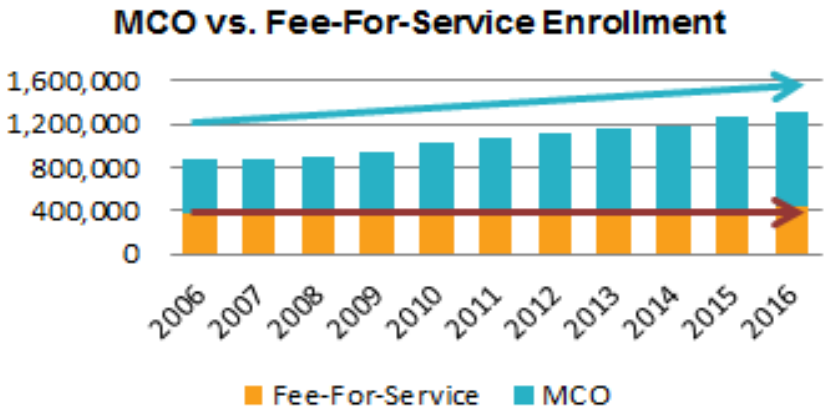


Medicaid covers 1 in every 3 births in Virginia and almost 1 in 3 children. Virginia Medicaid provides access to medical services, such as: outpatient care (primary or specialty care services); hospital care, nursing facility services, and behavioral health services. Medicaid/FAMIS covers vital health care services like preventive screening, treatment or care for acute illness, and dental services. Medicaid/FAMIS focuses on giving Virginia's children a healthy start in life by keeping pregnant women healthy. Services for pregnant women include prenatal care, other comprehensive health care services and dental health.

To learn more about the services and people covered by Virginia refer to the 2016 Virginia Medicaid and CHIP Data Book at
http://www.dmas.virginia.gov/Content_atchs/atchs/2016%20DMAS%20Data%20Book%20PRINT.pdf.

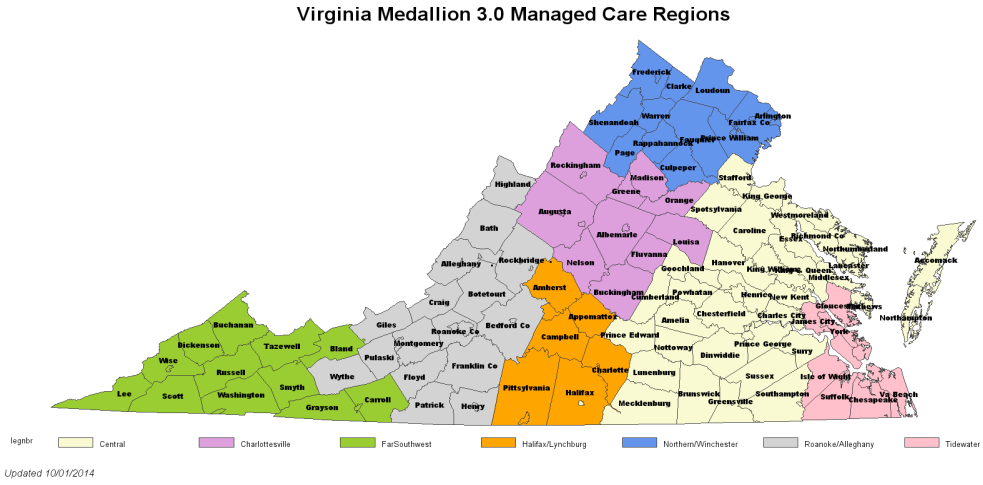
1.2 Managed Care Background

The Virginia Medicaid program covers approximately 1,140,000 individuals and is delivered to individuals through two models: fee-for-service and managed care. As of April 2017, 87% of Medicaid enrollees received their benefits through a Managed Care Organization (MCO) and 13% of enrollees participated in full benefit Medicaid through the Fee for Service (FFS) program. Virginia has been increasing its use of the MCO programs because of the value it provides to enrollees and the Commonwealth.



1.3 Current Medallion 3.0 Operations

Medallion 3.0 currently covers 783,852 members (children, aged, blind, disabled, caretaker parents, pregnant women, and acute care for waiver recipients) across seven (7) regions (see map below).



The table below illustrates enrollment data for the Medallion 3.0 program for February 2017 through July 2017. These numbers include populations that will transition to the Commonwealth Coordinated Care (CCC) Plus program beginning August 1, 2017.

Six Month Medallion 3.0 Enrollment Trend by Region

	CNVA	FSWV	HALF	LSWV	NOVA	TIDW	USWV	Total
Feb 2017	199,430	52,631	45,016	76,627	179,505	170,168	48,021	771,398
Mar 2017	199,959	52,902	45,040	77,299	180,585	171,164	48,561	775,510
Apr 2017	200,416	52,951	45,171	78,082	181,627	172,075	48,885	779,207
May 2017	199,667	53,223	45,392	78,924	182,317	173,103	49,156	781,782
Jun 2017	201,113	53,183	45,617	79,209	182,518	173,002	49,314	783,956
Jul 2017	202,807	53,094	45,690	79,490	183,497	169,794	49,480	783,852

CNVA–Central VA FSWV–Far Southwest VA HALF–Halifax LSWV–Lower Southwest VA NOVA–Northern VA TIDW–Tidewater USWV–Upper Southwest VA

Virginia pays an average monthly capitated payment for each enrollees' services (a "per-member, per-month" (PMPM)) of $349, translating to an annual payment of $4,188 PMPM. Under full risk contracts, the Medallion 3.0 MCOs provide all Medicaid and FAMIS covered benefits (excluding carved-out) and are responsible for a number of additional services, such as 24-hour nurse advice lines; care coordination; maintaining an adequate provider network; processing provider claims; monitoring quality of care; and, participating in reviews conducted by the DMAS contracted External Quality Review Organization (EQRO).

1.4 Commonwealth Coordinated Care (CCC) Plus Program

Beginning August 2017, DMAS will implement the new CCC Plus Program on a regional basis. CCC Plus will serve approximately 214,000 individuals, including children and adults with disabilities and complex needs. CCC Plus will include Medicaid members who:

- Receive Medicare benefits and full Medicaid benefits (dual eligible), including members currently enrolled in the Commonwealth Coordinated Care (CCC) program.
- Are eligible in the Aged, Blind, and Disabled (ABD) Medicaid coverage groups, including 85,920 ABD individuals currently enrolled in the Medallion 3.0 program. These individuals will transition from Medallion 3.0 to CCC Plus on January 1, 2018.
- Receive Medicaid long term services and supports (LTSS) in a nursing facility or through one of DMAS' home and community-based services (HCBS) waivers {This includes the 9,984 home and community-based members who currently are enrolled in Medallion 3.0 for acute care services only}:
  i. Building Independence (BI) {acute services only}
  ii. Family and Individual Support (FIS)
  iii. Community Living (CL)
  iv. Commonwealth Coordinated Care Plus Waiver {formerly the Elderly or Disabled with Consumer-Direction (EDCD) and Technology Assisted (Tech) waivers}

Additional information may be found at http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

1.5 Goals Of MEDALLION 4.0 RFP

RFP 2017-03, MEDALLION 4.0, is the next phase of program improvements to Virginia's managed care delivery system. The MEDALLION 4.0 program, through the contracted MCOs, will be the vehicle through which DMAS will drive innovations in service delivery and payment models for over 737,000 Medicaid and FAMIS members.

The new program will build on the strengths and experience of the twenty year Medallion program and will closely align with the new Commonwealth Coordinated Care Plus (CCC Plus) program. Together and where feasible, Medallion 4.0 and CCC Plus may streamline policies and processes related to a value-based purchasing, common core formulary, data integrity, quality, etc.

MEDALLION 4.0 will:

- Continue to serve children, pregnant women and parents,
- Begin covering and coordinating services, such as Early Intervention and non-traditional behavioral health services, that were previously "carved out" and paid through traditional fee for service Medicaid, and
- Support alternate payment methods in Virginia.

The goals and expectations of the MEDALLION 4.0 Program include:

- Improving quality of life and health outcomes for enrolled individuals;
- Providing a seamless, one-stop system of services;
- Facilitating communication between providers to improve the quality and cost effectiveness of care;
- Providing system-wide monitoring and quality improvement;
- Ensuring the use of culturally, linguistically and ability-appropriate consumer and family educational materials; and
- Increasing appropriate use of screening and prevention services.

DMAS is hereby soliciting proposals from Virginia licensed and qualified Offerors to enter into fully capitated, risk-based contracts to administer a coordinated delivery system that focuses on improving quality, access and efficiency under the Department's Medicaid/FAMIS Managed Care Program, known as MEDALLION 4.0, which includes approximately 737,000 eligible members.

DMAS intends to enter into annual contracts with selected Contractors to provide covered services to members with the possibility of six (6) twelve month renewals. All terms and conditions will be finalized in the MEDALLION 4.0 Contract. Contractors shall adhere to all requirements outlined in the MEDALLION 4.0 Contract. The contracts and rates will be reestablished annually and as needed, subject to CMS approval pursuant to 42 C.F.R § 438.6. Modifications will be issued on an as needed basis.

1.6 TECHNICAL REQUIREMENTS

To be considered, Offerors must respond to all technical requirements, provide all applicable documentation requested in this RFP, and submit proposals in the format outlined in Sections 3.0 through 8.0.

The Offeror shall provide detailed and succinct narratives for how it will define and perform each of the required tasks listed in this RFP. The Offeror's response must demonstrate its understanding of MEDALLION 4.0 populations, ability to perform tasks specified, compliance with the requirements listed in this RFP, and compliance with all requirements and deliverables in the MEDALLION 4.0 Contract. The response shall explain that the Offeror has considered all requirements and developed a specific approach to meeting the requirements to support a successful MEDALLION 4.0 Program. The Offeror shall provide all applicable documentation requested in this RFP. It is not sufficient to simply state that the requirements will be met.

Offerors are required to present innovative ideas in how the requirements outlined in this RFP can be accomplished. The Offeror may propose alternate strategies to accomplish any of the requirements described throughout and how the alternate strategies will meet the DMAS requirements and objectives as appropriate.

Unless otherwise required in this RFP, the Offeror may perform all of the processes outlined in this RFP internally or involve subcontractors for any portion, but the Offeror must identify subcontractors by name and by a description of the services/functions it will be performing. The Offeror shall be wholly responsible for the performance of the resulting contract whether or not subcontractors are used.

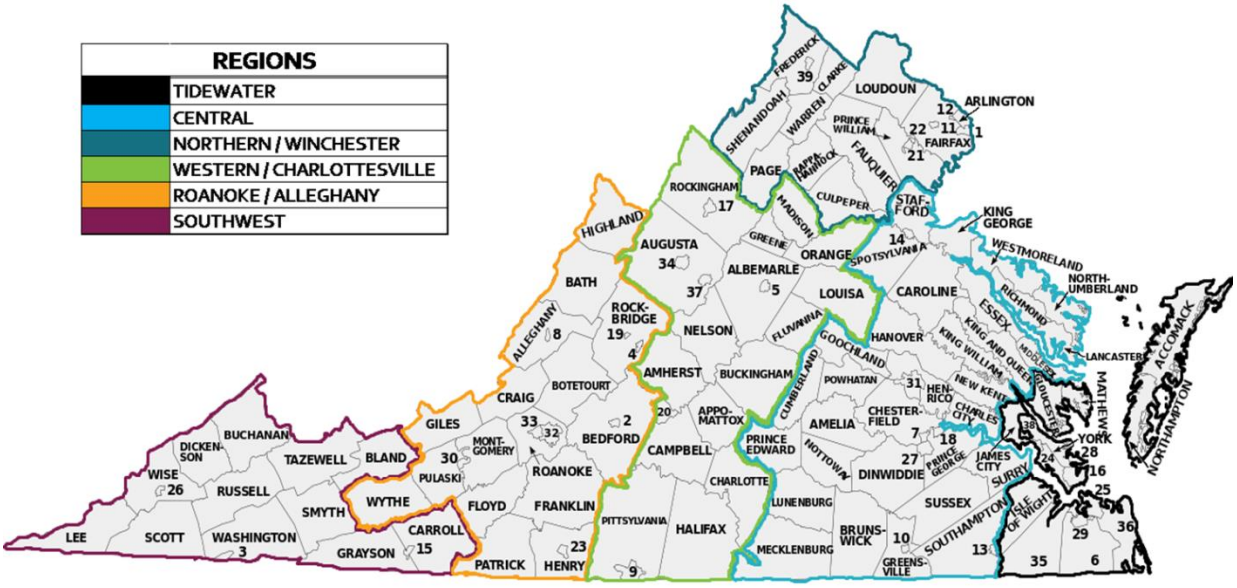
1.7 MEDALLION 4.0 PROGRAM

Throughout this RFP, MEDALLION 4.0 refers to the delivery of acute and primary care services, prescription drug coverage, and behavioral health services (as specified) for approximately 737,000 eligible Medicaid and FAMIS members including infants, children and adults in the low income families with children (LIFC) group, pregnant women, FAMIS, FAMIS MOMS, foster care and adoption assistance, children with special health care needs, and teens. Membership includes those with a third party liability (TPL) policy (excluding dual eligibles).

Although the current Medallion 3.0 program operates statewide in seven (7) regions, the MEDALLION 4.0 Program will operate statewide in six regions (see Attachment A Localities by Regions) and will be implemented by region starting in August 2018. The 2017-2018 Medallion 3.0 Contract will be an 18-month contract for the period of July 1, 2017 through December 31, 2018. As MEDALLION 4.0 is phased in, the Medallion 3.0 program will cease to exist in the specified regions. Contractors shall assume full financial risk for delivering and managing a care delivery system that will administer or arrange for the provision of all covered services as defined in this RFP and resulting Contract.

MEDALLION 4.0 Regions and Proposed Effective Enrollment Dates

Regions	Proposed Effective Dates
Tidewater	August 1, 2018
Central	September 1, 2018
Northern/Winchester	October 1, 2018
Charlottesville/Western	November 1, 2018
Roanoke/Alleghany	December 1, 2018
Southwest	December 1, 2018



1.8 MEDALLION 4.0 Eligible Populations

Contractors shall arrange for the provision of services for approximately 737,000 Medicaid and FAMIS eligible members including infants, children and adults in the low income families with children (LIFC), pregnant women, FAMIS, FAMIS MOMS, foster care and adoption assistance, children with special health care needs, and teens.

Population (as of 07/01/2017)

	Current Population	TPL Excludes Medicare	Totals
Medallion 3 (w/o ABD and HAP)	645,246	27,690	672,936
FAMIS	62,468	1,742	64,210
Potential MEDALLION 4	**707,714**	**29,432**	**737,146**

Potential MEDALLION 4.0 Population by Region (as of 07/01/2017)

AC	Description	Tidewater	Central	Northern/ Winchester	Charlottesville/ Western	Roanoke/ Alleghany	Southwest	Total
005	FAMIS Moms Pregnant Woman, Income > 133% FPL & <= 166% FPL	233	247	404	130	91	49	1,154
006	FAMIS Child under age 6, income >150% poverty and <=200% poverty.	2,577	3,917	6,418	2,009	1,389	633	16,943
007	FAMIS Child 6-19 years old, income >150% poverty and <=200% poverty.	6,991	9,411	14,237	5,161	3,693	1,821	41,314
008	FAMIS Child under age 6, income>133% poverty and <=150% poverty.	152	170	337	103	83	34	879
009	FAMIS Child 6-19 years old, income>133% poverty and <=150% poverty	346	528	731	218	207	86	2,116
010	FAMIS Deemed Newborn <1 year old	239	413	280	126	59	32	1,149
014	FAMIS Deemed Newborn Above 150% FPL	71	117	295	92	49	31	655
070	Former Foster Care. Age 19<26	128	205	114	132	140	84	803
072	Non-IVE Adoption-assistance Child; special Medical Needs Adoption-assistance Individual	1,475	1,782	1,235	1,178	1,051	812	7,533
076	Non-IVE Foster Care Child	915	1,188	680	888	758	608	5,037
081	Protected Covered Individual: Former Money payment Recipient--August 1972; Low-income Family with Child(ren) (LIFC) Individual; 4-month or 12 month-extended Medicaid Recipient	25,032	25,567	12,122	10,254	8,367	5,384	86,726
083	Former Money Payment Recipient--August 1972; Low-Income Family with Child(ren)-Unemployed Parent (LIFC-UP) Individual; 4-month or 12-month extended Medicaid Recipient	5,726	7,672	6,999	4,344	3,966	3,589	32,296
090	Child Under Age 6 with income between 100% and 133% of poverty	4,403	5,728	8,678	3,094	2,464	1,167	25,534
091	Pregnant Woman; Child under age 6 with income <=100% of poverty	33,215	38,038	35,604	16,787	14,391	8,793	146,828
092	Child Age 6 to 19 with income <= 100% poverty (insured or uninsured); Child age 6 to 19 with income > 100% and <=133% poverty (insured)	62,971	72,919	62,058	32,758	27,827	18,627	277,160
093	Newborn Child Under Age 1	6,978	8,741	10,022	4,280	3,352	1,890	35,263
094	Child Age 6 to 19. Income > 100% poverty and <= 133% poverty (uninsured)	9,969	12,795	18,202	6,932	4,940	2,918	55,756
	TOTAL	**161,421**	**189,438**	**178,416**	**88,486**	**72,827**	**46,558**	**737,146**

*AC – aid category

1.9 Other Provisions Impacting MEDALLION 4.0

1.9.1 Medicaid Managed Care Final Rule

In 2016, CMS published the final rule overhauling regulations governing Medicaid Managed Care. The final rule modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. DMAS will implement the MEDALLION 4.0 Program in accordance with these regulatory changes. The final rule can be found at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

Offerors, in response to this RFP, shall provide assurances to comply with all provisions of the Final Rule as they are implemented by the Department.

1.9.2 Joint Legislative Audit and Review Commission (JLARC)

In December 2016, the Virginia Joint Legislative Audit and Review Commission (JLARC) released a report, *Managing Spending in Virginia's Medicaid Program*, (http://jlarc.virginia.gov/medicaid-2016.asp) in response to a directive from the Virginia General Assembly to "review the cost-effectiveness of Virginia's Medicaid program." The report outlined 35 recommendations to manage spending in the programs.

Language related to this JLARC report was included in House Bill 2304 available at http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0749+pdf and in the 2017 Virginia Acts of Assembly, chapter 836. Item 310 U and V (beginning on page 332) https://budget.lis.virginia.gov/get/budget/3279/

Offerors are encouraged to read the full report; and Offerors, in response to this RFP, shall provide assurance to participate in and comply with all initiatives the Department undertakes as a result of these recommendations and/or any other General Assembly recommendations.

1.9.3 Virginia General Assembly

The 2017 Virginia Acts of the Assembly, Chapter 749 (http://lis.virginia.gov/cgi-bin/legp604.exe?171+ful+CHAP0749), directs the Department to impose additional requirements related to submission of data and information by managed care organizations; and requires the Department to implement a number of spending and utilization control measures in conjunction with managed care organizations.

Specifically, the Contractor shall:

- Comply with financial and utilization reporting requirements in the MEDALLION 4.0 Contract and the Managed Care Technical Manual, including requirements for submission of (i) income statements that show medical services expenditures by service category, (ii) statements of revenues and expenses, (iii) information about related party transactions, and (iv) information about service utilization metrics. DMAS shall monitor data submitted by the Contractor to identify undesirable trends in spending and service utilization and work with Contractor to address such trends.
- Comply with the Department's compliance enforcement review process in accordance with the Managed Care Technical Manual, MEDALLION 4.0 Contract, and federal standards.
- Collaborate with the Department and relevant stakeholders, where appropriate, to annually publish a uniform and agreed-upon managed care organization report card for the Department for the managed care program and make such information available to new enrollees as part of the enrollment process.
- Upon the inclusion of behavioral health services in the managed care program, provide to the Department information about (i) the Contractor's policies and processes for identifying behavioral health providers who provide services deemed to be inappropriate to meet the behavioral health needs of the individual receiving services and (ii) the number of such providers that are disenrolled from the Contractor's provider network.
- Comply with the Department's process that allows managed care organizations to determine utilization control measures for services provided but includes monitoring of the impact of utilization controls on utilization rates and spending to assess the effectiveness of each managed care organization's utilization control measures.

Offerors, in response to this RFP, shall provide assurance to participate in and comply with all initiatives the Department undertakes as a result of these requirements and/or any applicable directives passed by the General Assembly related to Medicaid managed care.

1.9.4 Medicaid Enterprise System (MES)

The Department is replacing its Virginia Medicaid Management Information System (VAMMIS) with a Medicaid Enterprise System (MES). During the transition, the Contractor shall exchange data through

the Department's Integrated Services Solution (ISS) vendor and/or other vendor(s) designated by DMAS. The MES will be fully implemented after the initial MEDALLION 4.0 roll-out, therefore, Contractors shall develop/support two different DMAS systems implementations in the first 1-2 years of this Contract.

The ISS vendor and/or other vendor(s) designated by DMAS will establish a secure data exchange between the Contractor and application modules. The ISS vendor will provide a master integration plan and oversee the service oriented architecture (SOA) and environments, and the Commonwealth will implement a State-run Encounter Processing Solution (EPS) supporting the Medicaid Information Technology Architecture (MITA) business processes framework.

The Contractor shall have the ability to produce/consume Simple Object Access Protocol (SOAP), Representational State Transfer (RESTful) web services. The Contractor will exchange with the DMAS EDI Gateway information that is needed to support any electronic standard healthcare transactions that are mandated by DMAS and any other transactions required to operate its solution. The Contractor shall send and accept batch and real-time representations of applicable HIPAA mandated and other standard health care transactions supporting a variety of formats, including but not limited to X12, NCPDP, XML, and JSON formats. The ISS vendor and/or other vendor(s) designated by DMAS will be the source to consume or retrieve data for the Contractor's data requirements.

The Contractor shall establish and maintain the ability to exchange EDI transactions with DMAS' designated MES vendor(s). These transactions may include, but are not limited to the 837P, 834, 820, 835 and 270/271 real-time and batch. All EDI HIPAA compliant transactions must conform with DMAS Business Associate Agreement (BAA) requirements and industry standards, and where applicable are required to meet the HIPAA Security standards for electronic protected health information. Files must be transferred via secure File Transfer Protocol (FTP) utilizing procedures established by DMAS' and/or its designated vendor(s). X12 files shall post based on a predetermined schedule. The Contractor shall comply with all technical procedures and coding requirements as documented in the Virginia DMAS EDI Companion Guides, Procedure Manuals, Technical Manual(s), and other supporting documents referenced in the MEDALLION 4.0 Contract. The Contractor shall maintain and test upgrades to EDI formats as required by DMAS.

The Medallion 4.0 Contractor will be required to work cooperatively with all MES Procurement vendors, as necessary, to enable the new Medicaid Enterprise System to meet the needs of the Commonwealth, and must provide assurances of such intent to cooperate.

Offerors are encouraged to download the MES Procurement RFP available at http://www.dmas.virginia.gov/Content_pgs/RFP_Business_Oppurtunity.aspx for a more complete understanding of the transition from a traditional MMIS to a Medicaid Enterprise System. Offerors, in response to this RFP, shall provide assurance to comply with all system transformations the Department undertakes.

1.9.5 Behavioral Health

Behavioral health services that are typically offered to a commercial population are currently offered through Virginia's contracted MCOs. Community-based behavioral health services (those services that are more typically accessed by the Medicaid population) and services provided in psychiatric residential treatment facilities (PRTFs) currently are offered through a contracted behavioral health services administrator (BHSA).

Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including those provided in psychiatric residential treatment facilities (PRTFs), shall be covered under the MEDALLION 4.0 Program as outlined in Attachment B – Covered Services and the MEDALLION 4.0 Contract. The Contractor also shall be fully responsible for meeting the CMHRS network adequacy standards.

Additional information about Community Mental Health Rehabilitation Services may be found at http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx and at the Magellan of Virginia website http://magellanofvirginia.com/.

The Offeror, in response to this RFP, shall explain in detail a full understanding of and experience in providing non-traditional community mental health services that will be covered under the MEDALLION 4.0 Contract.

1.9.6 Optional Services

The Department is interested in the Offeror's capabilities and expertise in providing services described in this section. Services may be implemented at the Department's discretion during the period of the contract resulting from this RFP. The Offeror's proposal shall describe the Offeror's abilities, experience, and process for each of these optional services.

DMAS will provide additional information regarding volume and participation, start-up and implementation periods, DMAS guidelines, and any additional services required from the Contractor for these services as this information is made available. As the initiatives described below are in the early phase of discussion, the information and the related requirements provided for these initiatives are subject to change.

1.9.6.1 School Based Services

Virginia's public schools provide health related services to children enrolled in special education. DMAS' School Services program helps public schools fund those health related services in the child's Individualized Education Program (IEP). The following special education health services are covered for billing school divisions: physical therapy, occupational therapy, and speech-language pathology services; skilled nursing services; psychiatric, psychological, and mental health services; and medical assessments.

Currently, school based services are provided to managed care enrollees under the age of 23 as a carved-out service.

Additional information may be found at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

1.9.6.2 Dental Services

Currently, dental services are carved-out of the managed care program and provided through a dental benefits administrator. The *Smiles For Children* began July 1, 2005 and provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS and FAMIS Plus children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). In March 2015, *Smiles For Children* began providing appropriate dental benefits (excluding orthodontics) to pregnant women age 21 and over enrolled in Medicaid and FAMIS MOMS.

Additional information may be found at http://www.dmas.virginia.gov/content_pgs/dnt-home.aspx.

1.9.6.3 Plan First Family Planning

Plan First is a program for eligible men and women that covers birth control and services to help prevent unplanned pregnancies. The goals of Plan First are to decrease unintended pregnancies and infant mortality rates, and increase spacing between births and positive birth outcomes.

Plan First coverage is limited to family planning (birth control) services and is not considered full coverage Medicaid. Men and women who meet the income requirements but do not qualify for a full-benefit Medicaid program may be eligible for the limited benefit Plan First.

Plan First covers:

- Annual physical exam for family planning (birth control)purposes, including PAP test (if appropriate), and sexually transmitted infection (STI) testing;
- Family planning education & counseling;
- Birth control methods provided by a clinician or obtained with a prescription such as contraceptive implants, ring, patch, IUDs, birth control pills, diaphragms, and Depo Provera
- Sterilizations for members over age 21, including tubal ligation or vasectomy, if that is your choice; and
- Non-emergency transportation to family planning services.

Additional information may be found at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

SECTION 2.0 GLOSSARY

Listed below are the Definitions and Acronyms used in this RFP. These terms utilize the meaning used in the MEDALLION 4.0 program rules and regulations. However, the following terms, when used in this RFP, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other sections of this RFP, the specific language in the RFP shall govern.

2.1 DEFINITIONS

Abuse – 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.

Accreditation – The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by a recognized industry standard accrediting agency, such as NCQA. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

Actuarially Sound Capitation Rates - As defined in 42 C.F.R. § 438.4 means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; and have been certified as actuarially sound by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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

Acute Care – Preventive care, primary care, and other inpatient and outpatient medical and behavioral health care provided under the direction of a physician for a condition having a relatively short duration.

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

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, a prepaid inpatient health plan (PIHP), or a prepaid ambulatory health plan (PAHP), 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; (iv) The failure to provide services in a timely manner, as defined by the State; (v) the failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §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 MCO, the denial of a member's request to exercise his or her right, under §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.

All Payers 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.

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 shall include, but not be limited to, braille, large font, audio tape, video tape, and information read aloud to an enrollee.

Ameliorate – Necessary to improve or to prevent the condition from getting worse, with regard to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

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

Appeal (Enrollee) – In accordance with 42 C.F.R. § 438.400, it is a request for review of a Contractor's internal appeal decision to uphold the Contractor's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the Contractor's one step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Appeal (Provider) – Requests made by the Contractor's providers (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 administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (*Code of Virginia* section 2.2-4000 et seq.) and Virginia Medicaid's provider appeal regulations (12 VAC 30-20-500 et seq.).

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

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.

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 RFP, Health Homes will not need to meet the standards set forth in §2703 of the Patient Protection and Affordable Care Act.

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

"Traditional Behavioral Health & Substance Abuse Treatment Services" are defined as inpatient and outpatient behavioral health and substance abuse treatment services, including care coordination services that are covered by the Contractor under the terms of this contract.

"Non-Traditional Behavioral Health & Substance Abuse Treatment Services" are defined as the subset of community mental health and rehabilitation services that are covered by the Department

or its designee in accordance with the Department's established criteria and guidelines. Effective December 1, 2018, these services shall be covered by the Contractor.

Behavioral Health Services Administrator (BHSA) – An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. The Contractor may subcontract with a BHSA for administration of behavioral health benefits for Title XIX Medicaid individuals and Title XXI FAMIS members to include care coordination, provider management, and reimbursement of such behavioral health services.

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

Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Time, except for state holidays and unless otherwise stated.

Capitation Payment – A payment the Department makes periodically to a Contractor on behalf of each individual enrolled under a contract for the provision of services under the State Plan and waivers, regardless of whether the individual receives services during the period covered by the payment. Any and all costs incurred by the Contractor in excess of the capitation payment shall be borne in full by the Contractor.

Capitation Rate – The monthly amount, payable to the Contractor, per individual, for the provision of contract services as defined herein. The Contractor shall accept the annually established capitation rates paid each month by the Department as payment in full for all Medicaid and FAMIS services to be provided pursuant to the Contract resulting from this RFP and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Care Coordination – The Contractor's responsibility of assessing and planning of services; linking the individual to services and supports; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family members involved with the individual; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling that guides the individual and develops a supportive relationship.

Carved-Out Services – The subset of covered services for which the Contractor shall not be responsible under the program.

Case Management - The process of identification of patient needs and the development and implementation of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

Centers for Medicare & Medicaid Services (CMS) – The agency of the United States Department of Health and Human Services responsible for the administration of Titles XVIII, XIX, and XXI of the Social Security Act.

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

C.F.R. – Code of Federal Regulations

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

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

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

Community Service Board (CSB) – A citizens' board established pursuant to Virginia Code §37.2-500 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-500) and §37.2-600 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-600) that provides mental health, intellectual 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).

Complaint – See definition for "grievance."

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.

Contract – The signed and executed MEDALLION 4.0 document resulting from this RFP, including all Attachments or documents incorporated by reference.

Contractor – A managed care organization selected and contracted with DMAS to participate in the MEDALLION 4.0 program.

Coordination of Benefits (COB) or Coordination of Other Coverage – A method of integrating benefits payable under more than one form of health insurance coverage so that the covered member's benefits from all sources do not exceed 100 percent of the allowable medical expenses. COB rules also establish which plan is primary (pays first) and which plan is secondary; recognizing that Medicaid is the payer of last resort.

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

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

COV Security Standards – COV Information Technology Resource Management (ITRM) policies, standards, and guidelines that may be updated from time to time. A complete list can be located at http://www.vita.virginia.gov/library/default.aspx?id=537.

Covered Services – The subset of services for which the Contractor shall be responsible for covering under the program.

Credentialing – The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility to deliver covered services.

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

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

Days - Business days, unless otherwise specified.

Department of Medical Assistance Services (DMAS or 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.

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

Disenrollment – The process of changing enrollment from one Contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

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

Early Intervention (EI) – Services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three (3) who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

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

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance use disorder) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman 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 woman or the unborn child.

Emergency Services – Those health and/or behavioral health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms or behavior of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

Emerging High-Risk Member - Members who have limited or no current medical, or behavioral health needs, but may have needs in the future.

Encounter Data – Data collected by the Contractor documenting all of the health care and related services provided to a member. These services include, but are not limited to, inpatient and outpatient medical and behavioral treatment services, professional services, home health, medical supplies or equipment, medications, community behavioral health, and transportation services. Encounter data is collected on an individual member level and includes the person's Medicaid/FAMIS ID number. It also is specific in terms of the provider, the medical procedure, and the date the service was provided. DMAS 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.

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

Enhanced Benefits – Benefits Contractors may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor's capitation rates.

Enrollment – Assignment of an individual to a Contractor by the Department. This does not include attaining eligibility for the Medicaid program.

Enrollment Period – The time that a member is enrolled with a Contractor.

Excluded Entity - Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Section 3.2.4 of this RFP.

Exclusion from Managed Care/Exclusion from Medallion 4.0 - The removal of a member from the Medallion 4.0 Program on a temporary or permanent basis.

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

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

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

FAMIS – Family Access to Medical Insurance Security Plan - A comprehensive health insurance program for Virginia's children. FAMIS is administered by and is funded by the state and federal government. Also referred to as Title XXI or the state's CHIP (Children's Health Insurance Program).

FAMIS MOMS Members - Members who are uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level (plus a 5% disregard), and who are assigned and enrolled in the aid category of 05. Covered services for FAMIS MOMs are the same as the covered services for MEDALLION 4.0 members. Other MCO exemptions are specific to the Medicaid MEDALLION 4.0 program.

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

Fee-for-Service (FFS) – The traditional health care payment system administered by the Department in which 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. Firewall also includes physical security measures that establish barriers between staff, the public, work

areas, and data to ensure information is not shared inappropriately or in violation of any applicable State or Federal laws and regulations.

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

Formulary – A list of prescription drugs that the Contractor has approved. Dispensing some of the drugs may require service authorization for reimbursement.

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

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

Grievance – In accordance with 42 C.F.R. § 438.400, grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. 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.

Health and Acute Care Program (HAP) – Managed care program that provides acute and primary medical services to individuals enrolled in one of five HCBS waivers. Waiver services are paid as carved out services. This includes individuals enrolled in the Elderly or Disabled with Consumer-Direction (EDCD) Waiver, the Intellectual Disability (ID) Waiver, the Individuals and Family Developmental Disabilities Support (IFDDS) Waiver, the Day Support (DS) Waiver, and the Alzheimer's Assisted Living (AAL) Waiver. HAP individuals (other than AAL Waiver participants) will transition to CCC Plus and will be excluded in MEDALLION 4.0.

Health Insurance Portability & 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, Contractors, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.

Healthcare Effectiveness Data and Information Set (HEDIS) – Tool developed and maintained by the National Committee for Quality Assurance that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality.

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

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

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

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

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

Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) - A program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § 303.12) administered by the Virginia Department of Behavioral Health and Developmental Services. Early Intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development.

Informational Materials - In accordance with 438.10, written communications from the Contractor to members that educates and informs about services, policies, procedures, or programs specifically related to Medicaid/FAMIS.

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

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

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

Investigation – As used in this RFP 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. DMAS reserves the right to expand upon any investigation.

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

Local Lead Agency - 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.*

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 or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this RFP, and in accordance with 42 C.F.R. § 438.2, an entity that has qualified to provide the services covered under this RFP 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 C.F.R. § 438.116.

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

Marketing 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.

Medallion 3.0 – A statewide mandatory Medicaid program that operates under a CMS §1915(b) waiver and utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. Medallion 3.0 serves over 700,000 members: children, individuals who are aged, blind, and/or disabled, care taker parents, pregnant women, and acute care for waiver individuals. MEDALLION 4.0 will replace the Medallion 3.0 program.

Medallion Care System Partnership (MCSP) - An arrangement, such as a health care home, with the goal of improving health outcomes for members whereby the Managed Care Organizations form

partnerships and contractual arrangements tied to gain and/or risk sharing, performance-based incentives, and other Commonwealth-approved quality metrics and financial performance in an effort to increase participation of integrated provider health care delivery systems.

Medicaid – The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof.

Medicaid Covered Services – Services reimbursed by DMAS as defined in the Virginia Medicaid State Plan for Medical Assistance or State regulations.

Medicaid Enterprise System (MES) – DMAS is modernizing its technology system in accordance with CMS' MITA framework to replace the current Medicaid Management Information System.

Medicaid Fraud Control Unit (MFCU) – 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 Non-Covered Services – Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia Medicaid State Plan for Medical Assistance or State regulations.

Medical Necessity or Medically Necessary – 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 21) in accordance with 42 C.F.R. § 441 Subpart B (Sections 50-62) and Federal regulations as defined in 42 C.F.R. § 438.210 and 42 C.F.R. § 440.230.

Member Handbook – In accordance with 42 C.F.R. § 438.10, a document required by the Contract to be provided by the Contractor to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, member eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, member services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

Member, Individual, Recipient, Enrollee, Participant, or Client – Any person having current Medicaid/FAMIS eligibility and authorized by the Department to participate in the MEDALLION 4.0 program.

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.

MITA - The Medicaid Information Technology Architecture (MITA) initiative sponsored by the Center for Medicare and Medicaid Services (CMS) is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. The MITA Initiative is a national framework to support improved systems development and health care management for the Medicaid enterprise. MITA has a number of goals, including development of seamless and integrated systems that communicate effectively through interoperability and common standards.

Monitoring – The ongoing oversight of the provision of services to determine that services are administered according to the individual's plan of care 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 individual and/or the individual's family, as appropriate, and in person or by telephone, and/or interviewing service providers.

Monthly - For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period (except where otherwise specified by contract or technical manual). For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

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

National Provider Identifier (NPI) – A national health identifier for all typical health care providers, as assigned by NPPES. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers (including participating, non-participating, servicing, billing, ordering, referring, prescribing, attending, etc.) who provide services to individuals enrolled in MEDALLION 4.0 will be required to have and use an NPI.

Network Provider – The health care entity or health care professional who is either employed by or has executed a contract with the Contractor or its subcontractor to render covered services to members as defined in this RFP.

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

Nursing Facility (NF)/Certified Nursing Facility – Any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care 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.

Offeror – Unless otherwise stated, the entity that is offering a proposal in response to this RFP.

Ombudsman – The independent State entity that will provide advocacy and problem-resolution support for MEDALLION 4.0 participants, and serve as an early and consistent means of identifying systemic problems.

Open Enrollment – The time frame in which members are allowed to change from one MCO to another, without cause, at least once every 12 months per 42 C.F.R. § 438.56 (c)(2) and (f)(1). For Medallion 4.0 members, open enrollment timeframes are based upon the Department's regional open enrollment effective date. Within sixty (60) days prior to the open enrollment begin date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO shall remain in his or her current health plan selection until their next open enrollment period, unless they meet a good cause qualifying event.

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

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

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

Performance Incentive Award (PIA) - A program instituted by the Department that rewards or penalizes managed care organizations with possible incentive payments based upon the quality of care received by Virginia's Medicaid/FAMIS 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 C.F.R. 455 Subpart B, means a person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor's capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor.

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

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

Pre-Payment 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.

Prevalent Languages – When five (5) percent of the Contractor's enrolled population is non-English speaking and speaks a common language other than English.

Previously Authorized – As described in 42 C.F.R. § 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example: If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the 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.

Primary Care Provider (PCP) – A practitioner who provides preventive and primary medical care for eligible individuals 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, and clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Privacy – Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 C.F.R. §§ 431.300 through 431.307, as well as relevant Virginia privacy laws.

Private Duty Nursing – Nursing care services available for children under age 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.

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.

Provider Contract – An agreement between a Contractor and a provider that describes the conditions under which the provider agrees to furnish covered services to members under this Contract. All provider contract templates for Medicaid/FAMIS-funded services between the Contractor and a provider must be approved by DMAS.

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 disorder providers, community providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor.

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

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, Contractors, and/or members.

Quarterly - For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each calendar quarter (except where otherwise specified by contract or technical manual).

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

Reassessment – The periodic, but at least annual, review of an individual's condition and service needs.

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

Residential Treatment Facilities (Level C) (RTC)/ Psychiatric Residential Treatment Facilities (PRTFs)– A facility as defined in 12 VAC 30-130-860, as amended.

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

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

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

Safety Net Providers – Providers that organize and deliver a significant level of healthcare and other related services to Medicaid, FAMIS, uninsured, and other vulnerable populations.

Serious Emotional Disturbance – Used to refer to children, age birth through seventeen (17), who have had a serious mental health problem diagnosed under the DSM or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one

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 or more agency (see http://www.dbhds.virginia.gov/ for additional information).

Service Authorization (SA)/Prior Authorization (PA) – 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.

Social Determinants – Economic and social conditions that affect health risk and outcomes.

Stabilized – As defined in 42 C.F.R. § 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 woman who is having contractions, that the woman has delivered the child and the placenta.

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

State Institution for Mental Disease or State-run IMD or State Mental Hospital - A hospital, psychiatric institute, or other institution operated by the Department Behavioral Health and Developmental Services 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 otherwise covered by the resulting MEDALLION 4.0 contract but are medically appropriate, cost effective substitutes for state plan services included within the resulting MEDALLION 4.0 contract (for example, a service provided in an ambulatory surgical center or sub-acute care facilities, rather than an inpatient hospital). However, the Contractor shall not require a member to use a state plan substituted service/"in lieu of" arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

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

Subcontractor – A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities under this contract. For the purposes of this RFP, the subcontractor's providers shall also be considered providers of the Contractor.

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

Successor Law or Regulation – That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or

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

Technical Manual - A document developed by the Department that provides the technical specifications for the submission of encounters and/or 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/reports, and Departmental processes such as the processing of incarcerated members and the reconciliation of payments for newborn members.

Telehealth – The use of electronic information and telecommunications to support remote or long-distance health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services. Telehealth refers to all remote health care services which may include non-clinical services, such as provider training, administrative public health sessions, and continuing medical education. In contrast, telemedicine only refers to clinical remote technologies for the purpose of medical diagnosis and treatment.

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

Third-Party Liability (TPL) – Any entity (including another government program or insurance) that is, or may be liable to pay all or part of the medical cost for injury, disease, or disability of an applicant or recipient of Medicaid.

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 has played in their lives.

Treatment Foster Care (TFC) Case Management (CM) – Serves children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) 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.

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

Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical 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.

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

Value-Based Payment (VBP) – A broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures. Public and private payers use VBP strategies in an effort to drive improvements in quality and to slow the growth in health care spending.

Virginia Administrative Code (VAC) – Contains regulations of all of the Virginia State Agencies.

Waste – The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. This is generally not considered 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.

2.2 ACRONYMS

APM -- Alternate Payment Model
ARTS -- Addiction and Recovery Treatment Services
BAA -- Business Associate Agreement
BHA – Behavioral Health Authority
BHSA -- Behavioral Health Services Administrator
BOI -- Bureau of Insurance of the Virginia State Corporation Commission
CAHPS® -- Consumer Assessment of Healthcare Providers and Systems
CCBHC -- Certified Community Behavioral Health Clinic
C.F.R. -- Code of Federal Regulations
CMS -- Centers for Medicare and Medicaid Services
CMHRS -- Community Mental Health Rehabilitative Services
CSB -- Community Service Board
CY -- Calendar Year
CYSHCN -- Children and Youth with Special Health Care Needs
DBHDS -- Department of Behavioral Health and Developmental Services
DMAS -- Department of Medical Assistance Services
DSS -- Department of Social Services
EDI – Electronic Data Interchange
EI -- Early Intervention
EPSDT -- Early and Periodic Screening, Diagnostic, and Treatment
EQR -- External Quality Review
EQRO -- External Quality Review Organization
FAMIS -- Family Access to Medical Insurance Security
FFS -- Fee-for-Service
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
HAP -- Health and Acute Care Program
HCPCS -- Healthcare Common Procedure Coding System
HEDIS -- Healthcare Effectiveness Data and Information Set
HIPAA -- Health Insurance Portability and Accountability Act of 1996
HRA -- Health Risk Assessment
ICF/ID -- Intermediate Care Facility/Individuals with Intellectual Disabilities
ID -- Identification
IDEA -- Individuals with Disabilities Education Act.
IDEA-EIS -- Individuals with Disabilities Education Act - Early Intervention Services
IEP -- Individual Education Plan
IFSP -- Individual Family Service Plan
IHS -- Indian Health Services
I/T/U -- Indian Tribe, Tribal Organization, or Urban Indian Organization
IMD -- Institution for Mental Disease
LARC -- Long Acting Reversible Contraceptive

LDSS -- Local Department of Social Services
LEIE -- Listing of Excluded Individuals and Entities
LIFC -- Low Income Families and Children
MCHIP -- Managed Care Health Insurance Plans
MCO -- Managed Care Organization
MES -- Medicaid Enterprise System
MFCU -- Medicaid Fraud Control Unit
MITA - Medicaid Information Technology Architecture
MLTSS -- Managed Long Term Services and Supports
MMIS -- Medicaid Management Information System (also known as VAMMIS)
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
NF -- Nursing Facility
NPDB -- National Practitioner Data Bank
NPI -- National Provider Identifier
OIG -- Office of Inspector General
PA -- Prior Authorization (also known as Service Authorization)
PCP -- Primary Care Provider
PHI -- Protected Health Information
PIP -- Physician Incentive Plan
POC -- Plan of Care
PPE -- Provider Preventable Event (refer to Provider Preventable Condition)
PRTF -- Psychiatric Residential Treatment Facilities (formerly RTC)
PUMS -- Patient Utilization Management & Safety Program
QI -- Quality Improvement
QIP -- Quality Improvement Program
RHC -- Rural Health Clinics
RN -- Registered Nurse
SA -- Service Authorization (formally known as Prior Authorization)
SMI -- Serious Mental Illness
SPO -- State Plan Options
SSI -- Social Security Income
SSN -- Social Security Number
SUD -- Substance Use Disorder
TDO -- Temporary Detention Order
TFCCM -- Treatment Foster Care Case Management
TPL -- Third-Party Liability
TTY/TDD -- Teletype/Telecommunication Device for the Deaf
UM -- Utilization Management
USC -- United States Code
VAC -- Virginia Administrative Code
VAMMIS -- Virginia Medicaid Management Information System
VBP -- Value Based Payment
XYZ -- Any Named Entity

SECTION 3.0 ADMINISTRATIVE REQUIREMENTS

3.1 EXECUTIVE SUMMARY

The Executive Summary response shall highlight the Offeror's:

1. Overall approach to the scope of work and a summary of the content of the proposal.
2. Qualifications and experience as a Medicaid contracted health plan in the provision of all services to all populations specified in this RFP, particularly experience with women, pregnant women, infants, children, and children/youth with special health care needs.
3. Proposed regions of service. Regions are "all or nothing" and no individual FIPS codes within a region may be selected.
4. Commitment to DMAS' goals for MEDALLION 4.0 and Medicaid/FAMIS delivery system and payment transformation.
5. Commitment to work with DMAS on MEDALLION 4.0 pilot projects and new initiatives that may occur mid-year in the contract cycle including but not limited to implementing federal or state mandates, including JLARC recommendations, etc.

3.2 CORPORATE OVERVIEW

3.2.1 Licensure and Financial Participation Requirements

If currently operating in Virginia, the Offeror must submit a copy of its valid and current license (not under suspension or revocation) from the Virginia State Corporation Commission's Bureau of Insurance (BOI), and copies of quarterly and annual filings submitted to the BOI within the past three (3) calendar years.

If the Offeror does not have a valid and current license from the BOI to operate as a licensed health plan in Virginia, the Offeror must submit a copy of its last three (3) years of independently audited financial statements with the proposal. In addition, the Offeror must submit its financial plan that details how it would raise the capital required by BOI to operate as a health plan in Virginia as well as any similar state insurance department reporting in other states in which the Offeror is operating a Medicaid product line.

The Offeror must meet the solvency standards described in 42 C.F.R § 438.116 and shall retain the appropriate licensures at all times during the period of the contract, including licensure by the State Corporation Commission as set forth in the *Code of Virginia* § 38.2-4300 through § 38.2-4323, 14 VAC 5-211-10 et seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.

3.2.2 Certification

Pursuant to §32.1-137.1 through § 32.137 of the *Code of Virginia*, and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services it delivers.

If currently operating in a proposed region, the Offeror shall submit a copy of service area approval and certificate for each region(s) that the Offeror is proposing to operate. This approval is issued by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection.

If the Offeror is not currently operating in Virginia or in a proposed region, the Offeror must submit a copy of its application for service area approval with the proposal and the service area approval and certificate prior to MEDALLION 4.0 contract signing (if selected).

3.2.3 NCQA Accreditation

The Contractor must adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Offerors accredited by NCQA for the Virginia Medicaid line of business at the time of proposal submission shall submit verification and its most NCQA accreditation level in response to this RFP. Offerors not accredited by NCQA for the Virginia Medicaid line of business shall submit a plan and timeline indicating how it shall obtain accreditation for the Virginia Medicaid line of business and shall submit verification of NCQA accreditation and most recent NCQA accreditation level for a Medicaid line of business in another state Medicaid program similar in scope to this RFP. All Offerors shall explain its ability to retain accreditation, and how the entity shall meet all NCQA reporting requirements and standards.

Denial or revocation of NCQA accreditation status or a status of "Provisional" may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA.

3.2.4 Prohibited Affiliations with Entities Debarred by Federal Agencies

In accordance with requirements described in 42 C.F.R. §§ 438.610, 438.214(d)(1), and 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at http://www.cms.gov/smdl/downloads/SMD061208.pdf), the Contractor shall comply with all of the following Federal requirements. Failure to comply with accuracy, timeliness, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

Contractor Owner, Director, Officer(s) and/or Managing Employees:
The Contractor and or its subcontractors may not knowingly have a relationship of the type described below with:

1. An individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described below.

The relationships described in this section are as follows:

1. A director, officer, or partner of the Contractor
2. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity.
3. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

Consistent with Federal disclosure requirements described in 42 C.F.R. §§ 455.100 through 42 C.F.R. 455.106 and 438.610, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)* included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing.

In response to this RFP and on an annual basis, the Offeror shall provide the required information using the Disclosure of Ownership and Control Interest Statement (CMS 1513).

3.2.5 Corporate Structure

In response to this RFP, the Offeror shall submit an organizational chart, and description of the Offeror's corporate structure. This must include the Offeror's parent organization, its subsidiaries, and businesses owned. It also must explain the relationships between these entities and how long each has operated under the Offeror's parent organization. The Offeror also shall describe the major business services provided and any physical and digital firewalls that exist to prevent any conflicts of interest and to maintain the highest level of security and program integrity.

The Offeror also shall submit:

1. Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written
2. Federal Employer ID number
3. Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers)
4. List of board members and their organizational affiliations and
5. Legal status and whether it is a for-profit or a not-for-profit company
6. Most recent annual report to the Board of Directors for the Medicaid product line

In response to this RFP, the Offeror shall include a description of the proposed geographical locations of all office locations associated with operations under this RFP, and the operations handled from these locations (particularly note any Virginia-based locations that will be used). The central business office shall be located in the Commonwealth of Virginia. In addition, the proposed hours of operation shall be noted for each office. The Offeror shall clearly identify any overseas locations that may be used to support the resultant contract or any related transactions. If any aspect of the Contractors operation is conducted outside of the Commonwealth of Virginia, the Contractor shall pay for air travel and lodging (to include meals) for two DMAS staff to conduct site visits semi-annually.

In addition, Offerors shall describe strategies for each region proposed that demonstrate its plans to be good corporate citizens, investments in each community, and processes for community engagement/social responsibility activities.

3.3 Staff For Virginia Operations

The Offeror shall propose the specific Virginia team responsible for delivery and operations of the MEDALLION 4.0 program in each of the proposed regions. This team should have the ability to make rapid-cycle decisions. The Offeror shall describe the decision-making authority of the Virginia team to ensure timely and responsive decisions while enabling high-quality delivery.

The Offeror shall have a dedicated full-time Virginia MEDALLION 4.0 Project Director, MEDALLION 4.0 Project Manager, Virginia licensed Medical Director, and Behavioral Health Lead, and Quality Improvement Manager. These key staff must be located in Virginia. Provider relations and care coordination staff shall be located within the Commonwealth of Virginia and preferably in the geographic region(s) where the Offeror proposes to operate.

The MEDALLION 4.0 Project Director and the MEDALLION 4.0 Project Manager are expected to attend all required meetings as required by DMAS. Other key staff shall attend meetings as requested by DMAS.

The MEDALLION 4.0 Project Director shall be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia MEDALLION 4.0 business, claims payment, and provider relations/contracting. Additionally, the Virginia MEDALLION 4.0 Project Director must be directly employed by the Contractor and 100% dedicated to the MEDALLION 4.0 program and operations.

The MEDALLION 4.0 Project Manager shall be able to make decisions about MEDALLION 4.0 program issues and shall represent the Contractor at the Department's meetings. The MEDALLION 4.0 Project Manager must be able to respond to issues involving information systems and reporting, appeals, quality improvement, member services, service management, pharmacy management, medical management, care coordination, and issues related to the health, safety and welfare of the member.

The Contractor shall immediately notify DMAS whenever a key staff member vacates the assigned position. The Contractor shall also notify DMAS when the position is filled temporarily and permanently and by whom. Key staff include Virginia MEDALLION 4.0 Project Director, Project Manager, Quality Improvement Program Manager, Care Coordination Manager, Virginia licensed Medical Director, and top leadership positions including individuals responsible for network recruitment, credentialing and management, medical oversight, behavioral health oversight, pharmacy oversight, quality, financial management, claims payment, utilization management, and IT management.

If DMAS is concerned that any of the key personnel are not performing their responsibilities, DMAS shall inform the Contractor of this concern. The Contractor shall investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of the MEDALLION 4.0 Contract, and notify DMAS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of the MEDALLION 4.0 Contract, as determined by DMAS, corrective action provisions may be invoked by DMAS.

The Offeror shall include its proposed organizational structure for the Virginia team with names of the MEDALLION 4.0 Project Director, MEDALLION 4.0 Project Manager, and top leadership positions including individuals responsible for network recruitment, credentialing and management, quality improvement, care coordination, financial management, claims payment, utilization management, IT management, and oversight of medical services, behavioral health services, and pharmacy services.

The Offeror shall submit job descriptions and resumes outlining the qualifications of the MEDALLION 4.0 Project Director, MEDALLION 4.0 Project Manager, Virginia licensed Medical Director, and MEDALLION 4.0 Behavioral Health Lead. In addition, the Offeror shall submit job descriptions and resumes, if available, for the other top leadership positions. Resumes must be limited to two pages. The resumes of proposed personnel must include qualifications, experience, relevant education, professional certifications, and training for the positions they will fill.

The Offeror also shall include the proposed staffing plan (key staff and all other staff members) including the total number of proposed Virginia MEDALLION 4.0 FTEs by position and region. The staffing plan shall provide details on all needed functions including all the administrative, care coordination, and clinical oversight functions. The plan also shall detail the number of staff to be employed and number of staff to be obtained through subcontracting arrangements. If the Offeror plans to subcontract some positions, the Offeror must explain the roles for which it plans to subcontract and the oversight and management plan to ensure high quality delivery.

At a minimum, care coordinators assigned to MEDALLION 4.0 members shall have at least a bachelor's degree in a health or human services field or be a Registered Nurse or Licensed Practical Nurse (LPN). All care coordinators shall have at least one year of experience directly working with individuals who meet the MEDALLION 4.0 target population criteria. Licensed or certified care coordinators must be licensed or certified in Virginia or hold a multi-state license recognized by Virginia in accordance with §54.1-3030, et. seq., and 3040.1 et. seq., of the *Code of Virginia*. For members receiving private duty nursing services, the care coordinator shall be a registered nurse who is licensed in Virginia or holds a multi-state license recognized by Virginia and has at least one year of related clinical nursing experience with medically complex members.

A care coordinator's direct supervisor shall be a Licensed Social Worker, Licensed Mental Health Professional (as defined in 12 VAC 35-105-20) or registered care nurse with a minimum of two (2) years of relevant Medicaid health care experience. Care coordinators and their direct supervisors shall have demonstrated ability to communicate with members who have complex medical needs and may have communication barriers.

The Offeror shall establish care coordination staffing ratios that ensure compliance with all required care coordination activities required under this program. The Contractor's standards for care coordination ratios shall at least meet the Department's staffing ratio requirements in the table below. The Contractors shall be accountable for maintaining at least these caseload ratios at all times. The Contractor shall have sufficient care coordination staff to properly and timely perform the requirements as outlined in the Contract.

MEDALLION 4.0 Care Coordination Staffing Ratios by Populations		
MEDALLION 4.0 Target Populations	Vulnerable Subpopulations	Emerging High Risk Populations (Individuals Other Than Vulnerable Subpopulations)
Required Care Coordinator Ratio	1:100	1:350

Vulnerable subpopulations include children and youth with special health care needs, adults with serious mental illness, children with serious emotional disturbances, members with substance use disorders, children in foster care or adoption assistance, women with a high risk pregnancy, and members with other complex or multiple chronic conditions.

Care coordinators may have a "blended" caseload comprised of members in more than one sub-population to meet business operational needs or provide continuity of care for members as long as the standard ratio thresholds are met.

Adequate information management personnel and resources shall be in place to meet all standards and procedures regarding receipt, processing, and transmission of program data and information as outlined in the MEDALLION 4.0 Contract.

In response to this RFP, the Offeror shall describe quantitative methods it will use to identify and monitor members classified as vulnerable subpopulations and members with high-utilization or emerging high-risk factors. The Offeror shall describe how it will use this information to improve care coordination. The Offeror shall provide an explanation of this process (including the personnel involved, the metrics for identification of member trend analysis, etc.) and describe how the effectiveness of strategies implemented will be evaluated.

The Offeror shall submit a staff training approach for initial onboarding and ongoing training. In addition to the training approach for the entire MEDALLION 4.0 program, the Offeror's training approach shall include in-depth training on Virginia Medicaid behavioral health. The Offeror also shall submit its knowledge transfer approach as new staff are added to the Virginia team. This approach shall include a detailed plan on ensuring continuity of operations and provider relationships as staff transition to new roles.

3.4 COMMUNICATIONS

In response to the RFP, the Offeror shall describe the proposed overall communications structure, internal communications sharing and storage, and training and management on communications infrastructure.

Overall Communications Structure
Describe the Offeror's overall communication structure related to the entire MEDALLION 4.0 Program. In the Offeror's description, include how the communication structure connects the Offeror's internal staff, providers, members, public, and regulatory agencies. Provide details regarding accessibility of all systems of communication and the specific information available for each type of end-user.

Internal Communications Sharing and Storage
Describe how the Offeror preserves communications as evidence of care and contacts. Detail the specific internal processes used by the Offeror's staff for documentation of member contacts (e.g., customer service, care coordination, grievance and appeals, 24/7 nurse advice line, and any web-based telehealth approach) and how this information is integrated into the overall care coordination activities.

Training on Communication Infrastructure
Describe how the Offeror will provide outreach, training, and technical assistance on how to use each of the Offeror's modes of communication.

Management of Communication Infrastructure
Describe the Offeror's staff who have oversight responsibility for monitoring and evaluating communication effectiveness.

In response to this RFP, the Offeror also shall submit for review any tools or flow charts that illustrate the proposed communications processes.

3.5 CALL CENTER

A 24 hours per day, 7 days a week, toll-free call center (for members and providers) to respond to questions, concerns, inquiries, and complaints, shall be established and operated in accordance with the requirements detailed in this RFP and Section 3.5.1 and as further defined in the MEDALLION 4.0 Contract resulting from this RFP. DMAS requires a highly effective, responsive and quality-driven operation. Timely and accurate responses to member inquiries are required, while maintaining confidentiality of information. The call center shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues. Further, the call center shall be adequately staffed with qualified personnel who are trained to accurately respond to member and provider questions, including questions and concerns that are specific to the Virginia MEDALLION 4.0 program.

Member services information line policies and procedures shall be developed that address staffing, training, hours of operation, access and response standards, transfers/referrals, including MEDALLION 4.0 referrals from all sources, monitoring of calls via recording or other means, and compliance with standards.

Language assistance services, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids, shall be provided free of charge to members and/or the member's representative. The caller cannot be charged a fee for translator or interpreter services.

For a period of at least twelve (12) months following implementation in each MEDALLION 4.0 region, a dedicated queue to assist providers with enrollment, service authorization, or reimbursement questions or issues shall be maintained and shall ensure that providers are appropriately notified regarding how to access the dedicated queue for assistance. Such period may be extended as determined necessary by DMAS.

A specific process shall be in place, for hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The 24/7 nurse triage line may be utilized for this purpose. The total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting shall be tracked and reported. Reporting requirements for the 24/7 ED assistance line will be finalized in the MEDALLION 4.0 Contract.

3.5.1 General Call Center Components (Member and Provider) and Hours of Operation

1. General customer service (available 8:00am - 8:00pm, seven (7) days a week. Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays)
2. Provider services and coverage determinations (available 8:00am - 6:00pm, Monday through Friday)
3. Nurse triage/nurse advice line (available 24 hours per day; 7 days per week)
4. Behavioral health crisis line (available 24 hours per day; 7 days per week)
5. Care coordination support (available 24 hours per day; 7 days per week)
6. Pharmacy Technical Support Line (hours of operation for technical support cover all hours for which any network pharmacy is open, seven (7) days a week)

The Department shall be provided the capacity to timely monitor calls remotely from DMAS offices at no cost to the Department.

Additional information regarding the call center requirements will appear in the MEDALLION 4.0 Contract.
In response to this RFP, Offerors shall:

1. Describe experience operating member and provider call centers under a current state Medicaid program to include handling calls from individuals with cognitive, physical (e.g., speech and hearing), or intellectual disabilities, or from individuals with limited English proficiency (including access to interpreter and translation services as necessary)
2. Describe its proposed member call center operations and provider call center operations to serve its MEDALLION 4.0 members and providers and how the Offeror's proposal will comply with all DMAS call center requirements
3. Detail the geographic locations of the proposed call center operations and the number of full-time equivalent staff dedicated to the Virginia MEDALLION 4.0 program
4. Submit for review any process flows to describe its call center operations, and also detail the call center Interactive Voice Response (IVR) process, issue escalation process, and call center quality assurance process
5. Submit a copy of the Offeror's call center quarterly performance standards results for the quarter immediately preceding the RFP issue date for a Medicaid state contract of similar size and scope to that required by this RFP
6. Demonstrate operational readiness for all elements of its plan's call center to the Department prior to MEDALLION 4.0 implementation.

3.6 Enrollment Process

Enrollment in MEDALLION 4.0 will be mandatory for eligible individuals. The Department shall have sole authority and responsibility for enrollment into the MEDALLION 4.0 Program. There shall be no retroactive enrollment in MEDALLION 4.0 (except for newborns as stated in the Contract). Enrollment in MEDALLION 4.0 will be phased-in by region as indicated in Section 1.7. DMAS reserves the right to modify the order and/or timing of the regional phase-in at the Department's discretion. The Contractor shall adhere to additional enrollment and disenrollment processes and procedures that will be outlined in the MEDALLION 4.0 Contract.

All eligible members, except those meeting one of the exclusions outlined in Section 4.1.1, shall be enrolled in MEDALLION 4.0 as defined in the MEDALLION 4.0 Contract.

3.6.1 Intelligent Assignment Process

DMAS will use an intelligent assignment process during each regional implementation that seeks to preserve existing MCO history, or family history. If neither criteria is met, members shall be randomly assigned to an MCO in approximately equal numbers by MCO in each locality. This process also will be used on an on-going basis for initial monthly enrollments.

A limit of 70% 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 70%, the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at 70% 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 intelligent assignment methodology, as needed based upon DMAS' sole discretion.

3.6.2 Enrollment File

An enrollment file (834) will be sent to the Contractor on a schedule to be determined by DMAS and outlined in the MEDALLION 4.0 Contract. The monthly 834 files will contain maintenance (audit) records, add and termination records for eligibility/enrollment information for all members in the health plan for the current (prospective) enrollment dates. The member's coverage begin date will depend upon whether Medicaid eligibility and/or health plan change information is entered/uploaded into VAMMIS on or before the 18th or on or after the 19th of the month.

DMAS will send a Medical Transition Report (MTR) File for every newly enrolled member on the 19th of each month. The MTR includes claims and encounter history for the past two (2) years and service authorization (SA) history for the previous twelve months. The Contractor shall have established procedures to receive this critical service information, incorporate it into the Contractor's system(s) as needed, honor SAs, and initiate care management for these members.

The Contractor shall be responsible for providing and paying for covered services as of the effective enrollment date for each individual.

DMAS will notify individuals of their ability to change health plans during an annual open enrollment period at least sixty (60) calendar days before the end of their enrollment period.

In response to this RFP, Offerors shall describe experience in receiving/processing 834 and 820 files in currently contracted state Medicaid programs. Offerors shall document any deficiencies in its processes and solutions to correct such deficiencies.

3.6.3 Open Enrollment

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

3.6.4 Information Requirements Upon Enrollment

The following information shall be provided to new individuals: a member handbook, a provider network listing, an identification card, and information regarding how to access and/or request a provider directory. Member materials must be provided in accordance with Federal managed care requirements described in 42 C.F.R. § 438.10. Requirements for member materials will be fully described in the MEDALLION 4.0 Contract.

In response to this RFP, Offerors shall submit copies of the above noted information currently provided to new individuals for a Medicaid state contract of similar scope to that required by this RFP.

3.6.5 Disenrollment and Contractor Election Changes

Consistent with § 1932(a)(4) of the Social Security Act, as amended (42 U.S.C. § 1396u-2), the Department must permit a member to disenroll at any time for cause. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 C.F.R. § 438.56(d)(2) .

3.7 Member Outreach and Marketing Services

Marketing and promotional activities (including provider promotional activities) shall be specified in the MEDALLION 4.0 Contract and shall comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to members. [42 C.F.R. §438.104].

Policies and procedures shall be in place to ensure member access to services and expedient issuance of member ID cards, new member packets, provider directories, and member handbooks. Additionally, all written membership material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency (42 C.F.R. § 438.10(d)(1)(ii)). All marketing and informational materials shall be at or below a 12th grade reading level using the Flesch readability formula and certify compliance.

Member handbooks shall be available in languages other than English when five percent (5%) of the enrolled population is non-English speaking and speaks a common language. The populations will be assessed by MEDALLION 4.0 regions and will only affect handbooks distributed in the affected regions.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education (42 C.F.R. § 438.10(c)(4)). Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the member, a family member, or a friend. TTY/TDD services for the hearing impaired must be provided.

In accordance with 42 C.F.R. § 438.100, written policies and procedures regarding member rights shall be required and staff and affiliated providers shall comply with applicable Federal and State laws that pertain to member rights. At a minimum, such member rights include the right to: obtain information on available treatment options, seek and receive a second opinion, be treated with respect, participate in decisions, be free from restraint/seclusion and request/receive medical records.

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.

Free non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of $25.00 to any prospective member or family for marketing purposes shall be allowed. Such items must be offered to all prospective members for marketing purposes whether or not the prospective member chooses to enroll with the Contractor. The Contractor is encouraged to use items that promote good health behaviors (e.g., toothbrushes).

Offerors, in response to this RFP, shall demonstrate experience with the requirements outlined in this section and shall specifically

1. Demonstrate current capabilities with addressing the needs of the Medicaid populations covered under this RFP in a culturally competent manner
2. Provide a sample of current marketing and outreach material used in a Medicaid state program similar in scope and population to that required in this RFP
3. Describe innovative methods to contact and outreach MEDALLION 4.0 members in a culturally sensitive manner. Offeror shall provide a description for each region it proposes based off the culture of that region, i.e, rural vs. urban.

3.8 RELATIONSHIPS

The Offeror shall describe its approach to relationship management with regard to key partners and stakeholders. Specifically, the Offeror shall describe its plan, by region, to deliver high-quality client service, engage stakeholders to build strong partnerships and trust, share knowledge, collaborate and solve problems, and be proactive, responsive, flexible, adaptable, and innovative throughout the life of the MEDALLION 4.0 Contract. The Offeror shall describe specific examples from current Medicaid state programs that demonstrate its relationship management approach.

The key partners and stakeholders of particular interest include:

1. DMAS and other state agencies, to include but not limited to Virginia Departments of Health (VDH), Social Services (VDSS), Behavioral Health and Developmental Services (DBHDS), and Education (VDOE)
2. Providers (primary, specialty and acute care, community based organizations, health systems, community behavioral health, early intervention)
3. Associations (provider associations, advocacy associations)
4. Social Supports (community care coordination models, others)
5. Other Contractors that are part of the MEDALLION 4.0 program (e.g., enrollment broker)

3.8.1 Community-Based Partnerships

Community-based partners may include, but are not limited to Community Services Boards (CSBs), Local Lead Agencies (LLAs) for early intervention, Local Health Departments, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs). Inclusion of community-based partners is critical to the success of achieving the goals of the MEDALLION 4.0 Program.

In response to this RFP, Offerors shall:

1. Describe its current experience forming partnerships with community-based organizations to perform aspects of its care coordination functions.
2. Describe its successes and lessons learned associated with current partnerships in Virginia or other states.
3. Describe proposed innovative partnerships, by proposed region, in delivering a care coordination program for the Virginia MEDALLION 4.0 Program.
4. Describe the type and scope of the proposed partnership(s), including specific services and/or functions to be carried out through or in tandem with the partnership (e.g., care transitions), geographic area(s) proposed.

3.9 Provider Network Management

Provider networks shall include providers who are specialized in and capable of meeting the unique needs of the MEDALLION 4.0 program population.

A list of referral sources shall be established and maintained that includes community agencies, State agencies, “safety net” providers, teaching institutions and facilities that are needed to assure that the members are able to access and receive the full continuum of treatment.

3.9.1 Provider Recruitment Strategy

A provider relations function shall be established and maintained to effectively communicate with existing and potential network providers, and to conduct ongoing provider education and trainings to assist in contracting with qualified providers that meet the Contractor’s requirements and with whom mutually acceptable provider contract terms, including reimbursement strategies, are reached.

In response to this RFP, the Offeror shall describe the provider recruitment strategy for each region proposed, including, but not limited to:

1. Innovative approaches that will be used to develop and maintain its MEDALLION 4.0 provider network to ensure network adequacy standards and highest quality care
2. Plans to work with various provider associations

3. Plans to train providers and educate them about the benefits of the MEDALLION 4.0 program
4. Methods to assist providers who are hesitant about managed care delivery systems
5. Strategies to recruit providers in rural areas, if applicable
6. Processes to ease the transition for providers, particularly early intervention and community behavioral health providers, who are not accustomed to operating in a managed care environment

3.9.2 Credentialing/Recredentialing Policies and Procedures

Written policies and procedures shall be implemented to determine whether physicians and other health care professionals who are licensed or certified by the Commonwealth, and other providers who are under contract with the Contractor or its subcontractor(s) are qualified to perform their medical, clinical services, and support services. Written policies and procedures shall be established that comply with the requirements specified in 42 C.F.R. § 438.214 which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The Contractor shall utilize credentialing and recredentialing standards outlined by NCQA, in the MEDALLION 4.0 Contract and in accordance with MCHIP standards at 12 VAC 5-408-170 or other state regulations for network development and maintenance. Non-traditional behavioral health providers (public and private) also shall meet any applicable Department of Health Professions' Licensing Boards or DBHDS licensing/certification standards. Early intervention providers also shall meet DMAS' and DBHDS' provider participation requirements as described in the applicable DMAS Provider Manuals.

The Contractor shall verify that network providers are appropriately licensed by the State and received proper certification or training to perform the services agreed to under the contract. For providers where licensure is not required, the Contractor shall ensure providers are adequately qualified. The standards for licensure and certification shall be included in participating provider network contracts.

The recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract. A mechanism shall be in place for reporting to the appropriate authorities any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license. All providers who have failed to meet accreditation/credentialing standards, been denied application (including terminated providers), and/or have had program integrity-related adverse actions shall be reported to DMAS quarterly. Providers and subcontractors shall be required to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455 Subpart B.

Offerors, in response to this RFP, shall provide assurances to comply with all provisions of the Final Rule related to the credentialing and provider enrollment process as they are implemented by the Department.

3.9.3 Provider Network Adequacy and Submission

The Contractor shall be solely responsible for arranging and administering covered services to enrolled members and must ensure that its delivery system will provide available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services. The Contractor is not

required to contract with all willing providers, however its network must meet network adequacy requirements.

The provider network shall allow access in localities that fall adjacent to another region. For example, Accomack is located in the Tidewater region; however, for some parts of Accomack, member utilization patterns may require the Contractor to contract with providers located in the Central region or bordering state.

The full scope of behavioral health services as defined in Attachment B and further defined in the MEDALLION 4.0 Contract shall be covered at full-risk. Providers of these behavioral health services shall meet DMAS' qualifications as outlined in the most current DMAS behavioral health provider manuals, including the community mental health rehabilitative services (CMHRS), mental health clinic, and psychiatric services provider manuals found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

This requirement does not: (1) require the Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees (e.g., the Contractor can define the network and use a narrower network of providers as long as it is consistent with and meets the requirements outlined in the MEDALLION 4.0 Contract); (2) preclude the Contractor from using different reimbursement rates for different specialties or for different practitioners in the same specialty provided the Contractor adheres to Section 3.9.6 (Provider Payment) of the RFP; or (3) preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

To alleviate emergency department visits, Contractors shall be required to have a network of providers to cover after-hours urgent care services for members. Transportation to these services shall be required if medically necessary.

The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in trauma informed care, ACES and resiliency, and working with the medical/psychiatric aspects of caring for survivors and perpetrators of physical and/or sexual abuse, neglect, domestic violence and other forms of trauma. Such expertise and capability shall include the ability to identify individuals who are trauma survivors or who have the potential to be exposed to traumatic situations or events and demonstrated knowledge of statutory reporting requirements and local community resources for the prevention and treatment of abuse, neglect and domestic violence.

An adequate transportation network shall be maintained to cover all approved transportation requests, including emergency, urgent, and non-emergency transportation services to ensure that members have necessary access to and from Medicaid-covered services, including services carved-out of the MEDALLION 4.0 Contract, in a manner that seeks to ensure the member's health, safety, and welfare. Per 12 VAC 30-50-530, modes of transportation include, but are not limited to, emergency and non-emergency air ambulance, emergency and non-emergency ground ambulance, public transit, stretcher vans, wheelchair vans, mini-vans, sedans, taxis, volunteer drivers, and transportation network companies. Travel expenses determined to be necessary to secure medical examinations and treatments set forth in 42 C.F.R. § 440.170(a) shall be covered. 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, DMAS agents, or DMAS' Medical Support Unit.

The Contractor must honor authorizations (as will be outlined in the MEDALLION 4.0 Contract) in place for out-of-state treatment, including transportation services. The Contractor is encouraged to enter into contracts with taxies and commercial carriers as well as public agencies, non-profit and for-profit private agencies, and public carriers.

Nursing facility care shall not be covered under this program, however, all members in need of nursing facility care shall be referred to be prescreened prior to admission. This screening shall be done regardless of the member's anticipated length of stay in the nursing facility setting.

Once a nursing facility admission is entered into the DMAS MMIS system, any open managed care enrollment is closed on the day prior to the nursing facility admission date. The Contractor shall cover all medically necessary services until the member is disenrolled from the MCO.

Nothing in the MEDALLION 4.0 Contract shall preclude the Contractor from providing additional health care improvement services or other services not specified in this Contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to members.

Offeror, in response to this RFP, shall submit its preliminary provider networks by region, subject to DMAS credentialing policies outlined in Section 3.9.2, to include: health systems, acute, primary, pharmacy, specialty, early intervention, behavioral health (including Community Services Boards in the proposed regions), safety net (FQHC, RHC), hospital (including tertiary hospitals), and transportation in the format described in Attachment C. The Offeror shall include providers in its network submission who are specialized in and capable of meeting the unique needs of the MEDALLION 4.0 population. The Offeror's network submission must meet the Federal and State network standards described in 42 C.F.R § 438.206 and the requirements outlined in this RFP. These providers must cover all the services as referenced in Attachment B.

The Department will accept signed contracts or letters of intent (LOI) for the provider network submission as designated in Attachment C. Only providers who have either signed a LOI or signed a contract may be submitted. The Offeror must indicate this distinction (LOI vs. signed contract) for each submitted provider. The Offeror does not need to provide actual copies of signed contracts in response to this RFP. Such documents must be available to the Department upon request.

Offerors shall use licensed ARTS providers as defined in 12VAC30-130-5020, including ASAM Level 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4.0, Opioid Treatment Programs using the ARTS ASAM Level 2.1 to 4.0 Uniform Credentialing Form, Opioid Treatment Program Credentialing From, and ARTS Staff Roster available at http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx. Offerors shall use DMAS approved Office Based Opioid Treatment (OBOT) Providers based on the criteria set forth by the Department in 12VAC30-130-5121.

The final network analysis conducted during the readiness review process shall be based upon the Offeror's fully executed provider contracts. Final networks shall include all provider types in the region(s) in which the Offeror proposes to operate.

The Offeror shall submit a provider network file to the Department in an electronic format. Additional instructions are included in Attachment C and are detailed in the Managed Care Technical Manual 3.3.1 at http://www.dmas.virginia.gov/Content_pgs/mc-rpt.aspx and subsequent versions. Submissions not

meeting the network file requirements will be rejected and returned. DMAS will use this data to evaluate the Offeror's provider network in accordance with requirements described in this RFP.
The Department or its designee shall be the sole determiner of network sufficiency.

3.9.4 Ongoing Provider Support

Ongoing provider support is important for continuous improvement and high-quality care. The Offeror's response to this RFP shall describe its approach for:

1. Provider outreach and communications when programmatic changes are made
2. Ongoing provider training
3. Technical assistance, especially to early intervention and community behavioral health providers, and out of network providers during the continuity of care period
4. Issue resolution with providers

3.9.5 Provider Agreements

The Contractor shall comply with the requirements detailed at 42 C.F.R. § 438.602(b) regarding the screening, enrollment and revalidation of all network providers and with 42 C.F.R. § 455.436, requiring the Contractor to, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE) and other federal databases; (1) at least monthly for its providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and recredentialing.

Any provision that directly or indirectly prohibits, limits, or discourages network providers, through incentives or other means, from participating as network or non-network providers with any other Contractor participating with the Department for Medicaid and CHIP enrollees shall not be included in provider contracts.

In accordance with 42 C.F.R. § 438.206, a network of appropriate providers that is supported by written agreements and is sufficient to provide timely and adequate access to all services covered under the MEDALLION 4.0 Contract shall be maintained and monitored.

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

All providers (including participating, non-participating, servicing, billing, ordering, referring, prescribing, attending, etc.) rendering services under the MEDALLION 4.0 Contract shall have a National Provider Identifier (NPI) number. The NPI is provided by the CMS which assigns the unique identifier through its National Plan and Provider Enumeration System (NPPES).

The Contractor shall have the ability to determine whether providers are licensed or certified by the State and have received the proper certification and/or training necessary to perform the services agreed to under the MEDALLION 4.0 contract. The Contractor's standards for licensure and certification also shall be included in its participating provider network contracts.

The Contractor shall enter into provider contracts for the provision or administration of covered primary, acute, and behavioral health services. Coverage responsibility for behavioral health services

shall be the responsibility of the Contractor. There are two categories of covered services: (1) traditional and (2) non-traditional or community behavioral health and substance use treatment services. The Contractor shall cover traditional and non-traditional behavioral health services as defined in Attachment B.

The Department's BHSA shall be responsible for the provision of non-traditional services within the Department's established coverage criteria and guidelines until such time that the DMAS BHSA contract expires (no later than November 30, 2018).

Psychiatric residential treatment facilities (PRTFs) services are administered through the Department's BHSA for fee-for-service individuals through November 30, 2018. Any child admitted to a PRTF will be temporarily excluded from MEDALLION 4.0 until after they are discharged. The Department is currently restructuring the PRTF services. At the completion of this restructure, PRTF services will be transitioned to the MEDALLION 4.0 program and the Contractor (depending on the timing, the Department may require that the Contractor provide coverage for PRTF services through DMAS' BHSA until that contract expires).

Effective December 1, 2018, the Contractor shall be responsible for meeting the network adequacy standards and for the provision of the full scope of traditional and non-traditional services covered in the MEDALLION 4.0 Contract. To meet these standards, the Contractor may contract with a different BHSA or provide the full scope of required services through the Contractor's own network of behavioral health providers. Upon DMAS notification, the Department will review and approve the Contractor's complete BHSA behavioral health provider network and transition plan.

3.9.6 Provider Payment

Notwithstanding the exceptions outlined below, in accordance with section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), all in-and out-of-network providers shall be paid on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45 and section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered individuals who are enrolled with the Contractor at the time the service was delivered. In the absence of an agreement between the Contractor and the provider, the Contractor shall pay out of network providers, including out of state providers, at the prevailing DMAS rate in existence on the date of service. This reimbursement shall be considered payment in full to the provider or facility. Additionally, claims for emergency services shall be paid in accordance with the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171), Section 6085. Reference the CMS State Medicaid Director Letter SMDL #06-010.

The following exceptions shall apply:

1. Clean claims from community behavioral health, ARTS and early intervention providers shall be processed within fourteen (14) days of receipt of the clean claim.
2. Community behavioral health, early intervention, and ARTS providers shall be paid no less than the current Medicaid FFS rate or a different negotiated rate as mutually agreed upon by the provider and the Contractor and outlined in the provider agreement.

Interest charges shall be paid for Medicaid claims in accordance with § 38.2-4306.1 of the *Code of Virginia.*

To the extent the Governor and/or General Assembly implement a specified rate change for Medicaid/FAMIS specific service providers, and as identified by DMAS, and these rate adjustments are incorporated into the MEDALLION 4.0 capitation payment rates, where required by DMAS and/or regulation, the Contractor is required to change its reimbursement to providers at the same percentage as Medicaid's change as reflected in the revised fee-for- service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed upon by DMAS.

DMAS reserves the right to require uniform billing practices and claims submissions processes for providers. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected MEDALLION 4.0 Contractors.

3.9.7 Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

The Contractor shall notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Offeror shall provide assurances and documentation upon request 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.

3.9.8 Payment Using DRG Methodology

If the Contractor has a contract with a facility to reimburse the facility for services rendered to its members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, the Contractor shall be responsible for the full inpatient medical hospitalization from admission to discharge.

The Contractor shall provide coverage for payment of practitioner services rendered during the hospitalization for any dates in which the member was enrolled with the Contractor on the related date of service.

3.9.9 Provider Preventable Conditions

The Contractor shall comply with 42 C.F.R. § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §434.6(a)(12) and § 447.26. The Contractor shall submit all identified provider preventable conditions as will be outlined in the MEDALLION 4.0 Contract. Reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 C.F.R. § 447.26.

3.9.10 Billing Members for Covered Services

All in-network provider agreements shall include requirements whereby the member shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor, can bill the member for the service.

3.9.11 PCP Assignment

Each member shall be assigned a PCP at the date of enrollment with the Contractor. Individuals shall be allowed to select or be assigned a new PCP when requested by the individual, when the PCP has been terminated, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding.

In response to this RFP, the Offeror must explain how it assigns PCPs to members and how individuals are assisted if a change in PCP assignment is requested or necessary.

3.9.12 Provider Trainings

The Contractor shall attend meetings and forums with providers (e.g., early intervention providers, community behavioral health providers, etc.), and other contracted MCOs as necessary, and at DMAS' request, to resolve any identified issues. Trainings shall:

1. Provide technical assistance/guidance on an on-going basis. Trainings will be especially numerous during MEDALLION 4.0 regional start-ups and during open enrollments.
2. Encompass general information regarding the MEDALLION 4.0 program (e.g., what is MEDALLION 4.0, what is managed care, where do providers go for assistance, protected health information, etc.).
3. Cover specific topics, such as claims submission, claims processing, service authorizations, audit procedures, edit checks, etc.
4. Be tailored to the specific needs of MEDALLION 4.0 providers (e.g., how to achieve program goals, how to promote health and wellness in children and pregnant women, how to provide coordinated care, improving member experience, and how to promote the efficient use of services).

Offerors, in response to this RFP, shall describe how it will accomplish the training requirements and provide samples of provider training activities conducted in Medicaid state programs that are similar in scope and population to those listed in this RFP. Offerors also shall submit a plan that outlines provider training activities by region.

3.9.13 Provider Advisory Committee

In accordance with NCQA requirements, a provider advisory committee shall be established and maintained, consisting of providers contracting with the Contractor in each region to serve members. The committee shall consist of at least two providers that maintain practices that predominantly serve Medicaid members and other indigent populations, and at least one other participating provider who has experience and expertise in serving members with special needs. The committee shall meet at least quarterly and its input and recommendations shall help inform and direct Contractor quality management and activities and policy and operational changes, subject to DMAS approval. The Department may conduct on-site reviews of the membership of this committee, as well as the committee's activities throughout the year.

Offerors, in response to this RFP, shall provide samples of provider advisory committee activities conducted in Medicaid state programs that are similar in scope and population to those listed in this RFP.

3.10 QUALITY

3.10.1 Quality and Program Evaluation

The principles of continuous quality improvement (CQI) shall be applied to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements.

3.10.2 Quality Improvement (QI) Program

The QI program for MEDALLION 4.0 shall be structured separately from any of existing Medicaid, Medicare, or commercial lines of business. Specifically, required measures and reports for the MEDALLION 4.0 Contract must be reported for the MEDALLION 4.0 population only.

A QI organizational and program structure that is proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives shall be maintained in a competent and timely manner. The QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

The Contractor shall have in place a written description of the QI program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. The Contractor shall submit an annual QI Work Plan and evaluation.

The Contractor's QI program and work plan shall align with the Virginia Medicaid Quality Strategy (currently under development). The Contractor's QI initiatives shall be designed to help achieve the goals outlined in the Virginia Medicaid Quality Strategy.

The Contractor shall maintain sufficient and qualified staff employed to manage the QI activities required under the MEDALLION 4.0 Contract, and establish minimum employment standards and requirements (e.g., education, training, and experience) for employees who will be responsible for QI.

The Contractor shall participate in QI workgroups and meetings designed to support QI activities and provide forums for discussing relevant issues. These workgroups and meetings may be facilitated by DMAS (or its designee) and shall be attended by DMAS representatives, DMAS Contractors, or other entities, as appropriate. The Contractor also shall serve as a liaison to, and maintain regular communication with, DMAS or its designated QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

Offerors, in response to this RFP, shall outline the proposed QI program by region that addresses the scope of this section.

3.10.3 EQR Activities, Performance Measurement, and Other Quality Assurance Activities

The Contractor shall comply with all of DMAS' or the Department's designated agents (e.g., EQRO and/or other Contractors) on EQR activities, performance measurements and reporting, quality assurances activities, quality improvement activities and any additional studies, in accordance with the MEDALLION 4.0 Contract. This will include, but will not be limited to, readiness reviews; accreditation requirements; annual quality management plan and evaluation; the collecting and reporting of specified quality measures including surveys, and assurances, conducting quality improvement projects in the focus areas as directed by DMAS; operational systems reviews; performance measure validation; performance improvement project validations; DMAS audits on MEDALLION 4.0 Contractors; program evaluations; member advisory committee; and all other quality related activities.

3.10.4 MEDALLION 4.0 Quality Measurement Reporting Requirements

As part of the MEDALLION 4.0 reporting requirements, quality performance measures reporting will be required to cover the following four domains:

1. Enhanced member experience and engagement for person- and family- centered care
2. Better quality of care
3. Maintain or improve population health
4. Reduce per capita costs

MEDALLION 4.0 Contractors shall report on all NCQA adult and child core measures.

3.10.5 MEDALLION 4.0 Program Evaluation Activities

DMAS and its designated agents will conduct ongoing evaluations of the MEDALLION 4.0 program over time from multiple perspectives using both quantitative and qualitative methods. The evaluation will be used for program improvement purposes and to assess the program's overall impact on various outcomes including but not limited to, enrollment patterns, member access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, behavioral health, prescription drugs, care coordination, program staff and provider experiences, etc.).

As such, the evaluations will include surveys, site visits, claims and encounter data analysis, focus groups, key informant interviews, observations, waiver assurance results, reporting records, and document reviews or any other means the Department deems necessary. The Contractor shall participate in evaluation activities as directed by DMAS or its designee and provide information or data upon request and in the manner requested.

NCQA Accreditation Quality Management and Improvement:

Offeror's Medicaid plan shall meet requirements outlined in Section 3.2.3 and shall provide the following (in a chart format for items #1 – 3):

1. Name of each health plan as it appears on NCQA's website and whether it is a Medicaid product.
2. Current accreditation level (must include a copy of the most recent accreditation/re-accreditation confirmation letter). If the current accreditation level is different from the confirmation letter, an explanation must be included.
3. Any deficiencies noted within the previous three years by NCQA.
4. A copy of the auditor-locked interactive data submission system (IDSS) from the most recent HEDIS audit.
5. A copy of the most recent Adult and Child CAHPS report for a Medicaid product of similar scope and population to this RFP.

Medicaid Managed Care External Quality Reviews:

Offerors, in response to this RFP, shall submit the most recent two (2) years of EQRO reports from up to two (2) Medicaid state programs. The EQRO reports must include the most recent three mandatory external quality improvement activities per the Federal Managed Care Regulations (42 C.F.R § 438.358): a comprehensive operational systems review, performance measure validations, and performance improvement projects validations.

Medicaid Managed Care Annual Quality Improvement Plan and Evaluation:
Offerors, in response to this RFP, shall submit the most recent QI description, plan and annual evaluation results from up to two (2) Medicaid state programs, including QI reports.

3.10.6 HEDIS Measures

The Contractor shall consent to publication via NCQA's Quality Compass of all Medicaid HEDIS measures for the Virginia Medicaid product. In addition, the Contractor shall, at a minimum, consider the Medicaid HEDIS measures as outlined in the MEDALLION 4.0 Contract, specifically, the adult core performance measures and the child core measures as a priority. The Contractor shall assure annual improvement in these Medicaid HEDIS measures until such time that the Contractor is performing at least at the 50th percentile for "HMOs" as reported by Quality Compass. Thereafter, the Contractor is to at least sustain performance at the Medicaid 50th percentile. The Contractor is encouraged to set goals to support the Department's goal of attaining the seventy-fifth (75th) percentile for each of these measures. Beginning with HEDIS 2016, in alignment with NCQA requirements, the Contractor shall not be permitted to rotate any HEDIS measures. All measures must be calculated without rotation per NCQA Technical specifications.

The Contractor shall perform the Children and the Adult CAHPS annually. The CAHPS Adult Survey and the CAHPS Child Survey reports provided to the Department shall include detailed results for all survey items. Composite scores shall also be reported. Performance on CAHPS surveys may also be publicized as described above. Beginning with HEDIS 2017, the Contractor shall 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.

Offerors, in response to this RFP, shall submit HEDIS performance reports for the past three (3) years for Medicaid state contracted programs that are similar in scope and population to this RFP.

3.10.7 Other Quality Activities

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the EQRO contracted by the Department to perform quality studies. The Contractor shall at a minimum respond favorably and promptly to requests for members' medical records in the format and timeframe requested by the EQRO or the Department.

The Contractor also shall submit requested information from the Department or EQRO for Performance Measure Validation, Performance Improvement Projects, and Comprehensive or Modified Operational Systems Reviews as described in the MEDALLION 4.0 Contract by the due date provided by the EQRO or as communicated by the Department.

3.11 MEETINGS

Participation shall be required in meetings with the Department of Medical Assistance Services as defined in the MEDALLION 4.0 Contract, including the Case Managers (including Foster Care Case Manager) meetings, DMAS Managed Care Advisory Committee meetings, MCO Work-Group meetings, Quality Collaborative meetings, Financial Workgroup meetings, Program Integrity meetings, CMO and Pharmacy Director, ARTS workgroup, or any other groups as necessary when requested to do so by the Department. Each meeting is comprised of MCO staff members with subject matter expertise for the

subject under discussion in regular attendance. Any substitutions of regularly attending staff at a specific meeting require informal notification twenty-four (24) hours in advance to the Department.

The Contractor shall not request any meetings with other Commonwealth agencies to discuss exclusive Virginia Medicaid business without prior Departmental knowledge.

3.12 Reporting Requirements

3.12.1 Encounter Reporting

The Contractor shall meet all data requirements as defined by the Department. All data, including encounters, shall be transmitted in a HIPAA-compliant manner. Any data required by the Department shall be described in supporting documentation from the Department that details data expectations including, but not limited to, EDI companion guides, EDI implementation guides, MEDALLION 4.0 Technical Manual, MEDALLION 4.0 reporting requirements, or other documents that refer to reporting requirements.

The Contractor shall:

- Collect and maintain 100% encounter data for all services provided to enrollees, including encounter data from any subcontractors. Such data must be able to be linked to DMAS eligibility data.
- Maintain staff with the necessary technical expertise to support all EDI and encounter reporting requirements. The Contractor shall have expertise for each transaction type supported by the Department (e.g., NCPDP, X12).
- Participate in site visits and other reviews and assessments by DMAS, 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 previously submitted data from the Contractor that shall be compared to data received by the Department. Upon request by the Department, or its designee and with 30 days' notice, the Contractor shall provide DMAS-specified member records in order to permit the Department to conduct data validation assessments.
- Upon request by DMAS, or its designee, provide medical records of enrollees and a report from the Contractor's administrative databases of the encounters of such enrollees in order to conduct validation assessments. The Contractor shall conduct validation assessments annually at the direction of DMAS or its designee.
- Produce encounter data according to the specifications, format, and mode of transfer established by DMAS, or its designee. Such encounter data shall include elements and level of detail determined necessary by DMAS and specified in DMAS' EDI Companion Guides, EDI Procedure Manuals, and/or Technical Manuals.
- Develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 U.S.C. § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program. Contractor shall identify encounter claims administered under section 340B in the manner specified by DMAS that allows for an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing.
- Submit complete, timely, reasonable and accurate encounter data to DMAS no less than weekly and in the form and manner specified by DMAS. The encounters submitted will be in the current EDI X12 and NCPDP standards.

- Submit encounter data that meets all documented DMAS requirements for completeness, timeliness, and accuracy. The Contractor must correct and resubmit all encounter errors that are identified during DMAS' encounter processing. Error corrections must be completed within the timeframe specified by DMAS,
- Report 100% of all encounter data, including but not limited to paid, denied, voided, replacements, and subcontractor claims. The Contractor shall submit encounter data for all services to the members for which the Contractor incurred a financial liability, and shall include claims for provided services that were eligible to be processed, but where no financial liability was incurred. The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:
  a. expected utilizations;
  b. actual visits to expected visits;
  c. service date lag time benchmarks;
  d. expected EDI fail amounts;
  e. average paid amount per service, by billing code; and
  f. provide weekly or monthly claim expenditure data from its system for DMAS to use in reconciling the completeness of the encounter data reporting. DMAS will rely on this encounter data for capitation rate setting effective no later than rates for SFY23. DMAS also will impose graduating monetary penalties for non-compliance with encounter data requirements. These penalties will be described in detail in the Contract.
- DMAS reserves the right to modify encounter requirements with advance notice.

Offerors, in response to this RFP, shall demonstrate experience and expertise with all EDI and encounter submissions for each transaction type supported by the Department (e.g., NCPDP, X12) for Medicaid state contracted programs similar in scope to this RFP. Offerors also shall demonstrate experience with the requirements listed above and in one or more Medicaid states of similar size and scope to this RFP.

3.12.2 Other Required Reporting and Data Deliverables

DMAS is in the process of expanding its data integration and analytics capabilities by developing a system that collects, integrates, and analyzes data from a variety of sources across the full continuum of care (primary, acute, and behavioral care). DMAS will track health metrics for the Medicaid population across fee-for-service and managed care programs, including the MEDALLION 4.0 program. Use of the data system will help DMAS evaluate how well the MEDALLION 4.0 program is serving individuals, identify best practices, and opportunities for improvement. In addition, this comprehensive data mining approach will enable the Department to project risk, enhance care coordination, mitigate service gaps, and promote efficiencies.

The Contractor shall provide raw data, including data from subcontractors, in a format and frequency determined by DMAS and that will be outlined in the MEDALLION 4.0 Contract. The data shall be compliant with industry standards (e.g., National Information Exchange Model) and state companion guides.

DMAS will work closely with MEDALLION 4.0 Contractors to develop the technical requirements for providing the data outlined above as well as the mechanism for data transmission, including file formats and submission frequency.

MEDALLION 4.0 Contractors shall adhere to DMAS' standards for solutions that align with the Department's data integration goals, based upon evidenced-based data standards which ensure the highest degree of data quality and integrity. It will be crucial that MEDALLION 4.0 Contractors submit the required data in a timely manner, and in the contractually required format(s). MEDALLION 4.0 Contractors shall be subject to liquidated damages and sanctions when data is submitted contrary to DMAS established standards of timeliness, completeness and accuracy, and where the method of submission is non-compliant with MEDALLION 4.0 contractual standards. The data requirements and related sanctions will be further defined in the MEDALLION 4.0 Contract.

Offerors, in response to this RFP, shall describe current experience in a Medicaid state contract with ensuring high quality data that complies with standards for accuracy, timeliness, and completeness.

As described by the Department in its supporting documentation, the Contractor shall successfully exchange all required data with the Department no later than 180 days after the start of the contract. The Department may require any data inclusive or relevant to the members from the Contractor within 60 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. The Contractor shall produce any required or requested data according to the specifications, format, and mode of transfer established by the Department, or its designee, within 60 days of notice.

The Contractor may be expected to provide data files or reports including, but not limited to, the following:

- Financial data including income expenses and balance sheets
- Related party transactions
- Service authorizations metrics, including behavioral health service authorization metrics
- Full provider networks
- Out of network providers
- Provider data for billing, ordering, referring, prescribing providers
- Clinical data compliant with HL7 standards
- Visit verification data
- Assessment data
- Medical records
- Service authorizations
- Appeals and grievances
- Care coordination data (e.g. HRA)
- Formulary data
- Member TPL
- 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. Payments to subcontractors
    e. Cost recovery transactions (e.g., third party liability explanation of benefits, fraud/waste investigations, and/or legal actions)
    f. Other financial data related to medical expenditures

The Contractor shall disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor shall provide prior notification to the Department of any anticipated changes that may have an impact on the substance or process of data exchanges between the parties, and shall engage with testing in order to ensure continuity of existing data exchanges.

The following requirements shall apply to all submissions, including encounter data. For each data submission, the Contractor shall:

1. Collect and maintain 100% of the data required by the Department.
2. Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which shall include:
    a. Metrics that measure completeness, timeliness, and accuracy of the data;
    b. Benchmarks that describe whether the Contractor's performance is compliant with the Department's requirements;
    c. A description of how each measure is calculated by the Department.
3. Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation.
4. 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).
5. Provide any reports on required data as requested by the Department.

Consistent with Federal and State guidelines, the Contractor shall be responsible for robust and transparent reporting on critical elements of MEDALLION 4.0 covered services and the Contractor's major systems. The Contractor shall have adequate resources to support MEDALLION 4.0 reporting needs as required by DMAS. Examples of data to be included in reports shall include, but are not limited to, behavioral health, pharmacy, service authorizations, financial transactions, provider network, grievance and appeals, quality, program integrity, call center statistics (broken out by behavioral health including crisis calls and all other service categories), assessments, participant health and functional status, marketing, outreach, and training high-utilizer intervention activities, under-utilization analysis with reasons, appointment assistance activities, value-based payment activities, and related dashboards. See Managed Care Technical Manual (MCTM) at http://www.dmas.virginia.gov/Content_pgs/mc-rpt.aspx for examples of current deliverables and expectations. Final requirements will be reflected in the Technical Manual that accompanies the final MEDALLION 4.0 Contract.

Detailed data shall be reported in the areas listed above on a weekly, monthly, quarterly, annually, and as needed by program area, including separate reports for acute medical care, behavioral health, pharmacy, and ARTS services where specified.

The Department, or its designee, may investigate suspected data quality issues including, but not limited to, deviations from expected data volume, or expected data corrections, voids or adjustments. Suspected data quality issues discovered by such investigations may result in the addition of metrics to the Data Quality Scorecard or the requirement that the Contractor replace data with suspected data quality issues at no cost to the Department. Upon review of submitted reports, DMAS may require the Contractor to take corrective action, if needed. To minimize administrative burden on all parties, DMAS

intends to use standardized electronic reporting formats so that reported information can be tracked and trended across MEDALLION 4.0 Contractors over time.

Additional reports may be required in the MEDALLION 4.0 Contract, especially those in response to federal or state mandates, such as the new federal managed care rules or the JLARC recommendations on Managing Medicaid Spending. DMAS reserves the right to request ad hoc reports and to modify reporting requirements with advance notice. The final MEDALLION 4.0 reporting requirements will be included in the MEDALLION 4.0 Contract and Technical Manual.

At least twice yearly or as otherwise requested by the Department, the Contractor shall conduct a data inventory as a predicate to disclosing to the Department all data sources inclusive of data on its members 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; and
3. comprehensive description of all metadata elements, including:
    a. list of all data fields;
    b. business description of the content of each field;
    c. the field's format; and
    d. list of valid values (where the data field is defined by a limited value set).

Should the Contractor possess a new data source with data on the members, the Contractor shall inform the Department within 60 days of that data source's acquisition or creation.

The Contractor shall provide the Department with an annual data quality strategic plan that addresses:

1. Plans 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. Procedures and automated checks that exist in the Contractor's systems to prevent transmission of non-compliant data
4. The compliance actions and data quality standards expected of servicing providers, billing providers, sub-contractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

3.12.3 Critical Incident Reporting and Management

The Contractor shall identify, document details, track, review, and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS), if available); cooperate with VDSS and LDSS on reporting; identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The Contractor shall require its staff and contracted providers to report, respond to, and document critical incidents to the Contractor in accordance with applicable requirements.

The Contractor shall develop and implement a critical incident reporting and notification process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for staff and contracted providers to report an incident to the Contractor shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

The Contractor shall participate in the DMAS' mortality review activities for MEDALLION 4.0 populations.

Additional critical incident requirements will be outlined in the MEDALLION 4.0 Contract.

3.13 DMAS Compliance Monitoring

DMAS shall monitor Contractor compliance with all aspects of the MEDALLION 4.0 Contract. As part of this contract monitoring process, the Department may, at its sole discretion, conduct any or all activities as outlined in the MEDALLION 4.0 Contract, including but not limited to:

- conducting periodic audits and surveys of the Contractor
- investigation of complaints
- review of marketing materials and procedures
- review of grievance and appeals data and procedures
- review of the Contractor's member outreach and informational materials and procedures
- conducting site visits as determined necessary to verify the accuracy of reported data
- analysis of encounter data and quality reviews conducted by the external quality review organization
- inspection or other means, to determine the Contractor's compliance with reporting requirements, and quality, appropriateness, and timeliness of services performed by the Contractor and its provider network
- conducting periodic audits of the Contractor, including, but not limited to an annual independent external review and annual site visit
- conducting annual member surveys
- meeting with the Contractor at least semi-annually to assess the Contractor's performance
- conducting audits of encounter data accuracy and completeness

3.13.1 Compliance Monitoring Process (CMP)

In addition, DMAS utilizes a Compliance Monitoring Process (CMP) to detect and respond to issues of noncompliance and to remediate contractual violations when necessary. The CMP assigns points based upon key areas of non-compliance. Depending upon the severity of the violation and the accumulation of points, a Corrective Active Plan, Improvement Plan, fines, and/or other sanctions may be imposed upon the Contractor as defined in the MEDALLION 4.0 Contract.

The Contractor shall develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. §§ 438.600-610, 42 C.F.R. 455. The compliance program must, at a minimum, include written policies, procedures and standards of conduct that:

- Articulate the Contractor's commitment to comply with all applicable federal and state standards
- Describe compliance expectations as embodied in the standards of conduct

- Implement the operation of the compliance program
- Provide guidance to employees and others on dealing with potential compliance issues
- Identify how to communicate compliance issues to appropriate compliance personnel
- Describe how potential compliance issues are investigated and resolved by the Contractor
- Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

Offerors, in response to this RFP, shall demonstrate experience with a compliance monitoring program for Medicaid state contracted programs similar in scope to this RFP and provide an example of such program including noted areas of non-compliance and corrective action and/or sanctions.

3.13.2 Corrective Action Plans and MCO Improvement Plans

In addition to sanctions, the Department may require the Contractor to submit MCO Improvement Plans and Corrective Action Plans.

3.13.2.1 MCO Improvement Plans (MIPs)

The Department may require the MCO to submit an MCO improvement plan to address minor compliance violations/failures/deficiencies. A MIP is only used for issues that do not rise to the level of a formal corrective action plan, and are not intended to be disclosed by the Contractor in its business outside of the Commonwealth of Virginia.

3.13.2.2 Corrective Action Plans (CAPs)

When necessary, a corrective action plan (CAP) shall be initiated to address findings and observations that have been identified by the Department. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and state/federal regulations.

Offerors, in response to this RFP, shall submit the names of the state Medicaid programs in which the Offeror was required, at any point during the contract, to submit a MIP and/or a CAP and the outcomes.

3.14 PROGRAM INTEGRITY

The Contractor shall have a formal comprehensive Virginia Medicaid Program Integrity Plan for MEDALLION 4.0, reviewed and updated annually, to detect, correct, and prevent fraud, waste, and abuse. This plan shall be specific to the Virginia MEDALLION 4.0 program and shall 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 shall define how it will adequately identify and report suspected fraud, waste and abuse by members, network providers, subcontractors, and the Contractor.

The Contractor shall have surveillance and utilization control programs and procedures (42 C.F.R. §§ 456.3, 456.4, 456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The Contractor shall have in place a process for assessment of all claims for fraud, waste, and abuse activity by members and providers through utilization of computer software and through regularly-scheduled audits of medical records. The Contractor shall have methods

for identification, investigation, and referral of suspected fraud cases (42 C.F.R. §§ 455.13, 455.14, 455.21).

The Contractor shall have adequate staffing and resources to investigate complaints and unusual incidents, and develop and implement corrective action plans to address all potential fraud, waste, and abuse activities, specific to Virginia Medicaid. Pursuant to 42 C.F.R. § 455, et seq., the Department may conduct audits of services rendered and claims paid by the Contractor to its provider network, and as a result of those audits, may recover funds as appropriate. The Department may also choose to conduct joint audits with Contractors. The Contractor shall agree to provide any staffing or technical support required by DMAS to conduct audits. DMAS may direct Contractors to investigate particular providers identified by data analysis or referrals and report its findings to DMAS. The Contractor will be expected to prioritize these investigations and may be given a deadline for completing the investigation.

Some program integrity activities may identify issues that constitute potential fraud. DMAS and its Contractors are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). The Contractor shall maintain the same level of diligence in its provider network, and cooperate fully with any request for information or technical support made by the MFCU to support its investigations. DMAS shall verify that some of these referrals constitute a "credible allegation of fraud." In these instances, Contractors will be notified and shall suspend payments to those providers as set forth in 42 C.F.R § 455.23. Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty recovered through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia. Additional program integrity and oversight requirements will be outlined in the MEDALLION 4.0 contract.

This Program Integrity Plan shall be specific and include identification of relevant staff members and the proportion of their time that will be dedicated to performing program integrity activities for this contract. The Contractor shall identify specific program integrity monitoring activities to be performed for that contract year, including projections of the number and type of investigations that are planned.

This plan will be evaluated by DMAS staff on an annual basis to determine if it provides adequate protection against program integrity abuses. Part of this evaluation will include the completion of an annual Program Integrity Compliance Audit (PICA), which is a compliance and evaluation measure to evaluate organization-level compliance and adherence to the terms of the MEDALLION 4.0 contract and best practice models. Completion of the PICA requires electronic submission of any and all referenced materials (Policies and Procedures manuals, etc.) and documents annually to DMAS, as will be specified in the MEDALLION 4.0 contract. The Department may customize the PICA to reflect areas of particular importance or focus based on trends, previous PICA findings, or other Departmental concerns. The Contractor shall use the most current version of DMAS' PICA tool. The Contractor shall include a risk assessment of its various fraud and abuse/program integrity processes. The assessment shall at a minimum include a listing of the Contractor's top three vulnerable areas and shall outline action plans in mitigating such risks.

The Offeror's response shall:

1. Outline the program integrity activities it proposes to perform, including an estimate of the number and type of reviews that would be performed under the MEDALLION 4.0 program (on a per region, per member, per claims expenditure, and/or per claim basis.)

2. Describe the sampling methodology
3. Provide examples of program integrity reviews performed in the past three (3) years in a Medicaid state contracted program of similar scope to this RFP, focusing on the size of the review(s) (claims/dollars/providers), specific overpayment amounts identified, and outcomes of these activities (including but not limited to, recovery of overpayments)
4. Describe oversight of subcontractor program integrity activities and direct investigations to verify the effectiveness of subcontractor program integrity
5. Describe the scope, design, and efficacy of its prepayment analytics program to identify fraud, waste, and abuse.

3.15 Grievances And Appeals

3.15.1 Grievances

An enrollee may file a grievance with the Contractor and the Contractor shall be responsible for properly responding to all grievances. The DMAS Appeals Division does not handle grievances.

In accordance with 42 C.F.R. § 438.400 et seq., and as directed by DMAS, the Contractor shall have a system in place for addressing enrollee grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. The Contractor shall maintain written records of all grievance activities and notify DMAS of all internal grievances through a reporting format approved by DMAS.

3.15.2 General Appeals Requirements

The Contractor shall maintain written records of all appeal activities, and provide a bi-weekly report to DMAS of all appeals in the manner and format determined by Contract. The report of appeals shall include:

- total number of adverse benefit determinations and adverse actions per period with a breakdown of how many result in appeals, both internally and after final action at the MCO, to DMAS
- total number of pending internal appeals and due dates for decisions from the MCO and the due dates for a final decision in those cases if appealed to DMAS
- total number of appeals pending at DMAS that are appeals from a final decision of the MCO
- Break down separately by member and provider

Member Appeals

In accordance with 42 C.F.R. §§ 438.10 and 438.404, the Contractor must give the enrollee written notice of any adverse benefit determination. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) days in advance of the date of its adverse benefit determination or as otherwise provided for in the C.F.R. For denial of payment, such notice shall be provided at the time of any action affecting the claim. The form and content of the notice must have prior approval by DMAS; however, the notice must explain:

1. The adverse benefit determination the Contractor has taken or intends to take;
2. The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination ;
3. The citation to the law or policy supporting such adverse benefit determination;

4. The enrollee's or the provider's right to file an internal appeal with the Contractor, including information on exhausting the Contractor's appeal processes and an explanation that the enrollee and/or provider has a right to file a request for a State Fair Hearing with DMAS only after the Contractor's appeal process has been exhausted;
5. The procedures for exercising the enrollee's rights to appeal;
6. The right to request an expedited appeal under 42 C.F.R. § 438.210(d)(2), the circumstances under which expedited resolution is available and how to request it;
7. If applicable, the enrollee'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 enrollee may be required to repay the costs of these services; and,
8. The right to be represented by an attorney or any other individual.

The Contractor must mail the notice within the timeframes specified by 42 C.F.R. 438.404(c).

The written notice must be translated 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.

A member may request continuation of services during the Contractor's internal appeal and during the DMAS State Fair Hearing. A determination on continuation of services must be made in accordance with 42 C.F.R. § 438.420 and the regulations governing the MEDALLION 4.0 program. If the final resolution of the appeal upholds the Contractor's action and services to the member were continued while the internal appeal of or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services from the member to the extent that the services were furnished solely because of the requirements of 42 C.F.R. § 438.420 and the regulations governing the MEDALLION 4.0 program.

Written material 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. Enrollees must be informed that information is available in alternate formats and how to access those formats.

The Contractor is responsible for the preservation and production of documents associated with any appeal and State Fair Hearing process. The Contractor shall be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, Freedom of Information Act (FOIA) request, or any litigation involving the Contractor or the Department, including but not limited to, State Fair Hearings and judicial review.

The Offeror, in response to this RFP, shall describe how members will be informed of the MCO appeal rights and processes and the DMAS appeal rights and processes. Offerors also shall describe internal procedures utilized to process member appeals in a timely manner.

3.15.3 Contractor Level Internal Appeals

The internal appeal is the only level of appeal with the Contractor, and the member must begin the appeals process by filing an internal appeal with the Contractor. The filing of an internal appeal and exhaustion of the Contractor's internal appeal process is a prerequisite to filing a request for a State Fair Hearing with DMAS. If an appeal is sent to DMAS by the enrollee or provider, and the internal Contractor appeal process has not been exhausted, the Contractor must respond to DMAS within one

(1) business day of notification of the appeal by DMAS that the Contractor's internal appeal process has not been exhausted.

The Contractor's appeals process shall include the following requirements:

1. Give the Appellant any reasonable assistance in completing forms and taking other procedural steps related to an appeal, including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;
2. Acknowledge receipt of each appeal;
3. Ensure that the individuals who make decisions on appeals are individuals who were neither involved in any previous level of review or decision making nor a subordinate of any such individual;
4. Ensure that the individuals who make decisions on appeals of denials based on medical necessity or clinical issues have the appropriate clinical expertise, as determined by DMAS, in treating the Appellant's condition or disease and will take into account all comments, documents, records, and other information submitted by the Appellant or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;
5. An appeal may be submitted orally or in writing. If the Appellant does not request an expedited appeal pursuant to 42 C.F.R. § 438.410, the Contractor must require (42 C.F.R.§ 438.402) the Appellant to follow an oral appeal with a written, signed appeal;
6. Provide the Appellant a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The Contractor must inform the Appellant of the limited time available for this, especially in the case of expedited resolution;
7. Provide, free of charge and sufficiently in advance of the hearing, the Appellant and his or her representative the enrollee's case file, including any medical records and any other documents and records considered during the appeals process; and
8. Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

The Contractor shall respond in writing to standard internal appeals as expeditiously as the enrollee's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is need for additional information and that a delay in rendering the decision is in the enrollee's interest. For any appeals decisions not rendered within thirty (30) calendar days where the enrollee has not requested an extension, the Contractor shall make reasonable efforts to give the enrollee prompt oral notice of the delay; within two (2) calendar days, the Contractor shall give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of their right to file a grievance if the enrollee disagrees with that decision; and resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

The Contractor shall establish and maintain an expedited review process for internal appeals where either the Contractor or the enrollee's provider determine that the time expended in a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is not taken

against a provider that requests an expedited resolution or supports an enrollee's internal appeal. In instances where the enrollee's request for an expedited internal appeal is denied, the internal appeal must be transferred according to the timeframe for standard resolution of internal appeal, and the enrollee must be given prompt oral notice of the denial. Within two (2) calendar days of the oral notice of appeal, the enrollee must be sent written notice of the reason for the decision to deny the request for an expedited appeal, and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision.

The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee 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 enrollee's interest. For any extension not requested by the enrollee, the Contractor shall provide written notice to the enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up in writing within two (2) calendar days and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision, and resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

All Contractor internal appeal decisions must be made in writing and shall include, but not be limited to, the following information:

1. The decision reached by the Contractor, including a specific discussion of the reason for the denial, including citations to the policies, procedures, and/or authority that support the decision;
2. The date of the decision; and
3. For internal appeals not resolved wholly in favor of the enrollee:
    a. The right to request a State Fair Hearing with DMAS of the Contractor's denial. The denial letter shall clearly identify that the internal appeal process has been exhausted, and include the timeframe for filing an appeal, the address to file an appeal, and list pertinent statutes/regulations governing the appeal process; and
    b. The right to request to receive benefits while the State Fair Hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the State Fair Hearing decision upholds the Contractor to the extent that services were furnished (continued) solely because of the requirements of this section. [42 C.F.R. § 438.420(d)]

3.15.4 State Fair Hearing Process

Members have the right to appeal adverse benefit determinations to the Department. However, the Contractor's internal appeal process must be exhausted, or deemed exhausted due to the failure of the Contractor to adhere to the notice and timing requirements, prior to an enrollee filing an appeal with the DMAS Appeals Division.

DMAS enrollee State Fair Hearings are conducted in accordance with 42 C.F.R. §§ 431 Subpart E and 438 Subpart F and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include, but are not limited to, reductions in service, suspensions, terminations, and denials. 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 DMAS by the enrollee or the enrollee's representative. Expedited appeals may be filed by telephone or in writing. The request for a State Fair Hearing may be filed at any time after the Contractor's appeal process is exhausted and extending through 120 days after receipt of the Contractor's appeal decision. For requests not filed within this timeline, an acceptable reason for delay, as determined by DMAS, must exist.

The Contractor agrees to be fully compliant with all state and federal laws, regulations, and policies governing the internal appeal and State Fair Hearing process, as applicable, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited appeal requests. The Contractor shall be financially liable for all judgments, penalties, costs, and fees related to an appeal in which the Contractor has failed to comply with said requirements.

Upon receipt of notification by the Department of an appeal, the Contractor shall prepare and submit appeal summaries describing the basis of the adverse benefit determination to the DMAS Appeals Division, the DMAS MEDALLION 4.0 contract monitor, and the member involved in the appeal in accordance with required time frames.

The summary must be completed in accordance with 12 VAC 30-110-70, which describes notification requirements and also serves as a guideline for information necessary to include in both the notice and the summary. The Contractor shall submit the appeal summary to the Department within 21 calendar days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all cases, the summary must be received by the Department at least 10 calendar days prior to the scheduled hearing date and mailed to the member on the date submitted to the DMAS Appeals Division. The appeal summary shall include any and all justification that the Contractor wants considered as part of the State Fair Hearing, including but not limited to the policy and applicable regulations (not a summary thereof) upon which the Contractor's decision is based. For expedited appeals that meet the criteria set forth in 42 C.F.R. § 438.410, the appeal summary must be faxed to the Department and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) business hours after the Department informs the Contractor of the expedited appeal.

The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division. All expenses in relation to appeal activities, including travel and telephone expenses, shall be borne by the Contractor. Failure to attend and defend the Contractor's actions at all appeal hearings and/or conferences shall result in the application of liquidated damages as set forth in the MEDALLION 4.0 Contract.

State Fair Hearings

Failure to attend or defend the Contractor's decisions at all State Fair hearings or conferences shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's non-compliance, including but not limited to the amount in dispute together with costs and legal fees.

Remedies

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

All liquidated damages imposed pursuant to this section, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits within thirty (30) calendar days after Contractor's receipt of the notice of damages

Requests for State Fair Hearings to DMAS that do not qualify as expedited shall be resolved or a decision shall be issued by DMAS within ninety (90) days from the date the enrollee filed the internal appeal with the Contractor, not including the number of days the enrollee took to subsequently file for a State Fair Hearing. The timeline for resolution or issuance of a decision in State Fair Hearing appeals may be extended for delays not caused by DMAS, in accordance with 42 C.F.R. § 431.244(f)(4).

Request for State Fair Hearings to DMAS that qualify as expedited appeals shall be resolved within 72 hours or as expeditiously as the enrollee's condition requires.

For State Fair Hearings filed with the DMAS Appeals Division, an enrollee may request continuation of services. DMAS will make a determination on continuation of services in accordance 12 VAC 30-110-100, and 42 C.F.R. § 438.420. If the final resolution of the appeal upholds the Contractor's action, and services to the enrollee were continued while the internal appeal and/or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services from the enrollee, to the extent that the services were furnished solely because of the requirements of 12 VAC 30-110-100 and 42 C.F.R. § 438.420.

In accordance with 42 C.F.R. § 438.424, if the State Fair Hearing 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 or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

The Contractor does not have the right to appeal DMAS' State Fair Hearing decisions.

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, DMAS 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 DMAS or the OAG within one 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.

3.15.5 Provider Reconsiderations

The Contractor shall have a reconsideration process in place comparable to those stated in Sections 3.15.2 and 3.15.3 of this RFP 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.

If a provider has rendered services to a member enrolled with the Contractor in a Medicaid program and has either been denied authorization/reimbursement for the services or has received reduced authorization/ reimbursement, that provider can request a reconsideration of the denied or reduced authorization/ reimbursement. Before appealing to the Department, MCO providers must first exhaust the Contractor's reconsideration process. Providers (in limited circumstances) who are in the Contractor's network but are not also enrolled with the Department may not appeal termination actions to the Department.

3.15.6 Provider Grievances

Provider grievances are not appealable to the DMAS Appeals Division. A provider who wishes to file a grievance is limited to the process that the Contractor has established for handling these matters as noted in Section 3.15.1 of this RFP.

3.15.7 Provider Appeals

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 levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is held before an Informal Appeals Agent employed by the Department. The formal appeal is held before a hearing officer appointed by the Supreme Court of Virginia, and a Formal Appeals Agent employed by the Department helps present the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Department Director in issuing the Final Agency Decision. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor reconsideration decisions filed by providers.

All provider appeals to the Department must be submitted in writing and within 30 calendar days of the Contractor's last date of denial to the DMAS Appeals Division, 600 East Broad Street, Richmond, VA 23219. The Contractor's final denial letter must include a statement that the provider has exhausted its reconsideration rights with the Contractor and that the next level of appeal is with the Department of Medical Assistance Services. The final denial letter must include the standard appeal rights to the Department, including the time period and address to file the appeal.

Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS MEDALLION 4.0 Contract Monitor, and the provider involved in the appeal in accordance with required applicable regulatory requirements and timeframes. The appeal summary content and timelines are specified by appeal regulations. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. All documents, including appeal summaries, must be filed with

the Appeals Division by 5:00 p.m. on the deadline date. Failure to submit appeals summaries within the required timeframe and/or that fail to meet the applicable regulatory requirements shall result in the Contractor being liable for any costs that DMAS 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 the application of liquidated damages as set forth in the MEDALLION 4.0 contract.

Informal Appeal
Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's non-compliance, including but not limited to the amount in dispute together with costs and legal fees.

Formal Appeal
Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that the Department incurs as a result of the Contractor's non-compliance, including but not limited to the amount in dispute together with costs and legal fees.

Remedies
In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

All liquidated damages imposed pursuant to this section, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits within thirty (30) calendar days after Contractor's receipt of the notice of damages.

The Contractor shall 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 DMAS 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 shall 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, shall be borne by the Contractor. Failure to attend or defend the Contractor's reconsideration decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS 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 performance penalties specified in the Contract.

The Contractor does not have the right to appeal DMAS' State Fair Hearing decisions.

The Department's final administrative appeal decision may be appealed through the court system. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, DMAS and/or its counsel at the 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 lawsuit because the issue being contested is DMAS' appeal decision. The Contractor must respond to inquiries from DMAS or the OAG within one 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.

Offerors, in response to this RFP, shall describe its capacity and experience in Medicaid state contracted appeals processes for contracts of similar size and scope to this RFP.

SECTION 4.0 BENEFITS AND SERVICES REQUIREMENTS

4.1 ELIGIBILITY

The Department shall have sole responsibility for determining the eligibility of an individual for Medicaid/FAMIS-funded services. DMAS shall also have sole responsibility for determining enrollment with the Contractor. Such determinations shall be 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.

During the course of the MEDALLION 4.0 Contract, DMAS reserves the right to add and/or change the populations, eligibility, and/or services included in the program on a statewide or pilot basis.

4.1.1 Exclusions from MEDALLION 4.0 Participation

DMAS shall exclude individuals who meet at least one of the exclusion criteria listed below and further defined in the MEDALLION 4.0 Contract:

1. Home and Community-Based Waivers
2. Commonwealth Coordinated Care (CCC) Plus Program
3. Aged, Blind, or Disabled (ABDs) including SSI
4. PACE program
5. Money Follows the Person (MFP)
6. Dual eligible (Medicare and Medicaid enrollee)
7. Medicaid-approved hospice program at the time of enrollment
8. Limited life expectancy (physician certifies life expectancy of six (6) months or less
9. Under age 21 who are approved for DMAS PRTF programs as defined in 12VAC 30-130-860. Effective December 1, 2018, this shall no longer be an exclusion
10. Inpatient in long-stay hospitals
11. Spend down
12. Residents at Piedmont, Catawba, and Hancock State facilities operated by DBHDS
13. Residents in nursing facilities operated by the Veterans Administration
14. Plan First family planning program (unless implemented by DMAS as an optional population)
15. Newly eligible pregnant members in third trimester who request exclusion
16. Inpatient members in hospitals who are inpatients in hospitals at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date
17. Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund
18. Outside area of residence who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those members placed there for medically necessary services funded by the Contractor or other MCO
19. Limited eligibility period (less than three (3) months)
20. Retroactive eligibility
21. Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
22. Individuals enrolled in the Governor's Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories.

Individuals enrolled in MEDALLION 4.0 who subsequently meet one or more of the criteria outlined above shall be excluded as determined by DMAS. Individuals excluded from mandatory enrollment shall receive Medicaid services under the current FFS system unless eligible for one of DMAS' other managed care programs. When individuals no longer meet the criteria for MEDALLION 4.0 exclusion, they shall be required to re-enroll in MEDALLION 4.0, if eligible.

The Contractor shall promptly notify the Department upon learning that a member meets one or more of the exclusion criteria.

The Department shall, upon new State or Federal regulations or Department policy, modify the list of excluded individuals as appropriate. If the Department modifies the exclusion criteria, then the Contractor shall comply with the amended list of exclusion criteria.

4.1.2 Payment Coordination with Other Coverage

Members enrolled in Medicaid, determined by the DMAS as having comprehensive health coverage, other than Medicare, will be eligible for enrollment in MEDALLION 4.0, as long as no other exclusion applies. Members who obtain other comprehensive health coverage after enrollment in MEDALLION 4.0 shall remain enrolled in the program. Members who obtain Medicare after MEDALLION 4.0 enrollment shall be disenrolled and subsequently enrolled in CCC Plus. The Contractor shall be responsible for coordination of benefits for its members as described in the MEDALLION 4.0 Contract.

The Contractor is responsible for coordinating all benefits with other insurance carriers (as applicable) and following Medicaid "payer of last resort" rules. The Contractor also shall cover the 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 payor is a commercial MCO/HMO organization, the Contractor is responsible for the full member copayment amount. The Contractor shall ensure that the member is held harmless for payments and copayments for any Medicaid covered service.

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,
   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.

Under Section 1902(a)(25) of the Social Security Act (42 USC §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources, including Workers' Compensation, Estate Recoveries, and Comprehensive Health Coverage.

The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered from third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage.

DMAS 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 initiate litigation to seek recovery of any non-health insurance funds. Members with these other resources shall remain enrolled in the MEDALLION 4.0 program as long as they continue to meet eligibility requirements.

The Contractor shall notify DMAS monthly of any members identified during that past month who are discovered to have any of the above coverage, including members identified as having trauma injuries. The Contractor shall provide DMAS with all encounter/claims data associated with care given to members who have been identified as having any of the above coverage.

The Contractor shall provide member claim history when requested by the Department's TPL Unit staff to aid in the pursuit of non-health insurance resources.

Workers' Compensation

If a member is injured at his or her place of employment and files a workers' compensation claim, the Contractor shall remain responsible for all covered benefits and services. The Contractor may seek recoveries from a claim covered by worker's compensation if the Contractor actually reimbursed providers and the claim is approved for the worker's compensation fund. The Contractor shall notify DMAS monthly of any members identified during that past month who are discovered to have workers' compensation coverage.

If the member's injury is determined not to qualify as a workers' compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with workers' compensation regulations.

Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor shall notify DMAS monthly of any members identified during that past month who have died and are over the age of fifty-five (55).

Offerors, in response to this RFP, shall describe experience, capacity, and processes to coordinate benefits for Medicaid state contracted programs similar in scope to this RFP including how members with TPL are identified and the name of the subcontractor handling these activities.

4.1.3 Members with High-Utilization or Emerging High-Risk Factors

The Offeror shall describe quantitative methods it will use to identify and monitor members with high-utilization or emerging high-risk factors and how this information will be used to improve care coordination. The Offeror shall provide an explanation of this process (including the personnel involved, the metrics for identification of high-utilizer trend analysis, etc.) and describe how the effectiveness of strategies implemented will be evaluated.

4.2 Population Specific Focus

MEDALLION 4.0 will have a targeted population focus on pregnant women, infants, children, and parents/care caregivers. In order to have a more integrated focus, services such as early intervention, and community mental health rehabilitative services will be added to the program. As the Department

transitions the ABD population to CCC Plus (reference Section 1.4), DMAS will align requirements, where feasible, of MEDALLION 4.0 and CCC Plus to include, but not limited to, common core formulary and increased rebates, value based purchasing, and enhanced data quality and submission.

The Contractor shall form partnerships with other state agencies (VDH, DBHDS, DOE, VDSS), as outlined in the Contract, in an effort to increase participation in programs and services to improve the health of women, infants, children, and adolescents. This includes, but shall not be limited to, Title V Maternal and Child Health Programs, Bright Futures, WIC, Center for Disease Control (CDC), Fostering Futures, etc. In response to this RFP, Offerors shall demonstrate its commitment to work with DMAS on MEDALLION 4.0 pilot projects and new initiatives that focus on all populations indicated in this RFP and that may occur mid-year in the contract cycle. Offerors shall describe experience working with agencies as noted above in the provision of services to the MEDALLION 4.0 population.

For each of the populations described below, Offerors shall specifically demonstrate

1. Minimum of three (3) years' experience with providing services in Medicaid state contracted programs
2. Data, outcomes, and trends for past three (3) years, including any HEDIS or HEDIS-like outcomes
3. Efforts to control utilization trends over the past three (3) years
4. Any deficiencies experienced by the Offeror in the provision of services to the population and plans to overcome the deficiencies
5. By each proposed region, proposed innovations to improve the care, health and well-being of the population

4.2.1 Pregnant Women

Medicaid, FAMIS, and FAMIS MOMS covers one-third of all births in the Commonwealth of Virginia. Thus, DMAS has a strong commitment to the health and well-being of pregnant members and their babies. Offerors are encouraged to find ways to improve the efficiency and effectiveness of strategies, policies and procedures in order to positively impact maternity care for DMAS beneficiaries. The 2015-2016 Prenatal Care and Birth Outcomes Focused Study, conducted by the Department's EQRO, is available at http://www.dmas.virginia.gov/Content_atchs/mc/2015%20Birth%20Outcomes%20Focused%20Study.pdf.

The Offeror shall explain in detail a full understanding of maternity and maternity-related services for pregnant women that will be covered under the MEDALLION 4.0 Contract and describe any strategies or innovations, by each region, to:

- Increase early prenatal care, including identifying and serving high risk pregnant women
- Increase case management
- Increase post-partum care including depression screenings
- Reduce early elective deliveries
- Lower C-Section rates
- Increase breast feeding
- Increase family planning and LARC utilization
- Increase HEDIS scores related to maternity
- Implement Addiction and Recovery Treatment Services (ARTS), specifically for pregnant women with substance abuse

- Increase outreach and education, including the use of social media, to pregnant women
- Possible value-based purchasing arrangements
- Possible kick payments for maternity

4.2.2 Infants Ages 0 to 3

The Offeror shall explain in detail a full understanding of services for infants ages 0 to 3 that will be covered under the MEDALLION 4.0 Contract and describe any strategies or innovations, by each region, related to:

- Increase in immunizations
- Increase in well visits and required EPSDT screenings
- Implement safe sleep initiatives, including participating with the Department in pilot initiatives related to sleep boxes to include physician visits, home visiting, education, and evaluation
- Providing early intervention services
- Substance-exposed infants (SEI) and infants with Neonatal Abstinence Syndrome (NAS) (VDSS and LDSS Initiative)
- Reduction in infant death (Three Branch Workgroup Initiative)
- Early detection, screening and intervention
- Infant and early childhood mental health (Zero to Three Initiative), including trauma-informed care, ACES and resilience

4.2.3 Children Ages 3 to 18

The Offeror shall explain in detail a full understanding of services for children ages 3 to 18 that will be covered under the MEDALLION 4.0 Contract and describe any strategies or innovations, by each region, related to:

- Increase in oral health, vision
- Increase in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Prevent and/or reduce obesity, asthma, or other chronic conditions
- Focus on teens and adolescent health, including trauma-informed care, ACES and resilience
- Focus on children and youth with special health care needs (CYSHCN)
- Focus on foster care and adoption assistance children (VDSS and LDSS Initiatives)
- Transition planning to help teens and young adults prepare for changes following their 18th birthday

4.2.4 Adults

The Offeror shall explain in detail a full understanding of services for adults that will be covered under the MEDALLION 4.0 Contract and describe any strategies or innovations, by each region, related to:

- Wellness and prevention programs
- Chronic Diseases, including but not limited to diabetes, hypertension, heart disease, obesity
- Specialty Programs, including but not limited to ARTS, social determinants of health
- Behavioral health and community mental health rehabilitative services (CMHRS)
- Family planning/Long Acting Reversible Contraceptive (LARC)
- Emergency department use

4.2.5 Family Access to Medical Insurance Security (FAMIS) Plan

The Contractor shall promptly provide, arrange, purchase, or otherwise make available all services required under this RFP and subsequent contract to all of its FAMIS members as outlined in Attachment B Part 4.

FAMIS members may be subject to cost sharing provisions that will include nominal co-payments for services rendered. Cost sharing provisions will be determined by DMAS. Currently under FAMIS, total cost sharing for each 12-month eligibility period is limited to 2.5% of gross income for families with incomes below 150% of the federal poverty level (FPL), and to 5% of income for families with incomes between 150% and 200% of the FPL. Families below 150% of FPL are responsible for co-payments, which are currently capped at $180 per family per calendar year. Families with incomes between 150% and 200% of the FPL co-payments are capped at $350 per family per year. Copayments shall not be required for well-child, well baby, and pregnancy-related services.

The Contractor shall be responsible for calculating and tracking the total amount of co-payments made by each family for the year. Once a family has reached their maximum annual cost share level the Contractor shall be responsible for ensuring that all interested parties are apprised of the fact that additional co-pays cannot be levied.

The Contractor shall be responsible for developing a mechanism to stop collecting co-payments once the member/family has met the annual co-payment requirement.

The Offeror shall explain in detail a full understanding of services for children that will be covered under the FAMIS and describe any strategies or innovations, by each region.

4.2.6 Services Received Through an Indian Health Service (IHS) or Tribal Facility

In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the following shall be provided for Native American Members:

a. Coverage for services from an Indian Health Service or Tribal provider, including out-of-network Indian Health Service or Tribal providers, in accordance with the State Health Official Letter (SHO #16-002)(available at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf);
b. Offer Native American members the option to choose an Indian Health Care Provider as a PCP if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;
c. Sufficient Indian Health Care Providers in the network to ensure access to Covered Services;
d. Reimburse both network and non-network Indian Health Care Providers who provide covered services to Native American Members a negotiated rate which shall be no lower than the Department's fee-for-service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the covered service by a non-Indian Health Care Provider;
e. Reimburse non-network Indian Health Care Providers that are FQHCs for the provision of services to an Native American Member at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider; and,
f. Not impose enrollment fees, premiums, or similar charges on Native Americans served by an Indian Health Care Provider.

Offerors shall explain in full detail experience with the provision of services to Native Americans under a Medicaid state contracted program.

4.3 CARE COORDINATION SYSTEM

4.3.1 Coordination and Continuity of Care

In accordance with 42 C.F.R. § 438.208, the Contractor shall have systems in place that ensure coordinated patient care for all members and that provide particular attention to the needs of members with a history of trauma, complex, serious and/or disabling conditions. The systems, policies and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers.

At a minimum, care coordination systems shall:

- Provide a single, 24/7 toll-free number for assistance
- Facilitate referrals that result in timely appointments
- Provide communication and education regarding available services and community resources in a mode and manner that is culturally and developmentally appropriate and considers the member's physical and cognitive abilities and level of literacy.

Offerors shall take into consideration that individuals enrolled in MEDALLION 4.0 may receive mental health case management (exclusively provided by CSBs), substance use disorder (Addiction and Recovery Treatment Services {ARTS}), case management, treatment foster care case management (for children under age 21 years), early intervention, high risk prenatal and infant case management. These services include but are not limited to assessments, the development of specific care plans, referrals and related activities, and monitoring and follow-up activities.

Offerors, in response to this RFP, shall fully describe the care coordination system that addresses the following elements:

1. Primary Care - In accordance with 42 C.F.R. §438.208 (b), members must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. The member must be provided information on how to contact their designated person or entity.
2. Coordination/Prevention of Duplicate Services - provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.
3. HIPAA, Member Privacy, and Health Records - ensure that the process utilized to coordinate the member's care complies with member privacy protections described in HIPAA regulations and in Title 45 C.F.R. parts 160 and 164, subparts A and E, to the extent applicable. Under 42 C.F.R.§ 438.208(b)(6), ensure that each provider furnishing services to the member maintains and shares a member health record in accordance with professional standards.
4. Clinically Qualified Providers - pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services and referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

5. Communication for Members with Disabilities - require contracted providers to ensure that members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.
6. List of Referral Sources - a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed.

Offerors response shall:

- Describe how its care coordination system addresses each element noted above by each of its proposed region(s) and address the needs of the populations outlined in this RFP.
- Explain how its proposed care coordination system varies to meet regional needs and address regional culture and diversity.
- Demonstrate that it has the qualified staff, infrastructure, and systems in place to monitor the delivery of person-centered care coordination.
- Demonstrate how members receive the appropriate specialized care from providers such as high risk/maternal fetal medicine specialists, neuropsychologists, pediatric specialists, etc.
- Describe ER diversion and coordination strategies
- Describe proposed strategies to outreach to and engage individuals who are hard to contact/locate.
- Submit for review any tools or flow charts that illustrate the proposed processes.

4.3.2 Health Risk Assessments (HRAs)

In accordance with 42 C.F.R.§ 438.208(b)(3), the Contractor shall:

1. Make a best effort to conduct an initial screening of each member's needs, within ninety (90) days of the effective date of enrollment for all new members.
2. Make subsequent attempts to conduct an initial screening of each new member's needs if the initial attempt to contact the member is unsuccessful.

The Contractor shall meet the requirements for HRA compliance as defined in the MEDALLION 4.0 Contract. A successful assessment is considered a contact with the member, by the health plan that fully assesses all health care needs, including behavioral health, interventions received, and any additional services or referral needs.

In accordance with 42 C.F.R. § 438.208(c), all reasonable steps shall be taken to assure that all newly eligible/enrolled members defined as children/youth with specials health care needs receive an assessment within sixty (60) calendar days of initial enrollment to determine level of health and necessary interventions as may be appropriate.
Offerors, in response to this RFP, shall submit for review any other tools or flow charts that illustrate the proposed processes and:

a. Describe and submit all of the HRA tools the Offeror will use to identify the specialized needs of its members. At a minimum, HRA tools must encompass social (including housing and employment), functional, medical, behavioral, cognitive, wellness and preventive domains. The HRAs must identify member's primary care provider and specialists, strengths and goals, identify if the member utilizes case management services, community resources used/available for the member, and the plan for care coordination.

b. Describe in detail, the identification strategy, including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information that are used to prioritize the timeframes for when and how initial HRAs and reassessments are conducted for members. Clearly define when the stratification is conducted (e.g., how far in advance of effective date and on an ongoing basis). Also describe how the results of the HRAs are used to confirm the appropriate stratification level.
c. Describe the personnel who review, analyze, and stratify health care needs.
d. If an initial brief screening tool will be used for member stratification and identification of needs, submit a copy of this tool.
e. Describe proposed strategies to outreach to and engage individuals who are hard to contact/locate.
f. Describe how the Offeror involves members and family members/caregivers in the HRA process. The Offeror must describe efforts for the different populations covered under the MEDALLION 4.0 Program. Describe how the Offeror will accommodate the needs of individuals with communication impairments (e.g., speech, hearing and/or vision limitations) and individuals with limited English proficiency, in a culturally and developmentally appropriate manner and how the Offeror will consider an member's physical and cognitive abilities and level of literacy in the assessment process.
g. Describe how the Offeror will ensure that HRA reassessments to identify any changes in the specialized needs of its members are conducted.

4.4 Covered Services

The Contractor shall promptly provide, arrange, purchase, or otherwise make available all covered Medicaid/FAMIS services (Attachment B) as defined under the State Plan for Medical Assistance (State Plan) as amended, the §1915 (b) waiver, the MEDALLION 4.0 Contract, written Department policies (including, but not limited to, contracts, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The Contractor shall not be responsible for coverage of carved-out services as listed in Attachment B.

The Contractor shall assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the MEDALLION 4.0 program, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions. MEDALLION 4.0 members will be exempt from cost sharing. The cost sharing exemption shall not apply to FAMIS members.

The Contractor shall have care managers and staff familiar with all covered and carved out services as indicated in the MEDALLION 4.0 Contract. The Contractor shall have the ability to refer and communicate with DMAS, DBHDS, and other formal and informal supports to ensure coordination of care. See Attachment B and applicable provider manuals available on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal for additional information about covered services.

In response to this RFP, the Offeror shall explain in detail a full understanding of the covered services and explain any experience providing these or similar covered services to the populations outlined in this RFP, including how these services will be provided in each region to members as needed. The

Offeror's response shall include the following service categories: acute and primary, pharmacy, behavioral health, ARTS, early intervention, as detailed in Attachment B.

During the course of the MEDALLION 4.0 Contract, DMAS reserves the right to add and/or change the populations, eligibility, and/or services included in the program on a statewide or pilot basis.

4.4.1 Medical Necessity

Services shall be provided to enrollees in accordance with medical necessity requirements set forth in 42 C.F.R. 438.210. Medical necessity criteria shall be no more restrictive than the State Medicaid program as indicated in state statutes and regulations, State Plan, and other State policy and procedures, including all DMAS Program Memos and Manuals.

Medical necessity guidelines, program specifications and service components for services must, at a minimum, be submitted to DMAS annually for approval no later than 30 days prior to the start of a new Contract year, and no later than 30 days prior to any change.

4.4.2 Enhanced Benefits

Enhanced benefits are services offered to members in excess of the MEDALLION 4.0 covered services. Examples of potential enhanced benefits include, but are not limited to, routine and preventive dental coverage for adults, chiropractic care, vision, hearing for adults, etc. No increased reimbursement shall be made for enhanced benefits provided by the Contractor.

Enhanced benefits offered will be listed in the Department's MEDALLION 4.0 comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services shall be made only at open enrollment. However, the Contractor may revise enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services which have been added by the Contractor and approved by the Department.

Offerors, in response to this RFP, shall indicate its intent to offer enhanced benefits and provide a detailed description of the services, by region, to whom the benefits would be available (enhanced benefits do not have to be offered to individuals in every category of eligibility), the benefit limits, procedure codes, and criteria for the approval of requests for each enhanced benefit, including any service limits or authorization.

4.4.3 Member Healthy Incentives

The Contractor may offer non-cash incentives or discounts to their enrolled members for the purposes of rewarding healthy behaviors (e.g., immunizations [flu, pneumonia, etc.], EPSDT visits, prenatal visits, provider visits, or participating in disease management, HEDIS or HEDIS related measures/activities, etc.). Incentives shall be made available in equal amount, duration, and scope to the Contractor's membership in all localities served. Incentives shall be limited to a value of no more than $50.00 for each medical goal, unless otherwise approved by DMAS. Incentives over $50.00 per medical goal must be approved by DMAS prior to implementation; DMAS reserves the right to deny healthy incentive

initiatives that do not align with DMAS 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 (Wal-Mart, Target, etc.) for cash; cash incentives are not permitted.

Offerors, in response to this RFP, shall submit a current healthy incentives plan offered in a current Medicaid state contracted program similar in scope to this RFP. The plan shall describe the anticipated outcomes and how the Offeror measures the success of the incentives offered and return on investment.

4.4.4 Continuity of Care Provisions

To ensure there is no interruption of any covered services for enrollees, policies and procedures shall be developed by the Contractor to ensure continuity of care for all enrollees that include the information below. During the time period set below, the Contractor shall maintain the enrollee's current providers at the Medicaid FFS rate and honor service authorizations (SAs) issued prior to enrollment for the specified time period.

An enrollee shall be allowed to maintain his or her current providers (including out-of-network providers) for 90 days, or where services are authorized, for the duration of the service authorization or 90 days, whichever comes first. During the 90-day continuity of care period, the Contractor may change an enrollee's existing provider only in the following circumstances: (1) the enrollee requests a change; (2) the provider chooses to discontinue providing services to an enrollee as currently allowed by Medicaid; (3) the Contractor or DMAS identify provider performance and/or quality of care issues that affect an enrollee's health or welfare; or (4) the provider is excluded under state or federal exclusion requirements.

Within the first 90 days of an enrollee's membership with a health plan, reasonable efforts shall be made to contact out-of-network providers who are providing services to enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or the enrollee does not select a new in-network provider by the end of the 90-day period, the Contractor shall choose one for the enrollee. The Contractor must offer single-case agreements to providers who are not willing to enroll in the Contractor's provider network and under special circumstances that will be outlined in the MEDALLION 4.0 Contract.

Service authorizations (SA) issued by the Department or its Contractors shall be honored as provided through DMAS transition reports and DMAS' contracted entities for the duration of the SA or for 90 days from enrollment, whichever comes first.

If, as a result of the HRA development, the Contractor proposes modifications to the enrollee's SAs, the Contractor shall provide written notification to the enrollee and an opportunity for the enrollee to appeal the proposed modifications.

The Contractor shall transfer SA and other pertinent information, as defined by Contract, necessary to assure continuity of care to another Contractor, to DMAS, or its designated entity for enrollees who transfer to another health plan or back to fee-for-service. The information shall be provided within three (3) business days from receipt of the notice of disenrollment to the Contractor in the method and format specified by DMAS. The Contractor shall work with the Department to develop and implement

an automated process for sharing and honoring SAs for members who transition between the fee-for-service and MEDALLION 4.0 or other DMAS programs and from one health plan to another. The Contractor shall share the necessary data in a HIPAA compliant format as directed by DMAS.

Offerors, in response to this RFP, shall detail how a member's care will be seamlessly coordinate in a safe and effective manner through the care continuum.

4.4.5 Access to Care Standards

In accordance with 42 C.F.R. § 438.206, the Contractor shall be responsible for arranging and administering covered services to enrolled individuals and shall ensure that its delivery system shall provide available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services.

Members shall be provided with a choice of a minimum of two (2) providers for each type of service, as listed in covered services chart, Attachment B, in accordance to time and distance standards. Each provider must have the capacity to serve each member within the time and distance standards specified below. Additionally, the Contractor shall ensure that its provider network meets access to timely care for services, including where the provider travels to the member's home to provide services.

Offerors shall consider the following when establishing and maintaining its networks:

1. The anticipated enrollment for the MEDALLION 4.0 Program by region;
2. The expected utilization of services, taking into consideration the cultural and ethnic diversity characteristics and health care needs of the anticipated MEDALLION 4.0 program population to be served and the existing patterns of utilization, including in localities that fall adjacent to another region and localities that border that with other States;
3. The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted services;
4. The numbers of network providers not accepting new patients;
5. The geographic location of network providers and MEDALLION 4.0 enrollees, considering distance, travel time, and the means of transportation ordinarily used by MEDALLION 4.0 enrollees;
6. The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
7. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for MEDALLION 4.0 enrollees with physical or mental disabilities; and
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.

Offerors, in response to this RFP, also shall identify any deficiencies in its provider network that meets access to timely care for services and provide the plans to overcome such deficiencies.

4.4.6 Travel Time and Distance

Enrollee Travel Time Standard

For urban areas, each enrollee shall have a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving

during normal traffic conditions (i.e., not during commuting hours). For rural areas, each enrollee shall have a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any enrollee unless the Contractor has a Department-approved alternative time standard. Travel time standards only apply to the enrollee's travel time. Travel time standards only apply to the time an enrollee must travel to receive a service. Time standards do not apply to providers who travel to provide a service (e.g., home health).

Enrollee Travel Distance Standard
Each enrollee shall have a choice of at least two (2) providers per service type located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. Travel distance standards only apply to the distance an enrollee must travel to receive a service. Travel distance standards do not apply to providers who travel to provide a service (e.g., home health).

4.5 Additional Requirements

4.5.1 Interventions to Prevent Controlled Substance Use

The Contractor shall be responsible for complying with all DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the DMAS website at: https://www.virginiamedicaidpharmacyservices.com.

The Contractor shall 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 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 shall implement the DMAS approved clinical criteria detailed in the DMAS Provider Memo dated December 1, 2016 titled "Implementation of CDC Guideline for Prescribing Opioids for Chronic Pain – Coverage of Non-Opioid Pain Relievers and Uniform, Streamlined Prior Authorization for New Opioid Prescriptions Effective December 1, 2016".

Offerors, in response to this RFP, shall submit an annual report from a current Medicaid state contract that describes its interventions targeted to prevent controlled substance use. The report shall describe actions taken to prevent the inappropriate use of controlled substances, including but not limited to, any clinical treatment protocols, a detailed definition of what, if any substances targeted that are not scheduled substances under the Controlled Substances Act (21 U.S.C. § 801 et seq.) but may place an individual at higher risk for abuse, authorization requirements, quantity limits, poly-pharmacy considerations, and/or related clinical edits.

4.5.2 Prescription Drugs and Common Core Formulary

The Contractor shall be responsible for covering all Food and Drug Administration (FDA) approved drugs for members, as set forth in 12 VAC 30-50-210, and in compliance with § 38.2-4312.1 of the *Code of Virginia,* MEDALLION 4.0 Contract, as well as follow the Department's approved fee-for-service clinical criteria for drugs used in the treatment of opioid use disorder and pain management, including the quantity limits and uniform authorizations developed by DMAS for short-acting opioids, long-acting

opioids, and buprenorphine products. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of §1927 of the Social Security Act (OBRA 90 §4401), shall not be covered. The Contractor shall maintain a formulary to meet the unique needs of the members it serves; at a minimum, the Contractor's formulary shall include all the preferred drugs on the DMAS Preferred Drug List (PDL) available at https://www.virginiamedicaidpharmacyservices.com. The DMAS PDL is not an all-inclusive list of medications for DMAS members. Contractors are required to cover all medically necessary, clinically appropriate, and cost-effective medications that are federally reimbursable.

The DMAS PDL will serve as the common core formulary for the Contractor.

The Contractor may add medications to most common core formulary drug classes; however members cannot be required to try other drugs on the Contractor's formulary before being prescribed the "preferred drug" from the DMAS PDL. The common core formulary will include a select number of "closed drugs classes" to which the Contractor shall not add or remove drugs including alternative dosage forms. Information regarding the common core formulary can be found at https://dmastraining.adobeconnect.com/p3poko6m63q?launcher=false&fcsContent=true&pbMode=normal.

The Contractor shall have in place procedures to ensure continuity of care for members with established pharmacological treatment regimens. The Contractor shall ensure that members can continue treatment of any medications prescribed or authorized by DMAS or another Contractor (or provider of service) for at least ninety (90) days or through the expiration date of the active service authorization. This would not preclude the health plan from working with the individual and his treatment team to resolve polypharmacy concerns.

The Contractor shall implement a Medication Therapy Management (MTM) program. The MTM program shall include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists. Reimbursement for MTM services provided by participating pharmacists shall be separate and above dispensing and ingredient cost reimbursement. The Contractor's MTM program shall be developed to identify and target members who would most benefit from these interactions.

Pharmacy and Therapeutics (P&T) Committee

The Contractor shall have a P&T Committee that will ensure safe, appropriate, and cost effective use of pharmaceuticals for the Virginia Medicaid enrollees of this Contract. The P&T Committee shall serve in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of this Contract and the appropriate use of medications. The Contractor's P&T Committee shall be comprised of physicians, pharmacists or nurse practitioners holding valid professional licenses. The Committee must include at least one practitioner in each of the following specialties: pediatrics, gerontology/geriatrics, and psychiatry.

Drug Utilization Review (DUR) Programs

In following with 42 C.F.R. § 438.3, the Contractor shall develop and maintain a DUR program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 C.F.R. § 456, subpart K including prospective DUR, retrospective DUR and the DUR Board. The

Contractor's DUR program at a minimum shall include all the DUR activities conducted by the Department.

The Contractor is not required to have a separate DUR Board. The Contractor may utilize its P&T Committee or comparable committee to fulfill the DUR requirements defined at 42 C.F.R. § 456, Subpart K and 1927 (g) of the Social Security Act.

Offerors, in response to this RFP, shall describe current experience in a Medicaid state contract with implementing a common core formulary and a Medication Therapy Management program as well as describe how it will meet the requirements to implement Virginia's common core formulary.

4.5.3 Prescription Drug Rebates

Any outpatient drugs dispensed to members covered by the Contractor (including where the Contractor paid as the primary and/or secondary payer under the MEDALLION 4.0 Contract) shall be subject to the same rebate requirements as the State under section 1927 of the Social Security Act.

The Contractor shall submit to DMAS all drug utilization encounter data. The required reporting format and data elements will be included in the MEDALLION 4.0 Reporting Manual. Pursuant to section 2501(c)(1)(C)(III) of the Social Security Act, the Department will require encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS physician administered code. 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 physician administered code must be submitted with a valid NDC on each claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a claim line using the same HCPCS physician administered code. For the purpose of the MEDALLION 4.0 Contract the term "dispense" is defined to include the terms "provide" and "administer."

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 U.S.C. § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program. Failure to identify aforementioned 340b drugs on submissions to the Department or its rebate vendor shall be treated as a compliance violation. The Contractor shall identify encounter claims administered under section 340B in the manner specified by DMAS to support the identification and removal of those encounter claims from Medicaid Drug Rebate processing. If a Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services, the Contractor shall ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. The Contractor shall not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

The Contractor (and/or its Pharmacy Benefits Manager) shall make available two pharmacy representatives (one primary and one secondary) to work directly with the Department and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

Offerors, in response to this RFP, shall describe current experience in a Medicaid state contract with drug rebating including encounters use, results and rebates collected.

4.5.4 Addiction and Recovery Treatment Services (ARTS)

The Contractor shall implement the Department's ARTS program for members with a substance use disorder (SUD). The Department's goals for the ARTS include ensuring that a sufficient comprehensive, evidence-based continuum of care is available to effectively treat individuals with a SUD.

The Contractor's ARTS program shall be consistent with the Department's criteria for the Addiction and Recovery Treatment Services (ARTS) benefit based on the American Society of Addiction Medicine (ASAM) criteria and defined in 12 VAC 30-130-5000 et al. The Contractor's ARTS system of care shall include recognized best practices, including a robust array of services and treatment methods to address the immediate and long-term physical, mental and SUD care needs of the individual. The Contractor shall use the DMAS defined medical necessity criteria based on ASAM for coverage of ARTS.

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-130-5020 including an ARTS Care Coordinator. The Contractor shall use the ASAM treatment criteria when administering ARTS benefits and determining medical necessity for ARTS services in accord with 12VAC30-130-5100. The Contractor's ARTS Care Coordinator, or a licensed physician or Medical Director employed by the Contractor, will perform an independent assessment of requests for all ARTS services at ASAM Levels 2.1 to 4.0 using member information transmitted by providers. The Contractor shall review the requests on an individual basis and determine the length of treatment and service limits are based on the individual's most current multidimensional risk profile and apply the ASAM Treatment Criteria in accord with 12VAC30-130-5100.

Details on the ARTS program are available at http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.

Offerors, in response to this RFP, shall describe how it will implement the ARTS program and innovations it will implement for high risk populations such as pregnant women with substance use disorder, adolescents and/or foster care youth at risk of substance use disorder, and substance-exposed infants including infants with Neonatal Abstinence Syndrome.

4.5.5 Long Acting Reversible Contraception (LARC) Utilization and Reimbursement

Appropriate family planning and/or health services shall be provided based on the member's desire for future pregnancy and shall assist the member in achieving their plan with optimization of health status in the interim. Use of long acting reversible contraceptives shall be encouraged and barriers such as service authorization shall not be required for approval.

The Contractor shall participate in the Department's LARC initiative including reimbursement for all LARC devices provided in a hospital setting. This separate payment for the LARC device shall not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor also shall reimburse practitioners for the insertion of LARC device immediately post-delivery.

The Contractor shall provide coverage for all LARC devices. The Contractor shall not impose service authorization requirements or quantity limits on LARCs.

Offerors, in response to this RFP, shall describe its capacity to separate the payment for the LARC device from the DRG payment.

4.5.6 Virginia Emergency Department Care Coordination Program

The Contractor shall participate in the Virginia Emergency Department Care Coordination Program that will provide a single, statewide technology solution that connects all hospital emergency departments (EDs) in the Commonwealth to facilitate real-time communication and collaboration among physicians, other health care providers, and health plan clinical and care management personnel for patients receiving services in hospital EDs. This system will provide real-time patient visit information from and share such information with every hospital ED in the Commonwealth through integrations that enable receiving information from and delivering information into electronic health records systems utilized by such hospital ED; allow hospital EDs in the Commonwealth to receive real-time alerts triggered by analytics to identify patient-specific risks, to create and share care coordination plans and other care recommendations, and to access other clinically beneficial information; provide a patient's designated primary care physician and supporting clinical and care management personnel with treatment and care coordination information about a patient receiving services in a hospital ED, including care plans and hospital admissions, transfers, and discharges; and provide a patient's designated health plan and supporting clinical and care management personnel with care coordination plans and discharge and other treatment and care coordination information.

The Contractor shall work with the Department and hospital and physician representatives on any workgroup established by the Department to develop shared care coordination models to leverage this new statewide technology solution to improve outcomes for the MEDALLION 4.0 target populations with frequent use of EDs.

4.5.7 Patient Utilization Management & Safety (PUMS) Program for Members

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

Members may be placed into a PUMS program when either of the following trigger events occurs:

1. Specific utilization review of the member's past twelve (12) months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications found in the Technical Manual. Members with a cancer diagnosis are excluded.
2. Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

The Contractor shall use the triggers specified by DMAS to identify members for the PUMS program and is encouraged to utilize the Commonwealth's Prescription Monitoring Program (PMP), described in the MEDALLION 4.0 Contract, when evaluating PUMS members.

Offerors, in response to this RFP, shall describe a patient utilization management system currently utilized in a Medicaid state contract of similar scope to this RFP.

SECTION 5.0 INNOVATIONS

5.1 DRIVING DELIVERY SYSTEM INNOVATION

Innovation is the process of generating ideas into something of value. In health care delivery, innovation is generating new ideas about how to achieve the Triple Aim of better health outcomes, better patient experiences with health care, and lower total cost of care. These deliverables can be distilled into two core values that form the basis of innovative care delivery ideas. DMAS is seeking Contractor innovations that adhere to these two core values by:

1. Following a person-centered approach that ensures innovations are focused on the needs and preferences of MEDALLION 4.0 enrollees in design, measurement, and delivery;
2. Lowering the total cost of care. Research on person-centered care delivery methods finds innovations focused on needs of the whole person take into account the cost of services across the delivery system. As a result, person-centered innovations work to create efficiencies that reduce the total cost of care while also advancing quality of care.

The DMAS vision for delivery system innovation is to fundamentally change payment and service delivery to be more efficient and responsive to the true needs of MEDALLION 4.0 members. DMAS has five guiding principles for achieving this vision:

1. *Maintain innovation as a core value of agency culture.* Offerors shall describe the culture of innovation within its organization.
    - How do you discuss and communicate innovation within your culture?
    - How do you ensure innovation projects are embedded in your business strategy and not simply one-time projects? Examples might be specific funding structures, provider-led partnerships, systemic mechanisms to drive improvement, or others.
2. *Advance person-centered care and foster member engagement.* Offerors shall describe how its organization translates its value for person-centered care through policies, procedures, and cultural norms.
3. *Lower total cost of care.* In addition to improving care delivery and outcomes, Offerors shall describe how its innovations also produce cost savings.
4. *Facilitate provider-led change*. Offerors shall describe its efforts to engage providers through ongoing feedback and dialogue that shapes innovations providers value and innovations that support provider efforts to drive change.
5. *Be scalable.* Offerors shall describe how its innovations are replicable and applicable on a large-scale, such that the innovations could be implemented to serve Virginia's Medicaid population.

Offerors, in response to this RFP, shall describe its organization's commitment to achieving the three innovation deliverables of the Triple Aim as described in this section and how the organization employs the five guiding principles in its innovation work. Responses shall include examples of past performance in a Medicaid environment and plans for future performance where applicable.

Offerors also shall describe its organization's top three strategic innovation priorities. Response for each of the three innovation priorities should answer the following questions:

1. What is the problem your innovative solution is solving?
2. Please explain the business case, including a description of how the innovation is:
    a) Desirable

b) Feasible
c) Valuable

3. How are you measuring success?
4. How have you advanced these initiatives or how do you plan to advance and scale up this initiative?

Expanding on the Offeror's strategic innovation priorities, Offerors shall describe infrastructure investments, either planned or implemented, that will systemically change care delivery and payment. Offerors shall highlight investments that identify and address high-need or high-utilizer populations and investments for infrastructure that directly support members at the point of care.

In response to this RFP, Offerors also shall describe innovations, planned or implemented, related to Medicaid business processes and operations. Examples may include innovative strategies to deal with improper payments, managing and improving administrative costs, or others.

In response to this RFP, Offerors shall describe how its organization's innovation priorities and/or core values align with the following high priority issues for DMAS:

1. Addressing opioid use and increasing substance use treatment
2. Integrating behavioral health care
3. Ensuring access to care
4. Measuring and communicating with providers at the point-of-care to improve the quality of care and create efficiencies
5. Supporting provider-led change

In addition to the above responses about general innovation culture and strategies, Offerors also shall respond more in-depth to the specific innovation topics in the remainder of this section.

5.2 VALUE-BASED PAYMENTS (VBP)

Value-based payment (VBP) encompasses a broad set of payment strategies that link provider financial incentives to the provision of high-quality, efficient patient care. Provider performance on designated measures of quality, cost and/or resource use, and patient access and satisfaction can serve to determine the level and direction of incentives. DMAS is interested in the creation of VBP arrangements as a vehicle to improve care delivery for Medicaid members through implementation of payment reforms that move providers away from volume based financial incentives, instead enhancing flexibility and rewarding high-quality, efficient patient care.

The Offeror shall propose a VBP implementation and development strategy that follows the Alternative Payment Method (APM) Framework published in the Final White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) (see http://hcp-lan.org/workproducts/apm-whitepaper.pdf). This strategy shall place emphasis on the establishment of provider payment arrangements designated as categories 3 and 4 and the evolution of providers along the APM model continuum (i.e. from less sophisticated to more advanced categories and to more sophisticated models within a general category).

Figure 1. APM Framework (At-A-Glance)

The Offeror's VBP implementation and development strategy for MEDALLION 4.0 members shall clearly indicate what steps will be in place by contract execution. The strategy also shall indicate how the Offeror plans to expand or further enhance these initial efforts through articulation of steps to be taken in the first and second contract years.

The submission shall discuss the Offeror's specific goals for VBP implementation and development over the life of the Contract. Such goals shall incorporate the following:

The form of specific models and VBP arrangements the Offeror shall implement if selected.

The quantitative, measurable, clinical outcomes the Offeror seeks to improve through implementation of such models (e.g. reducing emergency department utilization associated with a specific patient population). Potential areas of priority Offerors should consider may include, but are not limited to, the following Departmental goals:

1. Improved birth outcomes
2. Appropriate, efficient utilization of high-cost, high-intensity clinical settings
3. Reduce all-cause hospital readmissions
4. Reduce hospital admissions for chronic disease complications

The expectation that the portion of the Offeror's medical expenditures (including drugs) governed under VBP arrangements shall either 1) increase by at least 20 percentage points by the end of year three of the Contract or 2) represent at least 50% of the Offeror's total medical expenditures by the end of year three of the Contract. To the extent that the Offeror's medical expenditures governed under VBP arrangements would already represent at least 50% of total medical expenditures, the Offeror's strategy shall demonstrate how it plans to increase the implementation of HCP-LAN APM categories 3 and 4 arrangements by at least 15 percentage points by the end of year three of the Contract, while also maintaining or expanding overall VBP arrangement penetration levels. For the purposes of these expectations, percentage increases are presumed off of the Offeror's prior year experience. The

Department reserves the right to adjust targeted penetration percentages, including increases or decreases of such percentages, at its discretion.

These goals shall pertain to specific measurable outcomes that are meant to improve quality, reduce costs, and increase patient satisfaction and engagement. This strategy shall place emphasis on the establishment of provider payment arrangements designated as HCP-LAN APM categories 3 and 4, as well as the evolution of providers along the APM model continuum. Emphasis will be placed on proposals that present a logical and realistically attainable strategy for implementation and evolution of such models. Additionally, the strategy shall include:

1. Designation and contact information for the individual in the Offeror's organization responsible for development and execution of the Offeror's VBP implementation and development strategy
2. Discussion of specific models and VBP arrangements proposed for implementation
3. Discussion of plans and strategies to develop provider readiness for VBP and evolution along the VBP continuum
4. Discussion of Offeror's approach to and experiences (if applicable) with episodic payment arrangements and the challenges and opportunities they present for implementation among providers serving the member population
5. Specific health outcomes and efficiency goals that will be tracked and evaluated for performance as part of each model
6. Description of how proposed or developing VBP arrangements align across books of business in Virginia or other markets. To the extent such alignment is relevant, the strategy should address how provider performance measurement and incentives align or will align across books of business in a way that maximizes the impact of such incentives while minimizing provider confusion caused by multiple, differing VBP arrangements
7. Discussion of how Offeror systems are designed to identify providers operating under VBP arrangements and track its performance
8. Discussion of how Offeror will share data with providers and support providers in using the data to improve performance
9. Methods and frequency for collecting and providing performance data to providers (please provide an example or template of a relevant, current data sharing report issued to providers)
10. Specific objectives for VBP arrangement implementation, including scope, provider performance, and a timeline for implementation related to each of the proposed VBP approaches, and
11. Plans for the provision of provider support to facilitate successful implementation and development of VBP arrangements, such as technical support, establishment of new data feedback systems, and financial support for provider infrastructure necessary to execute select model concepts

To the extent the Offeror has prior experience implementing VBP arrangements among its provider network, the Offeror's VBP submissions shall include a table indicating all of its current VBP arrangements across all lines of business and states. The table shall separately and explicitly identify any applicable VBP arrangements across lines of business. To the extent the Offeror has extensively implemented VBP arrangements, entries may be generalized across a specific model type (e.g. Accountable Care Organizations). Offeror's tables should address the following:

1. Name of the VBP program
2. Line(s) of business to which the program applies

3. State(s) in which the program applies
4. Description of the VBP program
5. Whether the VBP program was required by the state
6. Applicable HCP-LAN APM category/sub-category (e.g. Category 2c) in which the arrangement best fits
7. Provider types governed under the arrangement
8. Service types governed under the arrangement
9. Quality requirements under the VBP program
10. Percent of total medical spending (including drug spending) governed under the arrangement for the relevant line of business in CY 2016
11. Percent of total projected medical spending (including drug spending) governed under the arrangement for the relevant line of business in CY 2017

Test Cases

As part of the Offeror's submission, the Offeror shall submit responses to both of the test cases presented below and develop a summary proposal for how it might address implementation of a VBP arrangement.

Test Case #1: How would the Offeror propose to approach the development and implementation of an episodic payment with the primary goals of improving birth outcomes while decreasing health care spending associated with a perinatal episode? As part of this submission, please address the 10 elements of a maternity care episodic payment identified below. Additionally, please address anticipated challenges with implementation of such an episode, including provider readiness and data sharing issues. Offerors can find additional detail and examples of these 10 elements as enumerated in Appendix D of the HCP-LAN White Paper on Accelerating and Aligning Clinical Episode Payment Models at the following link (https://hcp-lan.org/groups/cep/clinical-episode-payment/):

1. Episode Definition
2. Episode Timing
3. Patient Population
4. Services
5. Patient Engagement
6. Accountable Entity
7. Payment Flow
8. Episode Price
9. Type and Level of Risk
10. Quality Metrics

Test Case #2: Within an Offeror's member group there is likely to be a group of individuals who are high-utilizers or emerging high-risk members who use a very high number and intensity of services. Part of implementing an effective VBP strategy that improves patient outcomes while reducing unnecessary utilization should include identification of this population of members and tailoring interventions that address the root causes driving their health care utilization. How would the Offeror propose to tailor a VBP approach that would determine and address these root causes?

Questions to consider include:

1. What characteristics would the Offeror use to define this group (e.g. number of chronic conditions, emergency department utilization, etc.)?

2. Following determination of the size and composition of this group, please describe the process the Offeror might undertake to determine what types of interventions would be most effective at improving the quality of care and utilization patterns exhibited by these members?
3. What utilization, quality, and outcome measures would the Offeror consider to assess performance under the intervention?
4. How might the Offeror determine and address non-clinical features of this patient population contributing to the poor health and high utilization exhibited by the group?
5. What provider incentives would be most appropriate as part of this VBP arrangement? Why are such incentives well suited to facilitating the desired outcomes of the VBP arrangement?

5.3 Social Determinants of Health

Social factors that affect health outcomes, also called social determinants of health, contribute significantly to the cost of care and the member's experience of health care. Examples of social determinants of health include: employment, housing, food security, health literacy, access to transportation, and education level. Because social factors are better predictors of health than clinical metrics, appropriately assessing and addressing social determinants is critical to improving population health. DMAS is seeking opportunities to lower the total cost of care and improve the health and wellbeing of the MEDALLION 4.0 population by addressing social determinants through care delivery innovations, and is seeking Contractors committed to collaborating with DMAS to advance this effort.

According to Healthy People 2020, the social determinants of health can be subdivided into five key domains:

- Economic Stability - Poverty, Employment, Food Security, Housing Stability
- Education - High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development
- Social and Community - Context, Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration/Institutionalization
- Health and Health Care - Access to Health Care, Access to Primary Care, Health Literacy
- Neighborhood and Built Environment - Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions

Nutritional insufficiency of Medicaid enrollees is a significant concern for the Commonwealth. The Federation of Virginia Food Banks notes "Virginia's 11.8% food insecurity rate means that over 912,790 people do not know from where their next meal will come." Many of these individuals are children and are Virginia Medicaid eligible. Such children may not have enough food to ensure that they can thrive and grow up healthy. To promote healthy children, Virginia Medicaid is supporting a pilot with doctors and current health plans to provide transportation to food resources for Medicaid children. DMAS will ask each health plan to commit to work with the Department to develop and implement an innovative pilot program that all plans will participate in to address nutritional insufficiency to support healthy Virginians and particularly healthy Virginia children.

In response to this RFP, Offerors shall describe the impacts of the social determinants of health within the five key domains as they relate to health risks, health outcomes, and quality of life. Offerors also shall describe its efforts to address the social determinants of health in the five key domains above. Offeror's response shall include, but is not limited to, the following elements:

1. Across the five key domains, rank the eight social determinants of health listed above in order of highest priority to lowest priority for your organization.
2. What work has your organization done to engage the social determinants of health within the five key domains? Specifically, describe work on the social determinants of health within the five key domains that your organization has advanced in Virginia or other markets. Also, describe work on the social determinants of health within the five key domains that your organization has advanced in other states.
3. How are social determinants assessed by your organization?
4. What social determinants data elements are currently captured for your member population, and from what sources?
5. What future data, data source(s), or technology enhancements are planned to capture more social determinants information?
6. What design and implementation challenges has your organization faced in addressing the social determinants of health within the five key domains?
7. How does the Offeror use social determinant data to address social factors for members?
8. What mechanisms are in place to identify social factors that put members at high-risk?
9. How does the Offeror partner with health care and social service providers to address social determinants? Describe any alternative payment arrangements that include social determinants reporting or intervention as a factor of payment.
10. How has your organization engaged community health workers or other types of workers to improve care?
11. Describe your organizations ideas for best practices that should be included in the pilot program related to addressing nutritional insufficiency, including outreach and coordination with schools, community resources (including food resources), primary care physicians and/or other social services.
12. Describe any additional innovations or enhancements that are planned to mitigate social determinants in the future.

Offerors shall highlight how its organization stays informed and contributes to the emerging field of complex health and social needs.

5.4 MEDALLION CARE SYSTEM PARTNERSHIP (MCSP)

The Department established the Medallion Care System Partnership (MCSP) with the goal of improving health outcomes for Medicaid/FAMIS members through a system designed to integrate primary, acute, and behavioral health services provided by contracted MCOs through Health Care Homes, Behavioral Health Homes, or other MCSP approved arrangements. The MCSP model allows the Contractor the flexibility to create and test innovative payment models, incentive structures and arrangements, and value-and-market-based programs within geographic areas, particular populations, or even at the physician practice level to determine how to bend the cost curve while improving quality.

The Contractor shall form partnerships with providers and/or health care systems, as outlined in the Contract, in an effort to increase participation of integrated provider health care delivery systems, improve member health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and member experience. As part of this MCSP arrangement, the Contractor shall enter into contractual arrangements that include:

- Gain and/or risk sharing,
- Performance-based incentives, and/or
- Other incentive reforms tied to Commonwealth-approved quality metrics and financial performance.

In response to this RFP, the Offeror shall describe:

1. How the Offeror will partner with community partners/providers across the continuum of care within the Offeror's proposed regions
2. How the Offeror's MCSPs will collectively serve as a comprehensive health management program in its proposed MEDALLION 4.0 region(s)
3. How its MCSPs will use a team-based treatment approach that integrates primary, acute, pharmacy, and behavioral health services
4. How its MCSPs will have staff and resources to improve overall health care delivery through a patient-centered interdisciplinary system for care coordination of comprehensive services
5. How it will rapidly respond and prevent acute episodes for individuals with quality driven services and supports

5.5 Performance Incentive Awards (PIA)

Performance Incentive Awards will be made to the Contractor according to criteria established by the Department and will include the quality performance measures listed in the Contract. The PIA criteria will include HEDIS measures and administrative measures designed to measure managed care quality as defined in Contract. The PIA awards/penalties will be proportionate to the extent by which the Contractor's performance compares with benchmarks for each HEDIS measure, thresholds determined by the Department for each of the administrative measures, and the relative performance as compared against other Contractors. The maximum amount at risk for each Contractor will be a percentage of the PMPM capitation rate system payments. Total awards for all Contractors will equal total penalties for all Contractors.

Offerors, in response to this RFP, shall describe experience in a performance incentive award system currently utilized in a Medicaid state contract of similar scope to this RFP, including any awards and/or penalties.

SECTION 6.0 FINANCIAL REQUIREMENTS

6.1 CAPITATION PAYMENTS

Capitation rates for the MEDALLION 4.0 program will be consistent with payment and contracting requirements under 42 C.F.R. § 438 Subpart A. DMAS will calculate PMPM costs from a two year base period, adjust for any policy and program changes between the base period and the rate year and trend to the rate year. DMAS will include adjustments for managed care and administrative costs. To the extent that encounter data is available, DMAS will use encounter data. If encounter data is not available for certain populations or services, FFS data will be used.

DMAS will make monthly PMPM Capitation Payments to the Contractor retrospectively for the previous month's enrollment (e.g., payment for June enrollment will occur in the first DMAS payment cycle in July, payment for July enrollment will occur in August, etc.). The PMPM Capitation Payment for a particular month will reflect payment for the beneficiaries with effective enrollment with the Contractor as of the member's first day of enrollment in the previous month.

DMAS shall issue actuarially sound capitation payments on behalf of enrollees at the rates established in the MEDALLION 4.0 Contract and which may be modified during the annual contract renewal process. The Contractor shall accept the annually established capitation rates paid each month by the Department as payment in full for all services to be provided pursuant to the MEDALLION 4.0 Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, sanctions or performance adjustments. Any and all costs incurred by the Contractor in excess of the capitation payment shall be borne in full by the Contractor. The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments. The payment information will be transmitted to the Contractor in the EDI X12 820 standard.

6.2 HEALTH INSURER FEE

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some MEDALLION 4.0 Contractors that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid line of business. DMAS will make an adjustment for the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes but the adjustment shall not exceed the Federal or State corporate income taxes reported on the Contractor's annual financial statement and allocated to the Virginia Medicaid line of business. Procedures for determining each plan's liability will be spelled out in the contract. DMAS will make a retroactive rate adjustment based on each plan's liability subject to a contract amendment. No adjustment will be made if the fee is not payable.

6.3 MINIMUM MEDICAL LOSS RATIO (MLR) AND LIMIT ON UNDERWRITING GAIN

The Contractor shall be subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a contract specific basis and will only include revenue and expense experience applicable to members included under the contract. The MLR is calculated first followed by the calculation of the Underwriting gain limit.

The Contractor shall be subject to a minimum MLR of 85%. The MLR shall be determined as the ratio of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue. If the MLR for a reporting year is less than 85% then the Contractor shall make payment to the Department equal to the deficiency percentage applied to the amount of adjusted premium revenue.

The Contractor is required to report a MLR annually based on 42 C.F.R. § 438.8 including any credibility adjustment. The Contractor shall submit to the Department, in the form and manner prescribed by the Department, the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year. The MLR reporting year shall be the contract year.

The Contractor shall be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid premium income. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year developed in the same manner as the MLR (i.e. with data through the ninth (9th) month following the MLR reporting year). Such amounts shall be determined consistent with the reporting requirements for the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance with two exceptions. First, the non-claims costs shall exclude the amount, if any, of non-allowable expenses as described in the Contract. Second, the Health Insurer Fee (HIF) shall be excluded from the non-claims costs and the reimbursement from DMAS, as described in the Contract, shall be excluded from revenue.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds 3.00% then the Contractor shall make payment to the Department equal to the sum of 50% of the excess of the percentage over 3.00% plus 50% of the excess of the percentage over 10.00% applied to the amount of Medicaid premium income attributable to the contract. Such amount will be remitted to the Department as a refund of an overpayment. To illustrate, if the underwriting gain is 9% then the Contractor shall refund to the Department 3% of Medicaid premium income. If the underwriting gain is 11% then the Contractor shall refund to the Department 4.5% of Medicaid premium income. If the underwriting gain is 4.0% then the Contractor shall refund to the Department 0.5% of Medicaid premium income.

All of the variables used in the calculation of the underwriting gain limit and the amount of any resulting payment shall be determined as if the limit did not exist but shall reflect any refund amount required due to the MLR contract provision. Contractors are required to notify the Department and provide supplemental information in the event that this limit impacted the financial results reported for a quarter. This supplemental financial information should include revised values for Medicaid underwriting gain and Medicaid premium income determined without application of the limit.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 member months during the calendar year. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than 12 months of experience in the program at the beginning of the calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based in whole or in part on the applicability of this contract provision.

The Contractor is required to report a MLR annually based on 42 C.F.R. § 438.8. Additional information regarding reporting of the underwriting gain will be specified in the annual contract. Both underwriting gain and medical loss ratio will be subject to audit.

6.4 REINSURANCE

The Department currently has a pharmacy reinsurance program and a stop loss for ARTS. The Department will annually determine the appropriateness of its reinsurance program. If appropriate, the Department also may implement other reinsurance programs.

Pharmacy reinsurance is a stop-loss program provided by Virginia DMAS to the Contractor. Reinsurance is available to cover 90% of a member's annual prescription drug costs above an attachment point. The attachment point will be increased from $150,000 to $175,000 effective July 1, 2017 and may be further revised in the future. The reinsurance coverage will be paid for by a reduction to the capitation rate otherwise payable during the contract year. The amount of the reduction shall be determined prospectively and shall be applied to all capitation payments.

The Department also provides stop loss protection for the new ARTS benefits through June, 30, 2018. DMAS has not determined if the ARTS stop loss will continue beyond June 30, 2018.

Medallion 4.0 reinsurance programs are subject to change. Terms and conditions will be included in the annual contract. Reinsurance programs are subject to audit.

6.5 RECOUPMENT/RECONCILIATION

The Department shall recoup a member's capitation payment for a given month in cases in which a member's exclusion or disenrollment was effective retroactively. The Contractor may retract provider payments made during a period when the enrollee was not eligible, and instruct the provider to invoice DMAS for payment. The Department shall not recoup a member's capitation payment for a given month in cases in which a member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to, death of a member, cessation of Medicaid eligibility, or transfer to an excluded MEDALLION 4.0 Medicaid category. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, etc. In these cases the total capitation payment for the month will be rescinded.

The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under the MEDALLION 4.0 Contract rendered to a member after the effective date of the member's exclusion or disenrollment.

The Department shall reconcile payments on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter.

6.6 INCENTIVES AND WITHHOLDS

In the annual Contract, DMAS will include a performance incentive program. It will include incentives based on meeting the MEDALLION 4.0 performance goals designated by the Department. DMAS intends to phase in the incentive program, both the amount at risk and the criteria.

Offerors, in response to this RFP, shall demonstrate an understanding and experience of each of the provisions outlined in Section 6 in a Medicaid contracted state program similar in scope to this RFP.

SECTION 7.0 INFORMATION MANAGEMENT SYSTEMS REQUIREMENTS

7.1 CMS Requirements of Seven Conditions and Standards

Under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act, the CMS has issued what is identified as the Seven Conditions and Standards that must be met by the states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced match funding. The Seven Conditions and Standards include the following: Modularity Standard, MITA Condition, Industry Standards Condition, Leverage Condition, Business Results Condition, Reporting Condition, and Interoperability Condition. The Contractor is expected to consistently meet or exceed CMS' Seven Conditions and Standards over the life of the contract.

The CMS Seven Conditions and Standards focus on key elements of development and deployment to improve the likelihood of successful system implementation and operation. The goal is to build a common framework for Medicaid to plan, architect, and engineer modern Medicaid IT systems that are more stable and uniform, supporting more efficient, cost-effective, and modern processes and systems.

The Contractor will be required to provide a solution that complies with and supports the CMS Seven Conditions and Standards, including alignment with the MITA 3.0 Framework, as well as future MITA advances. Offerors shall highlight how its organization will align with the MITA 3.0 framework and comply with the MITA Conditions and Standards.

7.2 State Technology Standards

Virginia's Enterprise Architecture is a strategic asset used to manage and align Virginia's business processes and Information Technology (IT) infrastructure/solutions within Virginia's overall strategy. The Enterprise Architecture is also a comprehensive framework and information repository which makes available the information necessary to perform the State's mission, and the technologies necessary to support that mission in response to the changing business policies and needs.

The Contractor's solution shall use Service Oriented Architecture when required by the Department to effectively communicate the data or information requested by other sources through the MES Integration Services Solution (ISS).

The Offeror shall address and adhere to the requirements relating to Virginia's Technology Standards, and any subsequent updates.

These requirements can be found in Attachment D Technology Standards.

7.3 Security Compliance/Audit Management

7.3.1 Security

DMAS, and its business partners, have a shared responsibility to meet HIPAA, Federal and State enterprise information security policies, standards, security initiatives, regulations and requirements relating to the protection of Electronic Protected Health Information (ePHI). To meet this responsibility, DMAS has identified the need for contractors to provide compliance tools, which will aid in managing

users across these various component systems, monitor system activity for unusual behavior, and support individual rights as specified in HIPAA and Commonwealth regulations. Additionally, these compliance tools will use data analytics functionality to alert security management of unusual trends, and the violations of defined thresholds.

The proposed solution meets or exceeds controls required by *VA IT Security Standard COV SEC501-09* (available on the VA VITA website) and *NIST 800-053 REV 4* (or latest).

The Contractor conducts and provides risk assessments and other required deliverables, e.g., an annually updated Security Plan (or more often as major system changes occur).

7.3.2 Compliance Audit

Contractors shall provide DMAS with periodic penetration and/or vulnerability reports. These include management reports covering key areas of concern and addressing typical control questions required by *VA IT Security Standard COV SEC501-09* (available on the VA VITA website) and *NIST 800-053 REV 4* (or latest) with online reporting.

Contractors shall conduct risk assessments and/or provide other required deliverables, e.g., a Security Plan (annually or more often as major system changes occur).

More detail pertaining to the Security/Compliance Audit Requirements can be found in Attachment E Security Compliance/Audit Management.

7.4 BUSINESS CONTINUITY AND DISASTER RECOVERY

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

The Contractor shall 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, together with the Department, shall affirm the BC/DR plan, including the essential roles, responsibilities, and coordination efforts necessary to support recovery and business continuity.

The Contractor shall 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 Business Continuity/Disaster Recovery Plan is in place and maintained at all times. The plans contain procedures for data backup, disaster recovery including restoration of data, and emergency mode operations. The plans shall 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. Also, access control will include procedures for emergency access to electronic information.

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

The Contractor shall develop and maintain a Business Continuity Plan which includes the following:

1. Identification of the core business processes involved in the solution
2. For each core business process:
    a. Identification of potential system failures for the process
    b. Risk analysis
    c. Impact analysis
    d. Definition of minimum acceptable levels of outputs
3. Documentation of contingency plans
4. Definition of triggers for activating contingency plans
5. Discussion of establishment of a business resumption team
6. Maintenance of updated Disaster Recovery Plans and procedures

The Contractor shall prepare and maintain a Disaster Recovery Plan which addresses the following:

1. Retention and storage of backup files and software
2. Hardware backup for critical system components
3. Facility backup
4. Backup for telecommunications links and networks
5. Staffing plan
6. Backup procedures and support to accommodate the loss of online communications
7. A detailed file backup plan and procedures, including the offsite storage of crucial transaction and master files; the plan and procedures shall include a detailed frequency schedule for backing up critical files and (if appropriate to the backup media) its rotation to an offsite storage facility. The offsite storage facility shall provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations
8. The maintenance of current system documentation and source program libraries at an offsite location

The Disaster Recovery Plan and results of periodic disaster readiness simulations shall be available for review by State or Federal officials on request. This report and test results shall be filed annually with the Department's named Point of Contact and any other agency authorized by the State or the Federal government. This report and test results shall be approved by the Department.

The Contractor will conduct annual, comprehensive technical and operational tests of the Business Continuity and Disaster Recovery plans. The Contractor will conduct role plays and update the Business Continuity and Disaster Recovery plans based on the results of testing with findings for improvement after each annual test and train on the Department approved changes.

Please see Attachment F Business Continuity and Disaster Recovery for more detailed information pertaining to the requirements.

7.5 Data Exchanges

7.5.1 DMAS EDI Gateway

The Contractor shall exchange with the DMAS EDI Gateway information that is needed to support any electronic standard healthcare transactions that are mandated by DMAS and any other transactions required to operate its solution. The Contractor shall send and accept batch and real-time representations of applicable HIPAA mandated and other standard health care transactions as required.

The information exchanged will support a variety of formats, including but not limited to X12, NCPDP, XML, and JSON formats.

It is the objective of DMAS for the Department and the Contractor to mutually participate in and support a versatile process to send and receive all batch and real-time HIPAA mandated and other standard compliant transactions that flow through an EDI exchange that is operated by DMAS.

7.5.2 Enterprise Data Warehouse

DMAS, as a part of the new MES initiative, established a centralized EDWS and business intelligence platform where disparate data sources shall be integrated, transformed, cleansed, and stored in a centralized repository. This single source of truth will enable timely and consistent reporting and provision data access for all user levels across DMAS, including Executive Management, Business Managers, External Stakeholders, and Data Analysts. The intent is to provide decision support to all DMAS business processes and deliver enterprise reporting.

Ultimately, the goal is to enable advanced analysis, such as continuity of care studies that may include descriptive, prescriptive, predictive, interactive, and simulative study of claims, clinical data, and related social data.

7.5.3 Data Interfaces Sent To and Received From DMAS

The Contractor shall have adequate resources to support the DMAS interfaces required to support the Program as defined in this solicitation. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, may include, but are not limited to:

Inbound Interfaces

- EDI X12 837I Post Adjudication Standard format Facility Encounters
- EDI X12 837P Post Adjudication Standard format Professional Encounters
- NCPDP D.0 or Post Adjudication Standard format Pharmacy Encounters
- MEDALLION 4.0 provider files
- MEDALLION 4.0 MTR (Service Authorization information) in a file format to be outlined in the MEDALLION 4.0 contract
- Clinical and care coordination related data in a file format to be outlined in the MEDALLION 4.0 contract
- Other operational and contractual data as specified by Medallion 4.0 Technical Manual (formats may include comma separated values, fixed length, Excel. PDF, etc.)

Outbound Interfaces

- EDI X12 834 weekly files
- EDI X12 820 monthly capitation payment file
- Service Authorization in a file format to be outlined in the MEDALLION 4.0 contract
- Medical Transition Report, including, service authorizations, and claims data, in a frequency and file format to be outlined in the MEDALLION 4.0 contract
- DMAS provider file
- Other operational files as specified by Medallion 4.0 Technical Manual

The Contractor shall conform to HIPAA compliant standards and all state and federal standards for data management and information exchange and must implement new versions as made available by HIPAA according to DMAS' needs and guidance.

The Contractor shall demonstrate controls to maintain data integrity.

The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DMAS for reconciliation processes to be determined upon contract award.

7.5.4 Data Certifications

Contractor encounter and other data submissions are required to be certified. The Contractor shall keep track of every encounter submission made through the State's Fiscal Agent during the month and the tracking number assigned to each. The Contractor shall report this data on the schedule specified by the Department with the required certification. The required certification and reporting mechanism will be defined by DMAS. In accordance with 42 C.F.R. § 438.606, the Encounter/Data Certification form shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor.

7.5.5 All Payers Claim Database (APCD)

The Contractor shall participate in APCD and comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia* for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contactor shall be responsible for the submission of claims data related to services provided under this Contract. 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*.

7.5.6 Interface and Connectivity to the Virginia Medicaid Management Information System (VaMMIS) and Medicaid Enterprise System (MES)

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 Standard, and the NCPDP Standard formats; and receiving capitation payments in the HIPAA standard X12 820 format. The Contractor shall retain staff with the necessary access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of the MEDALLION 4.0 Contract. The Contractor shall allow sufficient time for installation, configuration, and testing of the data and associated equipment prior to production.

Any expenses, including equipment, services, staff, etc., incurred in establishing and maintaining data exchanges between the Contractor and the Fiscal Agent-hosted VaMMIS /MES will be the responsibility of the Contractor. It is the responsibility of the Contractor to ensure that its systems are sufficient to

meet the performance requirements of the MEDALLION 4.0 Contract. The Contractor will be granted access to the DMAS EDI portal used for submission and receiving of X12/NCPDP standard data files and other non-X12 data files as determined during the contract implementation timeframe. This access will be through the secured EDI portal maintained by DMAS and production access will be granted after a testing process has been completed. Additional information may be found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDISupport.

The Contractor will be granted access to VAMMIS through the web portal (https://www.virginiamedicaid.dmas.virgini.gov) with a secure sign on. This will enable the Contractor to view current enrollment and pertinent VAMMIS data as deemed necessary by DMAS. The Contractor's Help Desk employees supporting this contract must have access to the Internet.

More information regarding the specific data exchange requirements can be found in Attachment G Data Exchanges.

Offerors, in response to this RFP, shall demonstrate its ability to fulfill the State's requirements for information management and data interfaces, especially as defined in Section 7.5.3. Offerors shall provide details about the proposed technical solution and any prior experience/qualifications in meeting similar data interface requirements.

SECTION 8.0 PAST EXPERIENCE

8.1 OVERVIEW OF RELEVANT EXPERIENCE

The Offeror shall describe its experience working with Medicaid/CHIP enrollees, specifically the population as outlined in this RFP. Responses must include a table with columns indicating experience operating Medicaid programs:

1. Programs/product lines;
2. Location (statewide or geographic region(s) covered);
3. Timeframe for operating the program (e.g., the year) and duration (e.g., months/year(s) operating the program);
4. Average program enrollment size by city/county within the region(s) the Offeror operates;
5. Whether enrollment in the program is/was mandatory or voluntary;
6. Populations included (document using the MEDALLION 4.0 included populations);
7. Age range of enrollees;
8. General type of services covered (e.g., acute and primary, behavioral health, etc.); and,
9. Prevalent conditions of the enrolled population.

Example-Relevant Experience

1.	**Programs/product line**	Medicaid-Only in Tennessee
2.	**Location**	Tennessee-statewide
3.	**Timeframe and Duration**	2012-2015; 2.5 years
4.	**Average program enrollment size**	1,200 individuals
5.	**Enrollment (mandatory or voluntary)**	Voluntary
6.	**Populations included**	Pregnant Women, and Children
7.	**Age range of enrollees**	Under and over 21 years old
8.	**General types of services covered**	Acute and primary; behavioral health
9.	**Prevalent conditions of enrolled population**	Chronic conditions, behavioral health issues

8.2 PAST EXPERIENCE AND REFERENCES

8.2.1 Past Experience Examples

Offeror shall provide three (3) past experience examples that demonstrate the Offeror's Medicaid experience with the following: value-driven care, care transitions, value-based payments design and implementation, integration of behavioral health and acute care, and social determinants of health, and needs of the Medicaid population. DMAS intends to contact the references provided in these past experience examples. DMAS will not accept DMAS employees as references.

For each past experience example, Offeror's response shall include the following information:

1. Contract name
2. Client name and contact information (title, address, phone, email)
3. Description of scope of services performed (covered lives, population types, services, provider types, geography, etc.)
4. Contract period of performance and duration
5. Contract type
6. Annual value of contract
7. Contract size (# of providers served,# of participants served, etc)

8. Description of key strategies and innovations implemented (system of care, staff, operations, technology, and relationship management, etc.)
9. Number of Contractor staffed assigned to contract
10. Description of risks and issues
11. Description of results and value achieved
12. Description of lessons learned
13. Any legal or adverse contractual actions against the Offeror related to the project

8.2.2 Stakeholder References

Offeror shall provide a minimum of four (4) total references from this group of stakeholders (DMAS intends to contact the stakeholder references submitted for this section):

1. State and Local Government (required) - DMAS will not accept DMAS employees as references
2. Federal Government
3. Providers (required and include VBP experience)
4. Community Based Organization (required)
5. Advocacy Organization (required)
6. Member (optional): if the Offeror submits a member reference, the Offeror's proposal submission for this section must include the member's contact information. The Offeror also shall include a signed copy of the member's consent to be included as a stakeholder reference for the Offeror. The Offeror shall redact any member references in the redacted version of its proposal
7. Contractor/Partner
8. Subcontractor

For each reference, the Offeror's response shall include:

1. Name
2. Contact Information (address, phone, email)
3. Type of stakeholder (from list above)
4. Nature of relationship
5. Time period of relationship

8.3 COMPLIANCE HISTORY

DMAS will perform a comprehensive evaluation of each Offeror's compliance with Medicaid program rules.

In response to this RFP, the Offeror shall report areas of non-compliance across Medicaid only lines of business (exclude Medicare/Medicaid lines of business that serve dual eligibles). The Offeror shall include the average number of lives covered by the organization, parent organization, or sibling organization during the 36 month prior to proposal submission. DMAS reserves the right to disqualify an Offeror if an Offeror is under sanction as enumerated in 42 C.F.R. § 438.702.

Offeror shall include non-compliance for itself, its parent organization, and sibling organizations for the time period of 36 months of the prior to the proposal submission.

For each item listed below, outline in a chart the type of non-compliance issued (e.g., letter, fines), date issued, the reason, the entity that issued it, the state(s) in which the Offeror was providing services for

which the non-compliance was issued, and the actions taken by the Offeror to address the non-compliance.

a. Compliance Letters – Includes Warning Letters, Notices of Non-Compliance, Corrective Action Plans (CAPs) or similar state notices, and letters
b. Failure to maintain fiscally sound operations – Negative net worth or financial loss greater than half of the applying Offeror's total net worth. The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.
c. Adverse financial audits – All contracts that receive adverse audit opinions or disclaimed audit reports during the 36-month performance period
d. Performance audits – All contracts failing more than 50% of the audit elements during the audit performance period
e. Exclusions enforcement actions– Imposed by CMS as an intermediate sanction
f. Termination and non-renewals –Three types of contract, or partial contract, termination include (i) Federal and/or State Imposed, (ii) Disruptive Mutual (i.e. members were transitioned to other providers in the absence of significant time and transition planning), (iii) Non-Disruptive Mutual. Indicate type of contract and type of termination
g. Significant compliance concerns not otherwise captured above.

The Offeror shall use the following timeframe in its response to this RFP:

- Non-compliance or poor performance in the Medicaid program must have either occurred or been identified within 36 months of the proposal deadline.
- Non-compliances that occurred in prior years but were not identified or addressed until sometime during the 36 month period shall be included.
- Non-compliances that occurred during the 36 month period but are not identified until after the end of the RFP review period and prior to contract signing are included in the assessment and must be reported to DMAS per the proposal contact instructions.

SECTION 9.0 PROPOSAL INSTRUCTIONS

9.1 General Instructions

The proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of this RFP and corresponding Contract. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals should be organized in the order specified in this RFP. A proposal that is not organized in this manner risks a lower score or elimination from consideration if the evaluators are unable to find where the RFP requirements are specifically addressed. The Department and the evaluators are not obligated to ask an Offeror to identify where an RFP requirement is addressed, and no Offeror should assume that it will have an opportunity to supplement its proposal or to assist the evaluators in understanding and evaluating its proposal.

9.2 Binding Of Proposal

Proposals shall be clearly labeled "RFP2017-03" on the front cover. The legal name of the organization submitting the proposal also shall appear on the cover.

The proposals shall be typed, bound, page-numbered, single-spaced no smaller than a 12-point font on 8 1/2" x 11" paper with 1" margins. Offerors may use a larger size font for section headings and may use a smaller font size for footers, tables, graphics, exhibits, or similar sections, if necessary. The smaller font size must be legible. Larger graphics, exhibits, organization charts, and network diagrams may be printed on larger paper as a foldout if 8 ½" x 11" paper is not practical. Each hard copy and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section (two digit level sections). The title of each major section shall appear on the tab sheet.

The Offeror shall submit one original and seven (7) copies of the bound proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked "RFP2017-03." The Offeror also shall submit five electronic copies (thumb drives preferred) of its proposal in MS Word format (Microsoft Word 2010 or compatible format). In addition, the Offeror shall submit a redacted electronic copy in PDF of its proposal, in which the Offeror has removed proprietary and trade secret information. Please note that, as described below, merely redacting information is not sufficient to comply with *Code of Virginia* § 2.2-4342(F).

9.3 Table Of Contents

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements. Each section of the proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

9.4 TRANSMITTAL LETTER

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contracts and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda (if issued).
At a minimum, the transmittal letter shall contain the following:

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
    a) The Offeror must identify any contracts or agreements it has with any state or local government entity that is a Medicaid provider, plan, or Offeror and the general circumstances of the contract. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest.
    b) Offeror must be able to present sufficient assurances to the Commonwealth that the award of the contract to the Offeror will not create a conflict of interest between the Offeror, the Department, and its subcontractors.
    c) The Offeror will meet all licensing and certification requirements to conduct business in the Commonwealth of Virginia.
2. An attestation that the Offeror has read, understands and agrees to perform all of the responsibilities and comply with all of the requirements and terms and conditions set forth in this RFP, any modifications of this RFP, the MEDALLION 4.0 Contract and Addenda
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number
4. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the corresponding Contract
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of twelve (12) months from its submission to DMAS

9.5 SPECIFIC INSTRUCTIONS

All information requested in Sections 1.6, 1.9, 3.0 through 9.0 of this RFP shall be submitted in the Offeror's proposals. By submitting a proposal, the Offeror certifies that all of the information provided is true and accurate. Offerors shall be accountable for providing services and meeting requirements as described in its response to this RFP and corresponding Contract and in accordance with all terms and conditions.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act and subject to *Code of Virginia* § 2.2-4342. Confidential information shall be clearly marked in the proposal and reasons why the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of § 2.2-4342(F) of the *Code of Virginia*, in writing, either before or at the time the data is submitted. The

written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method, such as highlighting or underlining, and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The electronic redacted copy of the technical proposal shall have the proprietary and confidential information removed or blocked out in its entirety so the content is not visible. The classification of an entire proposal document as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal. Attachment H of this RFP shall be used for the identification of proprietary or confidential information submitted with the proposal.

9.6 PROPOSAL

The Offeror's response shall contain all the documents required in this RFP including the signatory documents. These include the following:

1. RFP Cover Sheet
2. RFP Addenda (if issued)
3. Offeror's Transmittal Letter
4. Offeror's Technical Proposal Response including Network Submission File (Attachment C)
5. Proprietary/Confidential Information Identification Form (Attachment H)
6. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Attachment I)
7. State Corporation Commission Form (Attachment J)
8. Licensure and Financial Participation Requirements (per RFP Section 3.2.1)
9. Certification Requirements (per RFP Section 3.2.2)

Offerors must respond to all sections of this RFP.

Offerors may submit proposals for one or more region(s). Offerors do not need to submit a separate proposal for each region; however, proposals shall clearly indicate in which region(s) the Offeror is proposing to participate and respond with region-specific detail as applicable. An Offeror's region-specific response shall clearly indicate the regions in which it wishes to operate. The Department anticipates that it will enter into annual contracts with at least three (3) Contractors per region. Regions are "all or nothing" and no individual FIPS codes within a region may be selected. Following evaluation of the proposals, the Department will enter into contracts with the selected Offerors for each region.

The Offeror's Technical Proposal response shall adhere to the page limits for each section identified in the chart below. If the Offeror is proposing to operate in multiple regions, the Offeror should adhere to the page limits detailed below.

The page limit assigned is not tied to evaluation scoring criteria and should not be interpreted as a de facto measure of scoring weight or importance.

TECHNICAL PROPOSAL RESPONSE (RFP SECTION)	PAGE LIMIT	SPECIAL INSTRUCTIONS
1.0 INTRODUCTION		
1.9 Other Provisions Impacting MEDALLION 4.0	4	
3.0 ADMINISTRATIVE REQUIREMENTS		
3.1 Executive Summary	10	
3.2 Corporate Overview	10	Financial statements not included in page count. Resumes no more than 2 pages each, however are not part of the page limit
3.3 Staff for VA Operations	8	
3.4 Communications	4	
3.5 Call Center	3	Process flow charts not included in page count
3.6 Enrollment Process	3	
3.7 Member Outreach and Marketing	8	Samples are not included in the page count
3.8 Relationships	4	
3.9 Provider Network Management	10	Provider network file does not count in page limit
3.10 Quality	15	
3.11 Meetings	3	
3.12 Reporting Requirements	8	
3.13 DMAS Compliance Monitoring	10	
3.14 Program Integrity	5	
3.15 Grievances and Appeals	3	
4.0 BENEFITS AND SERVICES REQUIREMENTS		
4.1 Eligibility	1	
4.2 Population Specific Focus	20	
4.3 Care Coordination System	20	
4.4 Covered Services	8	
4.5 Additional Requirements	10	
5.0 INNOVATIONS		
5.1 Driving Delivery System Innovation	5	
5.2 Value-Based Payments	5	
5.3 Social Determinants of Health	8	
5.4 Medallion Care System Partnership	3	
5.5 Performance Incentive Awards	3	
7.0 INFORMATION MANAGEMENT SYSTEM REQUIREMENTS		
7.2 State Technology Standards	2	
7.5 Data Exchanges	2	
8.0 PAST EXPERIENCE		
8.1 Overview of Relevant Experience	20	
8.2 Past Experience and References	10	2 pages per Past Experience Example
8.3 Compliance History	20	

Guidance on Page Limits

*Note: Page limits outlined above remain regardless of how many regions the Offeror's proposal addresses.

Document Type	Included in Page Limits	Excluded from Page Limits
RFP question/test/requirement	• DMAS requires that the Section # precede the Offeror's response.	DMAS does not require that the RFP question or text be included.
Dedicated staffing numbers by position or staffing plan	✓	
Plan for becoming NCQA accredited	✓	
List of enhanced benefits	✓	
Locations (e.g., business offices)	✓	
Description of subcontracts/subcontractors	✓	
Oversight and management plan	✓	
Approach to staff training	✓	
Approach to knowledge transfer	✓	
Resumes, no more than two (2) pages each		X
Job descriptions or description of staff qualifications		X
Business licenses		X
Service area approval & certificates		X
Certifications		X
Verification of NCQA accreditation/re-accreditation		X
Organizational charts		X
Sample reports (e.g., QI reports)		X
Tools (e.g., HRAs)		X
Flow charts/flow process charts		X
Diagrams		X
Work plans		X
Prohibited Affiliation information via the Disclosure of Ownership and Control Interest Statement (CMS 1513)		X
Financial statements		X
Attachments H, I, and J Forms		X

9.7 Signed Cover Page Of The RFP And Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda (if issued), to the RFP; the Certification of Compliance with Prohibition of Political Contributions and Gifts during the Procurement Process form (Attachment I), and The State Corporate Commission form (Attachment J), Licensure and Financial Participation Requirements per RFP Section 3.2.1 and Certification Requirements per RFP Section 3.2.2, and submit them along with its proposal.

9.8 PROCUREMENT CONTACT

The technical point of contact for this RFP at DMAS shall be:

Adrienne T. Fegans
Senior Programs Administrator
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Email: RFP2017-03@dmas.virginia.gov

All communications with DMAS regarding this RFP shall be directed to the technical point of contact or the DMAS Contract Management Officer named in the cover memo. All RFP content-related questions shall be submitted in writing to the technical point of contact. An Offeror or any of its representatives who communicates with any other employees of DMAS concerning this RFP after its issuance may be disqualified from this procurement.

9.9 SUBMISSION AND ACCEPTANCE OF PROPOSALS

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 10:00 a.m. E.T. on September 8, 2017. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals will not be accepted and will be automatically rejected from further consideration. Proposals may be sent by US mail, Federal Express, UPS, etc. to:

Attention: Christopher Banaszak
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: Christopher Banaszak
Department of Medical Assistance Services
7th Floor DMAS Receptionist
600 East Broad Street
Richmond, VA 23219

DMAS reserves the right to reject any or all proposals. Reference *Code of Virginia* § 2.2-4319. DMAS reserves the right to delay implementation of the RFP if a satisfactory Offeror is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Offerors must check the eVA VBO at http://www.eva.virginia.gov for all official postings of addendums or notices regarding this RFP. DMAS also intends to post such notices on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx but the eVA VBO is the official posting site that Offerors must monitor.

9.10 Misrepresentation Of Information

Misrepresentation of an Offeror's status, experience, or capability may result in rejection of a proposal. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in rejection of a proposal or immediate contract termination.

9.11 Schedule Of Events

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. Offerors must check the eVA VBO at http://www.eva.virginia.gov for all official postings of addendums or notices regarding this RFP.

Proposals should be thorough but concise and include sufficient detail to allow DMAS to properly evaluate the Offeror's capacity, capability and relevant experience and expertise to implement the requirements contained within this RFP. The RFP evaluation process will include a brief in-person presentation by each Offeror.

The schedule below represents the State's anticipated timelines for this procurement. This schedule is subject to change.

MEDALLION 4.0 Program Milestones	Target Dates
State Issues RFP	**July 17, 2017**
Mandatory Preproposal Conference	**July 28, 2017**
Proposal Questions Due	**July 31, 2017**
Deadline for Submission of Proposals	**September 8, 2017**

9.12 Oral Presentation

The RFP evaluation process will include a two-hour (including question and answer period) in-person presentation by each Offeror. Additional details regarding the scheduling of the in-person presentation will be provided to respondents, but the presentation must demonstrate the Offeror's structural capacity and ability to excel at meeting the following:

- Mastery of Medicaid product
- Provider network, medical management, and utilization management
- Quality improvement programs
- Reporting capabilities, including encounters and data analytics
- Compliance enforcement and program integrity
- Mastery of all populations and services as listed in this RFP
- Member enrollment and onboarding processes
- Community relationships
- Value-based purchasing arrangements and performance incentive programs
- New innovations

SECTION 10.0 PROPOSAL EVALUATION CRITERIA

10.1 EVALUATION OF MINIMUM REQUIREMENTS

DMAS will evaluate the proposals received in response to this RFP in accordance with the instructions contained herein and the Virginia Public Procurement Act (Va. Code § 2.2-4300, *et seq*.).

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the proposal. Proposals shall comply with the instructions contained throughout this RFP. Failure to comply with the instructions may result in a lower score or elimination from further consideration. Reference Agency Procurement and Surplus Property Manual (APSPM) § 7.3(b). DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

Signature Sheets:

1. RFP Cover Sheet
2. Addenda (if issued)
3. Transmittal Letter (attestation of acceptance of all Terms and Conditions)
4. Proprietary/Confidential Information Identification Form (Attachment H)
5. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process (Attachment I)
6. State Corporation Commission Form (Attachment J)
7. Licensure and Financial Participation Requirements (RFP Section 3.2.1)
8. Certification Requirements (RFP Section 3.2.2)

These forms shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 9.9 before the closing of acceptance of proposals in the number of copies specified.

10.2 PROPOSAL EVALUATION CRITERIA

Offerors must demonstrate an understanding of all of the technical requirements as specified in the RFP. Offerors also must demonstrate it has the capacity, capability, and relevant experience and expertise to perform the requirements specified in this RFP. Proposals will be evaluated using a numerical scoring system consistent with the following factors:

PROPOSAL EVALUATION CRITERIA	WEIGHTS
1. QUALIFICATIONS	
a) Corporate qualifications and experience to serve as a Contractor for the MEDALLION 4.0 Medicaid/FAMIS Managed Care Program, including experience as a Medicaid contracted health plan.	
b) Demonstration in the written proposal of the Offeror's experience and capacity to provide all administrative requirements as they apply to the operation of a health plan for the Medicaid populations specified in the RFP, including but not limited to staffing, provider network and relations management, quality, compliance, etc.	
2. TECHNICAL REQUIREMENTS	
The following requirements as demonstrated in the written proposal of the Offeror's experience and strategies or innovations as a Medicaid contracted health plan to:	
a) Provide services to the populations specified in the RFP, particularly experience with women, pregnant women, infants, children, and children/youth with special health care needs.	
b) Improve the efficiency and effectiveness of strategies, policies and procedures in order to positively impact the populations specified in the RFP, including integration of primary, acute, and behavioral health, and needs of the Medicaid/FAMIS population.	
c) Develop strategic innovation priorities that address value-based payment designs, delivery system innovations, or payment innovations.	
d) Develop programs that recognize the importance of social determinants of health.	
e) Fulfill the State's requirements for information management and data interfaces and any prior experience/qualifications in meeting similar data interface requirements.	
f) Be good corporate citizens, investments in each region/community, and processes for regional community engagement/social responsibility activities.	
g) Outreach to and promote the delivery of services in a culturally competent manner, including interpretive services, to support all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.	
h) Develop regional provider network management systems to ensure network adequacy standards, access standards, and an ethnically diverse provider network that provides the highest quality care to members.	
i) Develop an overall strategy for quality improvement with regional variation for program improvement purposes and to assess the program's overall impact on various outcomes.	
j) Develop regional, coordinated patient care systems and supports for all members	
k) Develop operational infrastructure to effectively and efficiently manage all aspects of the program.	
3. REFERENCES	
a) References that demonstrate the Offeror's Medicaid experience with the following: value-driven care, care transitions, value-based payments design and implementation, integration of behavioral health and acute care, and social determinants of health, and needs of the Medicaid population. DMAS will not accept DMAS employees as references.	
b) References from stakeholders	

Please note that all technical requirements contained in this RFP are required to be in effect at the time of proposal submission and must be maintained throughout the duration of the RFP evaluation period, unless otherwise noted. The Department reserves the right to verify any Offeror's response to a requirement at ANY time during the evaluation process, and to adjust scoring accordingly.

10.3 Potential Means For Further Evaluation

At any point in the evaluation process, DMAS may employ any or all of the following means of evaluation:

- DMAS Review of Industry Publications and Literature
- Offeror Presentations
- Site Visits to Offeror
- Contacting Offeror's References
- Product Demonstrations by the Offeror
- Obtain a Dun and Bradstreet Report on the Offeror
- Obtain a Securities Exchange Commission Report on the Offeror
- Requesting Offeror to elaborate on and/or clarify specific portions of its proposals

No Offeror is guaranteed an opportunity to explain, supplement or amend its initial proposal. Offerors must not submit a proposal assuming that there will be an opportunity to negotiate, amend or clarify any aspect of its submitted proposals. Therefore, each Offeror is encouraged to ensure that its initial proposal contains and represents its best offer.

Offerors should be prepared to conduct product demonstrations, presentations or site visits at the time, date and location of DMAS' choice, should DMAS so request.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

10.4 Negotiation And Award

After the due date and time of proposal submission, the proposals received in response to the RFP will be screened to ensure compliance with Section 10.1, Evaluation of Minimum Requirements. Evaluators may request further information from Offerors to help determine those fully qualified and best suited. Offerors will be selected based on the strength of its proposals and three (3) or more of the top ranked Offerors for each region will then be selected for negotiations.

During negotiations, the Offerors will go through an extensive readiness review process conducted by DMAS or its designee to evaluate each Offeror's ability to comply with the MEDALLION 4.0 readiness requirements. At a minimum, each readiness review may include a desk review and a site visit to the Offeror's business operations location(s). The Offeror must demonstrate compliance to the readiness review and that the Offeror is ready and able to meet all MEDALLION 4.0 requirements identified in the readiness review prior to the contract execution. In addition, the Offeror must provide DMAS or its designee with any corrected materials requested as part of the readiness review. During readiness review, the Offeror will be provided with a draft rate book and Contract for consideration. Through this process, the MEDALLION 4.0 capitation rates will be finalized.

Upon completion of all negotiations, DMAS shall select the Offeror(s), which in its opinion have made the best proposal, and shall award contracts to those Offeror(s). DMAS anticipates that it will select no fewer than three (3) Offerors per region.

Once this determination is finalized, DMAS will post a Notice of Intent to Award (NOIA) to announce the Offerors selected to execute MEDALLION 4.0 Contracts. DMAS reserves the right to award contracts to all, or a subset of, the Offerors.

10.5 Readiness Review and Signing of Contract

The Offeror must demonstrate to DMAS' satisfaction that the Offeror is ready and able to meet all MEDALLION 4.0 Contract requirements identified in the readiness review prior to contract execution. In addition, the Offeror must provide DMAS or its designee with any corrected materials requested as part of the readiness review. Additionally, DMAS must determine that the Offeror has passed the readiness review and has signed a contract with DMAS under this procurement prior to conducting any marketing or accepting any enrollment for the MEDALLION 4.0 program. Any changes required to the Offeror's processes as identified through readiness review activities shall be made by the Offeror prior to implementation. Costs associated with these changes shall be borne by the Offeror.

DMAS reserves the right to award contracts to all, or a subset of, the Offerors with which the Department enters into negotiations. The Department anticipates awarding to three Offerors in each region. In the event the Department determines through its review that there is a locality where only one (1) viable Offeror exists, the Department may consider postponing the program implementation for that locality or implementing an optional MEDALLION 4.0 participation arrangement under the Federal rural exception guidelines per 42 C.F.R. § 438.52(b), if applicable to that locality, until at least one additional Offeror is approved by the Department to operate in the locality.

Contractor Readiness

As stated, based on the evaluation scores, DMAS will select Offerors with which the Department will then conduct an extensive readiness review process to evaluate each Contractor's ability to comply with the MEDALLION 4.0 requirements, including but not limited to, its ability to accurately process claims and enrollment information, accept and transition new members, provide adequate access to all covered services, meet Federal and state regulatory and contract standards, and meet MEDALLION 4.0 quality standards established by the Department. At a minimum, each readiness review may include a desk review and a site visit to the Contractor's headquarters and regional offices if applicable. The scope of the readiness review(s) will include, but not be limited to, review and/or verification of all areas listed in the table below.

Key Areas of Operational Readiness

- ✓ Health risk assessments
- ✓ Care coordination policies, procedures, processes
- ✓ Member outreach and education
- ✓ Confidentiality policy, procedures, and processes
- ✓ Member protections including continuity of care and out of network provisions
- ✓ Member services capability (materials, processes and infrastructure, e.g., call center capabilities)
- ✓ Comprehensiveness of quality management/quality improvement and utilization management strategies, policies, procedures, and processes
- ✓ Financial solvency, in accordance with 42 C.F.R. §438.116
- ✓ Organization structure and staffing capacity, including key personnel and functions directly impacting members (e.g., adequacy and training of staffing);
- ✓ Performance and quality improvement
- ✓ Internal grievance and appeal policies and procedures in accordance with 42 C.F.R. § 438 Subpart F
- ✓ Provider network composition and access to care; includes recruitment and development strategy, capacity, and access to care standards
- ✓ Subcontractor contracts and capacity in to perform functions on Offeror's behalf in compliance with 42 C.F.R. §§ 438.6(l), and 438.230(b)(1)
- ✓ Provider credentialing and contracting including any provider performance incentives
- ✓ Provider manuals, training, and technical assistance
- ✓ Fraud and abuse and program integrity policies and procedures, in accordance with 42 C.F.R. § 438 Subpart H
- ✓ Systems capacity for member and provider enrollment, claims processing, claims payment, encounter processing, care coordination, and reporting. Includes examination of dataflow, integration, and security capabilities to support seamless care coordination across ancillary systems
- ✓ Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of encounter data, including information technology testing and security assurances

Offeror's Plan for Demonstrating Operational Readiness

DMAS intends to take full advantage of the competitive procurement process to identify health plans that demonstrate the superior ability to perform all administrative functions and to provide high-quality services to the Commonwealth's most vulnerable populations.

In response to this RFP, the Offeror shall describe its comprehensive plan to achieve operational readiness in each region proposed as well as the process the Offeror plans to use to demonstrate readiness to the Department, especially for each of the areas listed in the table above, and that includes the following supportive documentation:

1. For each proposed region, the Offeror shall provide a detailed project work plan with timelines, responsible parties, milestones, and dependencies, and that explains how the Offeror will effectively prepare for MEDALLION 4.0 launch and scale its operations to meet the Department's readiness and implementation requirements. The Offeror's detailed project work plan shall:

a. Explain how it will assist providers toward readiness (through technical assistance, etc.) and how it will demonstrate that its providers are operationally ready for MEDALLION 4.0 implementation.
b. Include the proposed infrastructure development plan including call center operations, enrollment systems, claims systems, and other administrative supports.
c. Describe how it will prepare all ancillary programs to be operational for implementation (disease management, 24 hour nurse line, translation services, program integrity, compliance monitoring, etc.).
d. Detail how the Offeror will demonstrate its ability to incorporate MEDALLION 4.0 program operations into its current business structure/processes and shall demonstrate that it has the capacity to effectively manage additional lives.
e. Include a plan for development, implementation, and operations of behavioral health homes and any other health homes.
f. Describe the plan for securing regional community support such as community based organizations, provider and advocacy associations, and non-contracted safety net providers.
g. Include the implementation plan for care coordination.
h. Explain its plan to establish its quality program.
i. Include a comprehensive outreach and education plan for members and providers (both short and long-term).

2. The Offeror shall include a regional risk assessment including any provider contracting barriers or challenges and the plans to overcome the barriers/challenges.
3. The Offeror must explain how it will ensure its network has sufficient capacity across all regions proposed to be served in the Commonwealth and plans to overcome any deficiencies in its network.
4. The Offeror must list its subcontractors and how the Offeror will demonstrate its subcontractors' readiness to effectively meet the needs of the MEDALLION 4.0 Program and contract.
5. The Offeror shall describe its plan to recruit, hire, and prepare staff needed to meet the MEDALLION 4.0 program requirements.

SECTION 11.0 TERMS AND CONDITIONS

11.1 ENFORCEMENT, REMEDIES, AND COMPLIANCE

11.1.1 Basis for Imposition of Sanctions

Pursuant to 42 C.F.R. § 438.700, the Department shall establish intermediate sanctions, as specified in 42 C.F.R. § 438.702, that it may impose if it makes any of the determinations specified below. The Department shall base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source. The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth in 42 C.F.R. § 438 Subpart I and to resort to other remedies provided by law. Remedies shall be imposed in situations where the Department determines the Contractor acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its contract with the Department, to an enrollee covered under the contract.
- 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.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210.
- Has 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.
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

11.1.2 Remedies

In the event of any breach of the terms of the Contract resulting from the MEDALLION 4.0 Contract by the Contractor, including the violations described above, the Contractor shall pay damages to the Department, or shall comply with other intermediate sanctions identified in 42 C.F.R. § 438 Subpart I, for such breach at the sole discretion of the Department. The types of intermediate sanctions that a State may impose under this subpart include the following:

- Civil money penalties in the amounts specified in 42 C.F.R. § 438.704
- Appointment of temporary management for an MCO as provided in 42 C.F.R § 438.706
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to dis-enroll
- Suspension of all new enrollments, including default enrollment, after the effective date of the sanction
- Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur

The Department retains the authority to impose additional sanctions under State law or State regulations that address areas of noncompliance specified in §438.700, as well as additional areas of noncompliance.

In addition, if, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

11.2 Special Terms And Conditions

11.2.1 Audit

Consistent with Federal managed care regulations at 42 C.F.R. § 438.3(u), the Contractor shall retain all books, records, and other documents relative to this contract for ten (10) years, or longer if audited by the Commonwealth of Virginia. The agency, its authorized agents and/or state auditors shall have full access to and the right to examine any of said materials during said period.

11.2.2 Award

Selection shall be made of three (3) or more Offerors per region deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals. Negotiations shall be conducted with the Offerors so selected. After negotiations have been conducted, the Department shall select the Offerors which, in its opinion, have made the best proposals, and shall award the Contract to those Offerors. The Commonwealth reserves the right to make multiple awards as a result of this procurement. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia,* § 2.2-4359D). The award document shall be a Contract incorporating by reference all the requirements, terms and conditions of the RFP and the Offeror's proposal as negotiated.

11.2.3 Termination

This Contract may be terminated in whole or in part:

a. By the Department if the Department determines that the instability of the Contractor's financial solvency threatens delivery of services and continued performance of the Contractor's responsibilities; or
b. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

Each of these conditions for contract termination is described in the following paragraphs.

11.2.3.1 Termination Because of Financial Instability

If DMAS determines that there are verifiable indicators that the Contractor will become financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, DMAS shall require verification of the Contractors financial situation. If from the information DMAS determines the Contractor will inevitably become financially unstable, DMAS may terminate the contract before this occurs. If the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, DMAS may, at its option, immediately terminate this Contract

effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

11.2.3.2 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice shall 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, return or destruction of Department data and liability for medical claims.

In the event that DMAS 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 Medicaid/FAMIS Plus or FAMIS individuals, DMAS may immediately terminate this contract prior to providing notice to the Contractor.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

11.2.4 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.

11.2.5 Renewal of Contract

The Contract may be renewed or extended annually by the Commonwealth for up to six successive twelve month periods under the terms and conditions of the Contract. During the yearly Contract renewal or Contract amendment process, new capitation rates may be calculated and established by the Department. The Department and the Contractor shall sign a new contract yearly. Written notice of the Commonwealth's intention to renew will be given at least 90 days prior to the expiration date of each Contract period.

11.2.6 Business Associate Agreement (BAA)

The Contractor shall be required to enter into a DMAS-supplied Business Associate Agreement (BAA) with DMAS to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 C.F.R. Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement.

The Contractor shall keep abreast of any future changes to the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to DMAS, and agrees to comply with all terms set out in the DMAS BAA, including any future changes to the DMAS BAA. The current DMAS BAA template is available on the DMAS website at http://www.dmas.virginia.gov/Content_pgs/rfp.aspx.

11.2.7 eVA Orders and Contracts

The solicitation/contract will result in one (1) purchase order(s) with the applicable eVA transaction fee assessed for each order.

Vendors 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. Offerors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

11.2.8 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 J – 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.

11.2.9 Standards for the Electronic Health Record Technology Incentive Program

The Contractor shall comply with the current Federal laws and Regulations with regards to the Standards for the Electronic Health Record Technology Incentive Program as referenced under 42 C.F.R. Part 495 (the "Standards"). The Contractor shall comply with the current Standards at no additional cost to DMAS. The current Standards are located at the following site: http://www.ecfr.gov/cgi-bin/text-idx?SID=a54623b2e90c65d75cdbb7a443daad80&mc=true&node=pt42.5.495&rgn=div5#sp42.5.495.a

The parties will work diligently and in good faith to amend any future contract, including but not limited to changes in scope of work or price, to conform to any new or revised legislation, laws, or regulations regarding the Standards to which DMAS or Contractor become subject subsequent to the start of the Period of Performance.

11.2.10 Risk Management and Security

The Contractor, at a minimum, shall comply with VITA standards, which may be found on the VITA website at http://www.vita.virginia.gov. DMAS requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document Contractors compliance with the most stringent requirements listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- 45 C.F.R. 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
- COV ITRM Policy SEC5519-00 (latest version);
- COV ITRM Standard SEC501-09 (latest version).
- At a minimum, the following specific security measures shall be included in the Risk Management and Security Plan Computer hardware controls that ensure acceptance of data from authorized networks only:
    - Manual procedures that provide secure access to the system with minimal risk.
    - Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel;
    - All Contractor database software changes may be subject to the Department's approval prior to implementation; and

- System operation functions must be segregated from systems development duties.

If requested, the Contractor agrees that the plan will be made available to appropriate State and Federal agencies as deemed necessary by DMAS. If any changes to the plan occur during the contract period, the Contractor shall notify the contract administrator at the Department within 30 days to the change occurring.

11.2.11 Continuity of Operations

The Contractor shall be required to provide written assurances that it has a Continuity of Operations (COOP) Plan that relates to the services or functions provided by them under this contract. Key information to be included in the Contractor's COOP and used as an example can be found on the VITA website at http://www.vita.virginia.gov/library/default.aspx?id=537#securityPSGs for templates for Virginia Department of Emergency Management (VDEM) Continuity documents:

- VDEM Continuity Plan Template
- VDEM Guide to Identifying Mission Essential Functions and
- Mission Essential Function Identification Worksheets

The COOP document shall be available to the Department at its request and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the Department's contract administrator within 30 days prior to the change occurring.

11.2.12 Security Training

The Contractor shall be required to provide written assurances that it has a Security Training Plan that relates to the services or functions provided by them under this contract. The Security Training Plan document shall be available to the Department at its request and at least 30 days prior to beginning operations. If any changes occur during the contract period, the Contractor shall notify the Department's contract administrator within 30 days prior to the change occurring and provide documentation of the changes.

11.2.13 Controls

11.2.13.1 Annual Review of Controls

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 corrective action plans to remediate the deficiency. The Contractor shall refer to RFP Attachment E – Security Compliance/Audit Management, for specific requirements [see XXXX-AUDIT-001 (OPTION A), XXXX-AUDIT-001 (OPTION B), XXXX-AUDIT-002 (OPTION A), and XXXX-AUDIT-002 (OPTION B)] to provide American Institute of Certified Public Accountant (AICPA) Service Organization Control (SOC) Reports for the contractor and its subcontractors. Reports shall be provided annually each June 1st for the preceding calendar year.

11.2.13.2 Fraud and Abuse

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. Such policies and procedures must be in accordance with federal regulations described in 42 C.F.R. Parts 455 and 456. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.

11.2.13.3 Fraud and Abuse Compliance Plan

a. The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls and policies and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department with this Contract and as an annual submission as part of the Contract. The Plan must define how the Contractor shall adequately identify and report suspected fraud and abuse by Medicaid enrollees, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls necessary to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse and describe the type and frequency of training that will be provided to detect fraud. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or federal laws and regulations.

The Department shall provide notice of approval, denial, or modification to the Contractor within 30 calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within 30 calendar days of a request. At a minimum the written plan shall:

i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;
ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
    a. Service Authorization
    b. Relevant subcontractor and provider agreement provisions;
    c. Utilization Management
iv. Contain provisions for the confidential reporting of plan violation to DMAS by providers and subcontractors.
    v. Contain provisions for the investigation and follow-up of any compliance plan reports;
    vi. Ensure that the identities of individuals reporting violations of the plan are protected;
vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
viii. Require any confirmed or suspected provider fraud and abuse under state or federal law be reported to the Department and that Medicaid enrollee fraud and abuse be reported to the Department;
ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is subjected to retaliation

b. The Contractor shall designate an officer or director in its organization who has the responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.

c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within 2 business days of initiation of any investigative action by the Contractor or within 2 business days of Contractor notification that another entity is conducting such an investigation of the Contractor. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other state and federal offices. The Contractor shall provide an annual report to the Department of all activities and results.

11.2.13.4 Referrals for Fraud (MFCU)

All cases where fraud is suspected or detected shall be referred to the Department for referral to MFCU prior to any actions or recoupment taking place. The Contractor shall provide support to the MFCU on matters relating to specific cases involving detected or suspected fraud. Referrals shall be submitted to the Department in a format specified by the Department.

11.2.14 Audited Financial Statements and Income Statements

The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance.

11.2.15 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all Attachments on any matter arising out of this contract.

11.2.16 Subcontractors

Legal Responsibility

In accordance with requirements described in 42 C.F.R. § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at http://www.cms.gov/smdl/downloads/SMD061208.pdf), the Contractor shall comply with all of the following federal requirements. Failure to comply with accuracy, timeliness, and in accordance with federal and contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated damages by the Department.

11.2.16.1 Contractor Owner, Director, Officer(s) and/or Managing Employees

(a) The Contractor and/or its subcontractors shall not knowingly have a relationship of the type described in paragraph (b) of this section with:

(1) An individual or entity who is debarred, suspended, or otherwise excluded from participating in federal health care programs, as listed on the Federal List of Excluded Individuals and Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) The relationships described in this paragraph are as following:

(1) Director, officer, or partner of the Contractor.

(2) Person with beneficial ownership of 5percent or more of the Contractor's equity.

(3) Person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

(c) Consistent with federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. and § 455.106, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, and financial interest information; any changes to ownership and control, relationship, and financial interest; and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the Disclosure of Ownership and Control Interest Statement (CMS 1513).

(d) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these federal regulations. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions_list.asp.
(e) The Contractor shall report to the Department within 5 business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.
(f) Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in refusal to execute this Contract, termination of this Contract, and/or liquidated damages by the Department.

11.2.16.2 Contractor and Subcontractor Service Providers

(a) In accordance with 1902(a)(39) and (41), 1128, and 1128A of the *Social Security Act*, 42 C.F.R. § 438-610, 42 C.F.R. § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled "Excluded Individuals/Entities from State/Federal Healthcare Programs."
(b) The Contractor shall 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 shall inform providers and subcontractors about the U.S. Department of Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in federal health care programs. Providers and subcontractors shall 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. The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its providers against the LEIE database to ensure that its contracted health care professionals have not been included on the Federal List of Excluded Individuals/ Entities (LEIE) database, available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp. Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States.
(c) The Contractor shall report to the Department within 5 business days of discovery of any network providers or its subcontractor providers that have been identified on the Federal LEIE database and the action taken by the Contractor.
(d) Failure to disclose the required information accurately, timely, and in accordance with federal and contract standards may result in sanctions by the Department in accordance with this subsection of the Contract.

11.2.16.3 Third Party Administrators

The Contractor may utilize subcontracts with third party administrators (TPAs) for the purpose of processing claims, "back office," and other purely administrative functions. All contracts between the

Contractor and its chosen TPA must be submitted to the Department for initial approval ten (10) days prior to execution, and then annually or upon amendment thereafter.

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a TPA for additional services beyond those referenced above, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent Contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. 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.

11.2.16.4 Prior Approval

All subcontracts, amendments, and revisions that directly affect this contract must be approved in advance by the Department. All subcontracts shall be maintained in accordance with the applicable terms of this Contract. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to the Department within 30 business days of execution.

11.2.16.5 Notice of Approval

Approval of subcontracts shall not be considered granted unless the Department issues its prior approval in writing (to include e-mail). The Department may revoke such approval if the Department determines that the subcontractor(s) fails to meet the requirements of this Contract.

11.2.16.6 Notice of Subcontractor Termination

When a subcontract that relates to the provision of the scope of services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least 30 days prior written notice of the termination to the Department. Such notice shall include, at a minimum, the 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 the project shall be maintained. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and members of the change. 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.

11.2.17 E-Verify

Pursuant to *Code of Virginia*, §2.2-4308.2., any employer with more than an average of 50 employees for the previous 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 its Maintain Company page from E-Verify to prove that they are enrolled in E-Verify.

11.2.18 Severability

Invalidity of any term of this Contract/RFP, in whole or in part, shall not affect the validity of any other term. DMAS and 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 to this RFP.

11.2.19 Indemnification

Contractor agrees to indemnify the Commonwealth of Virginia, its officers, agents, and employees for any loss, liability, cost, or reasonable settlement cost incurred as a result of any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the contractor/any services of any kind or nature furnished by the contractor, provided that such liability is not attributable to the sole negligence of DMAS or to failure of the DMAS to use the materials, goods, or equipment in the manner already and permanently described by the contractor on the materials, goods or equipment delivered.

11.2.20 Mandatory Preproposal Conference

A mandatory preproposal conference will be held on July 28, 2017 at 1:00 p.m. Eastern Time at the Department of Medical Assistance Service, 600 E. Broad Street, Conference Room 7B, Richmond, VA 23219. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. DMAS will not respond to questions during the preproposal conference. Due to the importance of all Offerors having a clear understanding of the specifications/scope of work and requirements of this RFP, in person attendance at this conference will be a prerequisite for submitting a proposal. Proposals will only be accepted from those Offerors who are represented at this preproposal conference. Attendance at the conference will be evidenced by the representative's signature on the attendance roster. No one will be permitted to sign the register after 1:15 pm on day of conference. Due to space limitations, Offerors are limited to two (2) representatives each at the preproposal conference. To ensure adequate accommodations, Offerors need to pre-register with Adrienne T. Fegans by sending an email to RFP2017-03@dmas.virginia.gov stating the name of Offeror and Offeror's participating representatives. For planning purposes, Offerors should pre-register with Adrienne T. Fegans no later than 2:00 p.m. Eastern Time on July 26, 2017. Offerors should bring a copy of the RFP to the conference. Any changes resulting from this conference will be issued in a written addendum to the RFP.

11.2.21 Certification of Internal Controls

The Contractor shall 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. The Contractor shall provide evidence of compliant and ongoing internal control of sensitive data and processes through a standard methodology, such as but without limitation the American Institute of Certified Public Accountant (AICPA) Service Organization Control (SOC) Reports. The evidence of compliance shall be contained in a report describing the effectiveness of the contractor's internal controls. 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. If deficiencies in the contractor's internal control processes and procedures are described in

the most recent version of the report, the contractor shall automatically submit the report to the purchasing office within a timely manner and shall describe the corrective actions to be put into place by the contractor to remedy the deficiencies. Failure to report and/or repair deficiencies in a timely manner shall be cause for the Commonwealth to make a determination of breach of contract. 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. *When Used: For solicitation of a third-party service provider where sensitive data and/or processes are subject to Agency Risk Management and Internal Control Standards (ARMICS) standards or other certification is required to demonstrate adequate internal controls (e.g. outsourcing of financial services, when data is collected on behalf of the agency and/or shared with the contractor, and other significant agency functions).

SECTION 12.0 GENERAL TERMS AND CONDITIONS

12.1 VENDORS MANUAL

This solicitation 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 its entirety. The procedure for filing contractual claims is in Section 7.19 of the *Vendors Manual.* 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 "Vendors Manual" on the vendors tab.

12.2 APPLICABLE LAWS AND COURTS

This solicitation and any resulting 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 agency and the contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, § 2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual.* The contractor shall comply with all applicable federal, state and local laws, rules and regulations.

12.3 ANTI-DISCRIMINATION

By submitting its proposal, Offerors certify to the Commonwealth that it will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the *Virginia Public Procurement Act* (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any individual of goods, services, or disbursements made pursuant to the contract on the basis of the individual's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, sex, gender, disability 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,* § 2.2-4343.1 E).

To the extent allowed by Federal and State law, the Contractor agrees not to discriminate on the basis of race, sex, color, national origin, religion, sexual orientation, gender identity, age, political affiliation, disability, or veteran status. The Contractor must include the same requirements in every subcontract or purchase order over $10,000, so that the same provisions will be binding upon each subcontractor or vendor.

In every contract over $10,000, the provisions in Sections 12.3.1 and 12.3.2 below apply.

12.3.1 During the Performance of This Contract, the Contractor Agrees As Follows

a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis

prohibited by state law 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.

b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such contractor is an equal opportunity employer.

c. 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.

d. The requirements of these provisions 1. and 2. are a material part of the contract. If the Contractor violates one of these provisions, the Commonwealth 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.

e. 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.

12.3.2 Provisions in Subcontracts

The Contractor shall include the provisions of 12.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

12.4 Ethics in Public Contracting

By submitting its proposal, Offerors certify that its proposals are made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with its proposal, and that it has 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.

12.5 Immigration Reform and Control Act of 1986: Applicable for All Contracts Over $10,000

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.

12.6 Debarment Status

By participating in this procurement, the vendor certifies that they are not currently debarred by the Commonwealth of Virginia from submitting a response for the type of goods and/or services covered by this solicitation. Vendor 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 vendor is created or used for the purpose of circumventing a debarment decision against another vendor, the non-debarred vendor will be debarred for the same time period as the debarred vendor.

12.7 Antitrust

By entering into a 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 said contract.

12.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

12.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Adrienne T. Fegans at RFP2017-03@dmas.virginia.gov no later than 10:00 a.m. Eastern Time on July 31, 2017. Any revisions to the solicitation will be made only by addendum issued by the buyer.

12.10 Payment

1. To Prime Contractor:
   a) 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).
   b) Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
   c) 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.
   d) 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.

e) 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 -4364. Upon determining that invoiced charges are not reasonable, the Commonwealth 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).

2. To Subcontractors:
   a. Within seven (7) days of the contractor's receipt of payment from the Commonwealth, a Contractor awarded a contract under this solicitation is hereby obligated:
      (1) To pay the subcontractor(s) for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
      (2) To notify the agency and the subcontractor(s), in writing, of the contractor's intention to withhold payment and the reason.
   b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one 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 Commonwealth, 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 Commonwealth.
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.

12.11 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 solicitation, the Special Terms and Conditions shall apply.

12.12 Qualifications Of Offerors

The Commonwealth 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 Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth 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.

12.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to assure goods and services conform to the specifications.

12.14 Assignment Of Contract

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

12.15 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.
2. The Purchasing Agency 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 Purchasing Agency of the adjustment to be sought, and before proceeding to comply with the notice, shall await the Purchasing Agency's written decision affirming, modifying, or revoking the prior written notice. If the Purchasing Agency 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 Purchasing Agency a credit for any savings. Said compensation shall be determined by one of the following methods:
    i. By mutual agreement between the parties in writing; or
    ii. 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

iii. 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 or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. 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.

12.16 DEFAULT

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them 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 Commonwealth may have.

12.17 INSURANCE

By signing and submitting a proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia.* The Offeror 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.

MINIMUM INSURANCE COVERAGES AND LIMITS

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 Commonwealth 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.

1. Employer's Liability: $100,000.
2. 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.
3. 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.)

12.18 Announcement Of Award

Upon the award or the announcement of the decision to award a contract as a result of this solicitation, the purchasing agency will publicly post such notice on the DGS/DPS eVA VBO (www.eva.virginia.gov) for a minimum of 10 days.

12.19 Drug-Free Workplace - Applicable for all contracts over $10,000

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.

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.

12.20 Nondiscrimination Of Contractors

A bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, 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 state agency, department or institution has made a written determination that employing ex-offenders on the 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.

12.21 EVA BUSINESS-TO-GOVERNMENT VENDOR REGISTRATION, CONTRACTS, AND ORDERS

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 vendors to conduct business with state agencies and public bodies. All vendors 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:

a. For orders issued July 1, 2014, and after, the Vendor Transaction Fee is:
   (i) DSBSD-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DSBSD-certified Small Businesses: 1%, capped at $1,500 per order.
b. 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 60 days of the order issue date. Any adjustments (increases/decreases) will be handled through purchase order changes.

12.22 AVAILABILITY OF FUNDS

It is understood and agreed between the parties herein that the agency 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 agreement.

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 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 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. Determination 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.

12.23 Set-Asides In Accordance With The Small Business Enhancement Award Priority

This solicitation is set-aside for award priority to DSBSD-certified micro businesses or small businesses when designated as "Micro Business Set-Aside Award Priority" or "Small Business Set-Aside Award Priority" accordingly in the solicitation. DSBSD-certified micro businesses or small businesses also includes DSBSD-certified women-owned and minority-owned businesses when it has received the DSBSD small business certification. For purposes of award, bidders/Offerors shall be deemed micro businesses or small businesses if and only if it is certified as such by DSBSD on the due date for receipt of bids/proposals.

12.24 Price Currency

Unless stated otherwise in the solicitation, Offerors shall state offer prices in US dollars.

12.25 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. 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.

ATTACHMENTS

ATTACHMENT A - LOCALITIES BY REGIONS/RURAL AND URBAN LOCALITIES LISTING

FIPS	DESCRIPTION	REGION	M4 IMPLEMENT
001	Accomack County	TIDEWATER	8/1/2018
073	Gloucester County	TIDEWATER	8/1/2018
093	Isle of Wight County	TIDEWATER	8/1/2018
095	James City County	TIDEWATER	8/1/2018
115	Mathews County	TIDEWATER	8/1/2018
131	Northhampton County	TIDEWATER	8/1/2018
199	York County	TIDEWATER	8/1/2018
550	Chesapeake, City of	TIDEWATER	8/1/2018
650	Hampton, City of	TIDEWATER	8/1/2018
700	Newport News, City of	TIDEWATER	8/1/2018
710	Norfolk, City of	TIDEWATER	8/1/2018
735	Poquoson, City of	TIDEWATER	8/1/2018
740	Portsmouth, City of	TIDEWATER	8/1/2018
800	Suffolk, City of	TIDEWATER	8/1/2018
810	Virginia Beach, City of	TIDEWATER	8/1/2018
830	Williamsburg, City of	TIDEWATER	8/1/2018
007	Amelia County	CENTRAL	9/1/2018
025	Brunswick County	CENTRAL	9/1/2018
033	Caroline County	CENTRAL	9/1/2018
036	Charles City County	CENTRAL	9/1/2018
041	Chesterfield County	CENTRAL	9/1/2018
049	Cumberland County	CENTRAL	9/1/2018
053	Dinwiddie County	CENTRAL	9/1/2018
057	Essex County	CENTRAL	9/1/2018
075	Goochland County	CENTRAL	9/1/2018
081	Greensville County	CENTRAL	9/1/2018
085	Hanover County	CENTRAL	9/1/2018
087	Henrico County	CENTRAL	9/1/2018
097	King and Queen County	CENTRAL	9/1/2018
099	King George County	CENTRAL	9/1/2018
101	King William County	CENTRAL	9/1/2018
103	Lancaster County	CENTRAL	9/1/2018
111	Lunenburg County	CENTRAL	9/1/2018
117	Mecklenburg County	CENTRAL	9/1/2018
119	Middlesex County	CENTRAL	9/1/2018
127	New Kent County	CENTRAL	9/1/2018
133	Northumberland County	CENTRAL	9/1/2018
135	Nottoway County	CENTRAL	9/1/2018
145	Powhatan County	CENTRAL	9/1/2018
147	Prince Edward County	CENTRAL	9/1/2018
149	Prince George County	CENTRAL	9/1/2018
159	Richmond County	CENTRAL	9/1/2018
175	Southhampton County	CENTRAL	9/1/2018
177	Spotsylvania County	CENTRAL	9/1/2018
179	Stafford County	CENTRAL	9/1/2018
181	Surry County	CENTRAL	9/1/2018
183	Sussex County	CENTRAL	9/1/2018

FIPS	DESCRIPTION	REGION	M4 IMPLEMENT
193	Westmoreland County	CENTRAL	9/1/2018
570	Colonial Heights, City of	CENTRAL	9/1/2018
595	Emporia, City of	CENTRAL	9/1/2018
620	Franklin, City of	CENTRAL	9/1/2018
630	Fredericksburg, City of	CENTRAL	9/1/2018
670	Hopewell, City of	CENTRAL	9/1/2018
730	Petersburg, City of	CENTRAL	9/1/2018
760	Richmond, City of	CENTRAL	9/1/2018
013	Arlington County	NORTHERN/ WINCHESTER	10/1/2018
043	Clarke County	NORTHERN/ WINCHESTER	10/1/2018
047	Culpeper County	NORTHERN/ WINCHESTER	10/1/2018
059	Fairfax County	NORTHERN/ WINCHESTER	10/1/2018
061	Fauquier County	NORTHERN/ WINCHESTER	10/1/2018
069	Frederick County	NORTHERN/ WINCHESTER	10/1/2018
107	Loudoun County	NORTHERN/ WINCHESTER	10/1/2018
139	Page County	NORTHERN/ WINCHESTER	10/1/2018
153	Prince William County	NORTHERN/ WINCHESTER	10/1/2018
157	Rappahannock County	NORTHERN/ WINCHESTER	10/1/2018
171	Shenandoah County	NORTHERN/ WINCHESTER	10/1/2018
187	Warren County	NORTHERN/ WINCHESTER	10/1/2018
510	Alexandria, City of	NORTHERN/ WINCHESTER	10/1/2018
600	Fairfax, City of	NORTHERN/ WINCHESTER	10/1/2018
610	Falls Church, City of	NORTHERN/ WINCHESTER	10/1/2018
683	Manassas City, City of	NORTHERN/ WINCHESTER	10/1/2018
685	Manassas Park, City of	NORTHERN/ WINCHESTER	10/1/2018
840	Winchester, City of	NORTHERN/ WINCHESTER	10/1/2018
003	Albemarle County	WESTERN/ CHARLOTTESVILLE	11/1/2018
009	Amherst County	WESTERN/ CHARLOTTESVILLE	11/1/2018
011	Appomattox County	WESTERN/ CHARLOTTESVILLE	11/1/2018
015	Augusta County	WESTERN/ CHARLOTTESVILLE	11/1/2018
029	Buckingham County	WESTERN/ CHARLOTTESVILLE	11/1/2018
031	Campbell County	WESTERN/ CHARLOTTESVILLE	11/1/2018
037	Charlotte County	WESTERN/ CHARLOTTESVILLE	11/1/2018
065	Fluvanna County	WESTERN/ CHARLOTTESVILLE	11/1/2018
079	Greene County	WESTERN/ CHARLOTTESVILLE	11/1/2018
083	Halifax County	WESTERN/ CHARLOTTESVILLE	11/1/2018
109	Louisa County	WESTERN/ CHARLOTTESVILLE	11/1/2018
113	Madison County	WESTERN/ CHARLOTTESVILLE	11/1/2018
125	Nelson County	WESTERN/ CHARLOTTESVILLE	11/1/2018
137	Orange County	WESTERN/ CHARLOTTESVILLE	11/1/2018
143	Pittsylvania County	WESTERN/ CHARLOTTESVILLE	11/1/2018
165	Rockingham County	WESTERN/ CHARLOTTESVILLE	11/1/2018
540	Charlottesville, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018
590	Danville, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018
660	Harrisonburg, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018
680	Lynchburg, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018
790	Staunton, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018
820	Waynesboro, City of	WESTERN/ CHARLOTTESVILLE	11/1/2018

FIPS	DESCRIPTION	REGION	M4 IMPLEMENT
005	Alleghany County	ROANOKE/ ALLEGHANY	12/1/2018
017	Bath County	ROANOKE/ ALLEGHANY	12/1/2018
019	Bedford County	ROANOKE/ ALLEGHANY	12/1/2018
023	Botetourt County	ROANOKE/ ALLEGHANY	12/1/2018
045	Craig County	ROANOKE/ ALLEGHANY	12/1/2018
063	Floyd County	ROANOKE/ ALLEGHANY	12/1/2018
067	Franklin County	ROANOKE/ ALLEGHANY	12/1/2018
071	Giles County	ROANOKE/ ALLEGHANY	12/1/2018
089	Henry County	ROANOKE/ ALLEGHANY	12/1/2018
091	Highland County	ROANOKE/ ALLEGHANY	12/1/2018
121	Montgomery County	ROANOKE/ ALLEGHANY	12/1/2018
141	Patrick County	ROANOKE/ ALLEGHANY	12/1/2018
155	Pulaski County	ROANOKE/ ALLEGHANY	12/1/2018
161	Roanoke County	ROANOKE/ ALLEGHANY	12/1/2018
163	Rockbridge County	ROANOKE/ ALLEGHANY	12/1/2018
197	Wythe County	ROANOKE/ ALLEGHANY	12/1/2018
515	Bedford, City of	ROANOKE/ ALLEGHANY	12/1/2018
530	Buena Vista, City of	ROANOKE/ ALLEGHANY	12/1/2018
580	Covington, City of	ROANOKE/ ALLEGHANY	12/1/2018
678	Lexington, City of	ROANOKE/ ALLEGHANY	12/1/2018
690	Martinsville, City of	ROANOKE/ ALLEGHANY	12/1/2018
750	Radford, City of	ROANOKE/ ALLEGHANY	12/1/2018
770	Roanoke, City of	ROANOKE/ ALLEGHANY	12/1/2018
775	Salem, City of	ROANOKE/ ALLEGHANY	12/1/2018
021	Bland County	SOUTHWEST	12/1/2018
027	Buchanan County	SOUTHWEST	12/1/2018
035	Carroll County	SOUTHWEST	12/1/2018
051	Dickenson County	SOUTHWEST	12/1/2018
077	Grayson County	SOUTHWEST	12/1/2018
105	Lee County	SOUTHWEST	12/1/2018
167	Russell County	SOUTHWEST	12/1/2018
169	Scott County	SOUTHWEST	12/1/2018
173	Smyth County	SOUTHWEST	12/1/2018
185	Tazewell County	SOUTHWEST	12/1/2018
191	Washington County	SOUTHWEST	12/1/2018
195	Wise County	SOUTHWEST	12/1/2018
520	Bristol, City of	SOUTHWEST	12/1/2018
640	Galax, City of	SOUTHWEST	12/1/2018
720	Norton, City of	SOUTHWEST	12/1/2018

Rural and Urban Localities Listing:
Rural = Micro, Rural, and CEAC designations. Urban = metro and large metro designations

Rural Localities	FIPS Code	SSA Code	Rural = Micro, Rural, and Counties with Extreme Access Considerations (CEAC)
Accomack	001	49000	Micro
Alleghany	005	49020	Rural
Amelia	007	49030	Rural
Amherst	009	49040	Micro
Appomattox	011	49050	Rural
Augusta	015	49070	Micro
Bath	017	49080	CEAC
Bland	021	49100	Rural
Botetourt	023	49110	Micro
Brunswick	025	49120	Rural
Buchanan	027	49130	Rural
Buckingham	029	49140	Rural
Buena Vista City	530	49141	Rural
Caroline	033	49160	Micro
Carroll	035	49170	Micro
Charles City	036	49180	Rural
Charlotte	037	49190	Rural
Clarke	043	49210	Micro
Covington City	580	49213	Rural
Craig	045	49220	Rural
Culpeper	047	49230	Micro
Cumberland	049	49240	Rural
Danville City	590	49241	Micro
Dickenson	051	49250	Rural
Dinwiddie	053	49260	Micro
Emporia City	595	49270	Rural
Essex	057	49280	Rural
Floyd	063	49310	Rural
Fluvanna	065	49320	Micro
Franklin City	620	49328	Rural
Franklin	067	49330	Micro
Galax City	640	49343	Rural
Giles	071	49350	Rural
Gloucester	073	49360	Micro
Goochland	075	49370	Micro
Grayson	077	49380	Rural
Greene	079	49390	Micro
Greensville	081	49400	Rural
Halifax	083	49410	Rural
Highland	091	49450	CEAC
Isle of Wight	093	49460	Micro
King and Queen	097	49480	Rural
King George	099	49490	Micro
King William	101	49500	Micro
Lancaster	103	49510	Micro
Lee	105	49520	Micro
Lexington City	678	49522	Rural
Louisa	109	49540	Micro
Lunenburg	111	49550	Rural
Madison	113	49560	Rural
Mathews	115	49570	Rural
Mecklenburg	117	49580	Rural

Rural Localities	FIPS Code	SSA Code	Rural = Micro, Rural, and Counties with Extreme Access Considerations (CEAC)
Middlesex	119	49590	Micro
Nelson	125	49620	Rural
New Kent	127	49621	Micro
Northampton	131	49650	Micro
Northumberland	133	49660	Micro
Norton City	720	49661	Micro
Nottoway	135	49670	Rural
Orange	137	49680	Micro
Page	139	49690	Micro
Patrick	141	49700	Rural
Pittsylvania	143	49710	Micro
Poquoson City	735	49712	Micro
Powhatan	145	49720	Micro
Prince Edward	147	49730	Micro
Prince George	149	49740	Micro
Pulaski	155	49770	Micro
Rappahannock	157	49780	Rural
Richmond	159	49790	Rural
Rockbridge	163	49810	Rural
Rockingham	165	49820	Micro
Russell	167	49830	Micro
Scott	169	49840	Rural
Shenandoah	171	49850	Micro
Smyth	173	49860	Micro
Southampton	175	49870	Rural
Surry	181	49900	Rural
Sussex	183	49910	Rural
Tazewell	185	49920	Micro
Warren	187	49930	Micro
Washington	191	49950	Micro
Westmoreland	193	49960	Micro
Wise	195	49970	Micro
Wythe	197	49980	Micro

URBAN LOCALITIES	FIPS CODE	SSA CODE	URBAN = METRO OR LARGE METRO
Albemarle	003	49010	Metro
Alexandria City	510	49011	Large Metro
Arlington	013	49060	Large Metro
Bedford *Bedford city is no longer a valid FIPS, use 019 for Bedford City and County*	019	49090	Metro
Bristol City	520	49111	Metro
Campbell	031	49150	Metro
Charlottesville City	540	49191	Metro
Chesapeake City	550	49194	Metro
Chesterfield	041	49200	Metro
Colonial Heights City	570	49212	Metro
Fairfax City	600	49288	Large Metro
Fairfax	059	49290	Large Metro
Falls Church City	610	49291	Large Metro
Fauquier	061	49300	Metro
Frederick	069	49340	Metro
Fredericksburg City	630	49342	Metro
Hampton City	650	49411	Metro
Hanover	085	49420	Metro
Harrisonburg City	660	49421	Metro
Henrico	087	49430	Metro
Henry	089	49440	Metro
Hopewell City	670	49451	Metro
James City	095	49470	Metro
Loudoun	107	49530	Metro
Lynchburg City	680	49551	Metro
Martinsville City	690	49561	Metro
Manassas City	683	49563	Metro
Manassas Park City	685	49565	Large Metro
Montgomery	121	49600	Metro
Newport News City	700	49622	Metro
Norfolk City	710	49641	Metro
Petersburg City	730	49701	Metro
Portsmouth City	740	49711	Metro
Prince William	153	49750	Metro
Radford City	750	49771	Metro
Richmond City	760	49791	Metro
Roanoke	161	49800	Metro
Roanoke City	770	49801	Metro
Salem City	775	49838	Metro
Spotsylvania	177	49880	Metro
Stafford	179	49890	Metro
Staunton City	790	49891	Metro
Suffolk City	800	49892	Metro
Virginia Beach City	810	49921	Metro
Waynesboro City	820	49951	Metro
Williamsburg City	830	49961	Metro
Winchester City	840	49962	Metro
York	199	49981	Metro

ATTACHMENT B – MEDALLION 4.0 AND FAMIS COVERED SERVICES

The Contractor shall provide benefits as defined in this RFP and resulting MEDALLION 4.0 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, DMAS policy and guidance documents, and as described in the MEDALLION 4.0 Coverage Chart below. Services listed as non-covered by Medicaid shall be covered by the Contractor when medically necessary for children under age 21 in accordance with the Federal EPSDT requirements.

The MEDALLION 4.0 Coverage Chart provides detailed information for covered benefits and includes information on how the Contractor can assist its MEDALLION 4.0 members in accessing services that are carved-out (*) of the this Contract and covered through fee-for-service or other DMAS Contractor. Services are presented in the chart in the following order:

Part 1	Medical Benefits
Part 2A	Inpatient and Outpatient Mental Health Services
Part 2B	Community Mental Health Rehabilitation Services (CMHRS)
Part 2C	Addiction and Recovery Treatment (ARTS)
Part 3A	EPSDT Services
Part 3B	Early Intervention Services
Part 4	FAMIS Covered Services

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
Abortions, induced	12 VAC 30-50-100 12 VAC 30-50-40	Yes. Limited to cases where there would be substantial danger to life of mother	Yes. Limited to cases where there would be substantial danger to life of mother	Contractor shall not cover services for elective abortion. The Contractor shall cover for abortions in limited cases where there would be a substantial danger to life of the mother as referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and Federal law. The Contractor shall be responsible for payment of abortion services meeting State and Federal requirements under the fee-for-service program.
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.*
Christian Science Nurses	12 VAC 30-50-300	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Christian Science Sanatoria Facilities	12 VAC 30-50-300	Yes	No	Contractor is not required to cover this service. Individuals will be excluded from MEDALLION 4.0participation when admitted to a Christian Science Sanatoria and services shall be covered under the fee-for-service program with DMAS established criteria and guidelines.
Clinic Services	12 VAC 30-50-180	Yes	Yes	Contractor shall cover all clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	*Code of Virginia* Section 37.1-67.4	Yes	Yes	Contractor shall 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	Yes	Limited coverage	DMAS' contracted dental benefits administrator (DBA) shall cover routine dental services for children under 21 and for adult pregnant women; therefore, these services are carved out of MEDALLION 4.0 program (unless implemented as an Optional Services as listed in the RFP). However, the Contractor shall be responsible for transportation and medication related to covered dental services. The Contractor shall 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 shall cover medically necessary anesthesia and hospitalization services for its members when determined such services are required to provide dental care.
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 C.F.R. § 438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	Contractor shall cover all emergency services without service authorization. The Contractor shall cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a Member's choice of provider for emergency services.
Emergency Services - Post Stabilization Care	42 C.F.R. § 422.100(b)(1)(iv)	Yes	Yes	Contractor shall 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	MEDALLION 4.0 Contract	No	Yes	Enhanced benefits are services offered by the Contractor to members in excess of MEDALLION 4.0 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 MEDALLION 4.0 comparison chart. See contract section 'Enhanced Benefits' for more information.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
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 <21, 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.*
Family Planning Services	12 VAC 30-50-130	Yes	Yes	Contractor shall cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its members by network and out-of-network providers. Individuals enrolled in Plan First are excluded from MEDALLION 4.0 program participation (unless implemented as an Optional Services as listed in the RFP).
HIV Testing and Treatment Counseling	*Code of Virginia* Section 54.1-2403.01 12 VAC 30-50-510	Yes	Yes	Contractor shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The Contractor shall ensure that, as a routine component of prenatal care, every pregnant member shall be advised of the value of testing for HIV infection. Any pregnant member shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record.
Home Health Services	12VAC30-10-220 12VAC30-50-160 12VAC30-50-200 12 VAC 30-60-70 42 C.F.R. § 440.70 41 C.F.R. § 441.15	Yes	Yes	Contractor shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits per year shall be allowed. Skilled home health visits are limited based upon medical necessity. The Contractor shall manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in 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. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. • B-12 shots • Insulin injections • Central line and porta cath flushes • Blood draws, for example where the member is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance • Changing of indwelling catheter

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Hospice Services	12 VAC 20-50-270	Yes	No	Contractor is not required to cover this service. This service will continue to be covered through the DMAS fee-for-service system.
Immunizations	12 VAC 30-50-130	Yes	Yes	Contractor shall cover immunizations within the most current Center for Disease Control (CDC) guidelines. The Contractor shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. Also see EPSDT in part 3B for immunizations for children.
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	Contractor shall cover inpatient stays in general acute care and rehabilitation hospitals for all members; shall comply with maternity length of stay requirements; shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and shall cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery. 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*.
Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	Contractor shall cover all medically necessary laboratory, radiology and anesthesia services directed and performed within the scope of the license of the practitioner.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer. Screening mammograms for age 40 and over shall 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	Contractor shall cover medical supplies and equipment at least to the extent covered by DMAS. The Contractor shall cover nutritional supplements and supplies. The Contractor shall cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual.
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	Contractor shall cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Organ Transplantation	12 VAC 30-50-540 through 12 VAC 30-50-580 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-50-540 through 12 VAC 30-50-580. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. The Contractor shall cover necessary procurement/donor related services. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age).
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	Contractor shall cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor is required to cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor shall cover annual pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 C.F.R. § 441.50 1905(a) of Social Security Act	EPSDT	EPSDT	Contractor shall cover medically necessary personal care services for children under age 21 consistent with the Department's criteria described in the EPSDT Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal Individuals may receive personal care through an agency-directed or consumer-directed model of care. The model of care is chosen by the individual or the caregiver if the individual is not able to make a choice. For consumer directed personal care services, the Contractor must contract with and reimburse the DMAS Fiscal/Employer Agent (F/EA) for the administrative costs associated with the F/EA functions, as will be specified in the MEDALLION 4.0 Contract.
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	Contractor shall 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 shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130	Yes	Yes	Contractor shall cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT. The Contractor shall permit any female member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the *Code of Virginia*, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.
Podiatry	12 VAC 30-50-150	Yes	Yes	Contractor shall 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	Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall 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 shall cover pregnancy-related and post-partum 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 shall 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 shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements.
Prescription Drugs	12 VAC 30-50-210	Yes	Yes	Contractor shall cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Private Duty Nursing (PDN)	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 C.F.R. § 441.50 1905(a)of Social Security Act	EPSDT only	EPSDT only	Contractor shall cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal
Prostate Specific Antigen (PSA) and Digital Rectal Exams	12 VAC 30-50-220	Yes	Yes	Contractor shall 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	Yes	Yes	Contractor shall cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor shall cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	Contractor shall cover reconstructive breast surgery.
School Health Services*	12 VAC 30-50-130	Yes	No	Contractor is not required to cover school health services (unless implemented as an Optional Services as listed in the RFP). School health services that meet the Department's criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. Private duty nursing and personal care services provided through EPSDT, are not considered school health services, including when provided in the school setting or provided before or after school.
Skilled Nursing Facility Care	12 VAC 30-50-130	Yes	No	Contractor is not required to cover skilled nursing facility care. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from MEDALLION 4.0 upon entry into the DMAS nursing facility authorization database. The Contractor may provide step down nursing care as an enhanced benefit to Medicaid members.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 C.F.R. §440.170(a)	Yes	Yes	Contractor shall provide urgent and emergency transportation as well as non-emergency transportation to all Medicaid covered services, including those Medicaid services covered by a third party payer, transportation to carved-out services, and to services provided by subcontractors, such as dental. These modes shall include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, taxicabs, and transportation network companies (Uber/Lyft). The Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in C.F.R. § 440.170(a).
Vision Services	12 VAC 30-50-210	Yes	Yes	Contractor shall cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. The Contractor also shall cover eyeglasses for children under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
INPATIENT MENTAL HEALTH TREATMENT SERVICES - Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Inpatient Psychiatric Hospitalization in Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 12VAC30-50-130 12VAC30-50-100 12VAC30-50-105 Final Rule: 42 C.F.R. Part 438.6	Yes	Yes	Contractor shall 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 freestanding psychiatric hospital as an "in lieu of" service to Medicaid members between the ages of 21 and 64. Coverage must comply with Federal Mental Health Parity law and Federal provisions for IMDs. For members aged 21-64, the Contractor may provide services through an IMD (Institute of Mental Disease) for no more than 15 days in a calendar month, consistent with the Federal regulations described in 42 C.F.R. § 438.6 and section 4.12 *State Plan Substituted (In Lieu Of) Services* of this contract.
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	Yes	Yes	Contractor shall 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.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	No	Contractor is not required to cover this service. For members aged 21 through 64, the Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements. If a member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the MCO and reimbursed by the health plan as an enhanced service, that member will be excluded from managed care participation. The MCO will notify DMAS of all member admissions to state mental hospitals.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO) (Revenue Codes for TDOs and Service Code 0405 for ECOs)	*Code of Virginia* § 16.1-340 and 340.1 and §§ 37.2-808 through 810	Yes	Yes	Pursuant to 42 C.F.R. § 441.150 and the *Code of Virginia*, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age 21 through 64 and admitted to a freestanding facility. The 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 based on a diagnosis while the member is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing,

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
				based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. The duration of temporary detention shall be in accordance with the *Code of Virginia* , as follows: For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the 96-hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services. For Adults age 18 and over – Pursuant to § 37.2-809.H of the *Code of Virginia* , the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.
OUTPATIENT MENTAL HEALTH SERVICES - The Contractor shall cover medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity laws.				
Electroconvulsive Therapy	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	Contractor shall cover medically necessary electroconvulsive therapy services. Coverage must comply with Federal Mental Health Parity law.
Pharmacological Management, including prescription and review of medication, when performed with psychotherapy services	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	Contractor shall cover medically necessary pharmacological management services.
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law.
Psychological/ Neuropsychological Testing	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	Contractor shall cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law.

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law.

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)

Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including residential treatment centers (PRTFs), shall be covered under the MEDALLION 4.0 Program. The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
Behavioral Therapy Services under EPSDT	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000 EPSDT Manual	Yes	See green highlight above.	Contractor shall provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130, 12 VAC 30-130-2000, and the DMAS EPSDT Behavioral Therapy Provider Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal.
Crisis Intervention Services	12 VAC 30-50-226 12VAC 30-60-143 Community Mental-Health Rehabilitation Services (CMHRS) Manual	Yes	See green highlight	Contractor shall cover medically necessary crisis intervention services. Defined as immediate behavioral health care, available twenty-four (24) hours a day, seven (7) days a week, to assist members who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as members who are a danger to themselves or others. This service's objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the member, providing access to further immediate assessment and follow-up, and linking the member and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.
Crisis Stabilization Services	12 VAC 30-50-226 12VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary crisis stabilization services. Includes services provided to non-hospitalized members experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation.
Day Treatment/Partial Hospitalization	12 VAC 30-50-226 12VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary day treatment/partial hospitalization assessment and treatment services. Includes sessions of two (2) or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for members with serious behavioral disorders. The day treatment center could be attached to a psychiatric

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)

Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including residential treatment centers (PRTFs), shall be covered under the MEDALLION 4.0 Program. The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
				hospital or CSB clinic site. Services are for members with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital.
Intensive Community Treatment Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-61 12 VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Intensive Community Treatment Assessment and Treatment services. Includes an array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Intensive Community Treatment is provided through a designated multi-disciplinary team of behavioral health professionals. It is available twenty-four (24) hours per day.
Intensive In-Home Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Intensive In-Home Assessment and Treatment services.
Mental Health Case Management	12 VAC 30-50-420 12 VAC 30-50-430 12 VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Mental Health Case Management services.
Mental Health Skill-building Assessment and Treatment Services	12 VAC 30-50-226 ER 12 VAC 30-60-143ER http://www.townhall.virginia.gov/1/ViewStage.cfm?stageid=7391 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Mental Health Skill-building Assessment and Treatment Services.
Psychosocial Rehabilitation Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-61 12 VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Intensive Psychosocial Rehabilitation Assessment and Treatment 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 nonresidential 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

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)				
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SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
				medications. These services are limited to 936 units annually.
Residential Services (Community-Based) for children and Adolescents under 21 – Group Home (Levels A&B)	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 130-850-890 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Residential Services (Community-Based) for children and Adolescents under 21 – Group Home (Levels A&B).
Residential Treatment Center – Psychiatric (PRTC) for children under age 21 years – Level C	12 VAC 30-130-850 to 890 12 VAC 30-60-61 and 12 VAC 30-50-130 Emergency regulations for IMD cases (Level C and freestanding psych) are defined at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=6572 Psychiatric Services Manual	Yes	See green highlight	Contractor shall cover psychiatric residential treatment facilities (PRTFs) (formerly RTC Level C) services.
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 CMHRS Manual	Yes	See green highlight	Contractor shall cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents.
Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111	Yes	See green highlight	Contractor shall cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years.
Peer Support Services	To Be Determined; New Service	Yes	See green highlight	Contractor shall cover medically necessary Peer Support Services for children and adults.

SUMMARY OF COVERED SERVICES - PART 2C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Medically Managed Intensive Inpatient	ASAM Level 4.0	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Medically Managed Intensive Inpatient Withdrawal Management	ASAM Level 4.0 WM	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Medically Monitored Inpatient Withdrawal Management	ASAM Level 3.7 WM	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Clinically Managed High Intensity Residential Services	ASAM Level 3.5	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Residential Withdrawal Management	ASAM Level 3.2 WM	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
OUTPATIENT WITHDRAWAL MANAGEMENT				
ARTS Partial Hospitalization	ASAM Level 2.5	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
ARTS Intensive Outpatient	ASAM Level 2.1	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Ambulatory Withdrawal Management With Extended On- Site	ASAM Level 2WM	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)

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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MEDALLION 4.0 Covered	Contractor Responsibilities, Scope of Coverage	
Monitoring					
Ambulatory Withdrawal Management Without Extended On- Site Monitoring	ASAM Level 1 WM	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.	
MEDICATION ASSISTED TREATMENT (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Care Coordination Physician Visit - Induction Urine Drug Screen Labs Physician Visit – Maintenance	H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration S0109 Methadone 5 mg oral billed by provider G9012 Substance Abuse Care Coordination H0006 G0477-G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Care Coordination Physician Visit - Induction Urine Drug Screen Labs Physician Visit – Maintenance	H0020 Opioid Treatment - individual, group counseling and family therapy and medication administration J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider G9012 Substance Abuse Care Coordination H0006 G0477-G0483 CPT codes Use CPT E&M Established patient

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)

Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including residential treatment centers (PRTFs), shall be covered under the MEDALLION 4.0 Program. The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered	MEDALLION 4.0 Covered	Contractor Responsibilities, Scope of Coverage	
Buprenorphine/Naloxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	ASAM Office Based Opioid Treatment	Yes	Yes	Counseling and Medication Oversight Care Coordination Physician Visit - Induction Urine Drug Screen Labs Physician Visit – Maintenance	H0020: Individual or Group Psychotherapy / Patient given Rx; billed by Pharmacy G9012 Substance Abuse Care Coordination H0006 G0477-G0483 CPT codes Use CPT E&M Established patient

The following are required components of Opioid Treatment - H0020:

1. Components of Psychosocial Treatment for Opioid Use Disorder include at a minimum:
   - Assessment of psychosocial needs;
   - Supportive individual and/or group counseling;
   - Linkages to existing family support systems; and
   - Referrals to community-based services.
2. Provider Types for Psychosocial Treatment:
   - Physicians, Licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, a licensed psychiatric nurse practitioner, a licensed marriage and family therapist, a licensed substance abuse treatment practitioner; or
   - An individual with certification as a substance abuse counselor (CSAC) who is under the direct supervision of one of the licensed practitioners listed above.
   - Provider Types for Medication Administration:
     - Induction phase of MAT must be provided by Registered Nurse.
     - Maintenance phase of MAT may be provided by Licensed Practical Nurse or Registered Nurse.
3. Substance Abuse Care Coordination (G9012 Code):

Definition: Other specified case management services not elsewhere classified.

Description:

- Integrates behavioral health into primary care and specialty care medical settings through interdisciplinary care planning as well as monitoring patient progress and tracking patient outcomes.
- Supports in-person and telephonic conversations between buprenorphine-waivered physicians and behavioral health providers to develop and monitor individualized and personalized treatment plans that are focused on the best outcomes for the person.
- Links patients with opioid use disorder with community resources (including Alcoholics Anonymous, Narcotics Anonymous, peer recovery supports, etc.) to facilitate referrals and respond to social service needs.
- Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice. Follows up with patients within a few days of an

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS)

Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including residential treatment centers (PRTFs), shall be covered under the MEDALLION 4.0 Program. The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
emergency room visit or hospital discharge. Communicates test results and care plans to patients and families. 4. Diagnosis Code: This code must be billed with Opioid Use Disorder as the primary diagnosis. 5. Required Documentation: • Providers must submit initial interdisciplinary care plan and regular updates to the care plan based on the patient's progress to the Managed Care plan or Magellan. • Updates should be at least monthly and more regularly if significant events occur that require intervention (such as positive urine drug for other substances or negative urine screen for buprenorphine, missed counseling appointments, lost prescriptions, etc.) • Documentation required of actions taken to address any evidence of a significant event to prevent future reoccurrence or relapse. 6. Provider Types: • At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least one year of substance abuse related clinical experience providing direct services to persons with a diagnosis of mental illness or substance abuse; or • Licensure by the Commonwealth as a registered nurse or as a practical nurse with at least one year of clinical experience; or • At least a bachelor's degree in any field and certification as a substance abuse counselor (CSAC). **Reimbursement: Must be billed by buprenorphine-waivered physician who is prescribing Medication Assisted Treatment for opioid use disorder including buprenorphine/naloxone, buprenorphine (pregnant patients only), or naltrexone injections (Vivitrol)**				
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Abuse Case Management	12 VAC 30-60-185 12 VAC 30-50-431	Yes	Yes	Contractor shall cover SUD services within ASAM criteria.
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0	Yes	Yes	Contractor shall cover SUD services within ASAM criteria
Peer Recovery Supports	To Be Determined; New Service	Yes	Yes	Contractor shall cover SUD services within ASAM criteria Peer Support Services
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-50-180	Yes	Yes	Contractor shall cover SUD services within ASAM criteria

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**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES AND SERVICE CODES AS APPLICABLE**
EPSDT Program Global Coverage Guidelines	12 VAC 30-50-130 42 C.F.R. § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act	Yes	Yes	Contractor shall cover EPSDT screenings according to the American Academy of Pediatrics periodicity schedule, diagnostic services as well as any and all services identified as necessary to correct, maintain or ameliorate any identified defects or conditions. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. The Contractor shall 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.
Behavioral Therapy Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Contractor shall provide coverage for Behavioral Therapy. Behavioral Therapy under EPSDT may be provided to persons with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Behavioral Therapy under EPSDT services are available to individuals under 21 years of age, who meet the medical necessity criteria described in the EPSDT Supplement on Behavioral Therapy Program. The need for behavioral therapy must be identified by the child's physician, nurse practitioner, or physician assistant through an inter-periodic/problem-focused visit or an EPSDT screening/well-child visit. Therapy services are provided within the everyday routines and activities in which families participate, and in places where the family would typically spend time to ensure that the family's daily life is supported, such as a home environment.
Case Management for High Risk Infants (up to age 2)	12 VAC 30-50-410	Yes	Yes	Contractor shall reimburse case management services for high-risk Medicaid eligible children up to age 2.
Clinical Trials	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Clinical trials are not always considered to be experimental or investigational, and are considered under EPSDT when no acceptable or effective standard treatment is available for the child's medical condition and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.
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 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-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any 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**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES AND SERVICE CODES AS APPLICABLE**
				age three 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 shall 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 shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.
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 shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Coverage shall also be within CDC guidelines. The Contractor shall coordinate coverage within the Virginia Vaccines for Children (VVFC) program. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

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**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES AND SERVICE CODES AS APPLICABLE**
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary: ○ hemoglobin/hematocrit ○ tuberculin test (for high-risk groups) ○ blood lead testing including venous and/or capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than 5 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to the Virginia Department of Health, Office of Epidemiology.
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	Contractor shall cover 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 shall be limited to no more than two visits per residence.
Private Duty Nursing	42 C.F.R. §§ 441.50, 440.80, Social Security Act §1905(a)and 1905(r) I.	Yes	Yes	Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement. Contractor shall use the Department's criteria, as described in the DMAS EPSDT Nursing Supplement when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument, if desired, which must be approved by the Department. However, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit. Examples of members that may qualify for PDN coverage include but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled

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**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES AND SERVICE CODES AS APPLICABLE**
				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 Private Duty Nursing shall 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 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 shall 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 shall 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.
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	Contractor shall 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 21.
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 shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.
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 treat defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's (under 21 years of age) current level of functioning or to prevent the child's medical condition from getting worse.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
Early Intervention Services	20USC § 1471 34 C.F.R.§ 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	Contractor shall 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 DMAS Early Intervention billing codes, reimbursement methodology, and coverage criteria shall be used and are described in the Department's Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Medical necessity for EI services shall be defined by the member's IFSP, including in terms of amount, duration, and scope. Service authorization shall not be required. The Contractor also shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Early Intervention Targeted Case Management/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	Contractor shall 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 on-going 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.
Early Intervention Initial Assessments for Service Planning and Development and Annual Review of the Individual Family Services Plan (IFSP)	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 120	Yes	Yes	Contractor shall provide coverage for Early Intervention initial and subsequent assessments for service planning in the child's natural environment or in a center based program.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES				
SERVICE	**STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE**	**MEDICAID COVERED**	**MEDALLION 4.0 COVERED**	**CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE**
IFSP Team Treatment Activities (more than one professional providing services during same session for an individual child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning	12VAC30-50-131 12 VAC 35-225-120 – 12VAC35-225-160	Yes	Yes	Contractor shall provide coverage for Early Intervention team treatment activities where more than one 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.
Developmental Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention developmental services for an individual child or for more than one child, in a group (congregate) in the child's natural environment.
Center-Based Early Intervention Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention center-based individual and group (congregate) services.
Early Intervention Physical Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child's natural environment.
Early Intervention Occupational Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child's natural environment.
Early Intervention Speech Language Pathology; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child's natural environment.
Developmental Nursing; individual and/or group	12VAC30-50-13112 VAC 35-225-120	Yes	Yes	Contractor shall provide coverage for Early Intervention individual and group (congregate) Nursing Services or Developmental Services provided by a nurse, in the child's natural environment.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Inpatient Hospital Services	Yes	$15 per confinement	$25 per confinement	Contractor shall cover inpatient stays in general acute care and rehabilitation hospitals for all members up to 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). The Contractor shall cover 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.
Outpatient Hospital Services	Yes	$2 per visit (waived if admitted)	$5 per visit (waived if admitted)	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.
Chiropractic Services	Yes	$2 (limited to $500 per calendar year)	$5 (limited to $500 per calendar year)	Contractor shall provide $500.00 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.
Clinic Services *Outpatient physician visit in the office or hospital* *Primary care* *Specialty care* *Maternity Services*	Yes	$2 $0	$5 $0	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. There are no copayments for maternity services.
Court Ordered Services	No			Contractor is not required to cover this service unless the service is both medically necessary and is a FAMIS covered service.
Dental Services	No except in certain circumstances			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. Pediatric dental services (for eligible children up to age 21) are covered through the Smiles for Children Program through the Department's Dental Benefit Administrator (DBA). For more information regarding SFC benefits, call 1-888-912-3456.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Early Intervention Services	Yes			Contractor is not required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted Contractor are covered by the Department within the Department's coverage criteria and guidelines. Early intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx The Contractor shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Early, Periodic, Screening, Diagnostic and Treatment (EPSDT)	No			Contractor is not required to cover this service. The Contractor is required to cover well-baby and well child care services.
Emergency Services using Prudent Layperson Standards for Access *Hospital emergency room* *Physician care* *Non-emergency use of the Emergency Room*	Yes	 $2 per visit $2 per visit waived if part of ER visit for true emergency $10 per visit	 $5 per visit $5 per visit waived if part of ER visit for true emergency $25 per visit	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. 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. Members who present to the emergency room shall pay the emergency room co-payment. If it is determined that the visit was a non-emergency, the hospital may bill the member only for the difference between the emergency room and non-emergency co-payments, i.e. $8.00 for <150% and $20.00 for >150%. The hospital may not bill for additional charges.
Post Stabilization Care Following Emergency Services	Yes			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 the following services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's network.
Experimental and Investigational Procedures	No			Contractor is not required to cover this service.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Family Planning Services	Yes	$2 per visit	$5 per visit	Contractor shall cover all family planning services, which includes services and drugs and devices for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. FAMIS covered services include drugs, and devices provided under the supervision of a physician. The Contractor may not restrict a member's choice of provider for family planning services or drugs and devices, and the Contractor is required to cover all family planning services and supplies provided to its members by network providers. *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.
Hearing Aids	Yes	$2	$5	Contractor shall cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five years.
Home Health Services	Yes	$2 per visit	$5 per visit	Contractor shall cover home health services, including nursing and personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to 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. 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.
Hospice Services	Yes	$0	$0	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 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.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Immunizations	Yes	$0	$0	Contractor shall cover immunizations. The Contractor shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP). Contractor shall work with the Department to achieve its goal 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 eligible members shall not qualify for the Free Vaccines for Children Program.**
Inpatient Mental Health Services	Yes	$15 per confinement	$25 per confinement	Inpatient mental health services are covered for 365 days per confinement, including partial day treatment services. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission. The Contractor is not required to cover any services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members. All inpatient mental health admission for individuals of any age to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria. The Contractor may cover services rendered in free-standing psychiatric hospitals as an enhanced benefit. Psychiatric residential treatment (level C) is not a covered service under FAMIS.
Inpatient Rehabilitation Hospitals	Yes	$15 per confinement	$25 per confinement	Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and which have been certified by the Department of Health.
Inpatient Substance Abuse Services	Yes	$15 per confinement	$25 per confinement	The Mental Health Parity and Addiction Act of 2008 mandate coverage for mental health and substance abuse treatment services. Inpatient substance abuse services in a substance abuse treatment facility are covered.
Laboratory and X-ray Services	Yes	$2 per visit	$5 per visit	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 co-pay shall be charged for laboratory or x-ray services that are performed as part of an encounter with a physician.
Lead Testing	Yes	$0	$0	Contractor shall cover blood lead testing as part of well baby, well childcare.
Mammograms	Yes	$0	$0	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Medical Supplies *Medical Equipment*	Yes	$0 for supplies $2 per item for equipment	$0 for supplies $5 per item for equipment	Contractor shall cover durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and prosthetic devices and eyeglasses are covered when medically necessary. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.
Medical Transportation	Yes	$2	$5	Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if 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 must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one 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. **Transportation services are not provided for routine access to and from providers of covered medical services**.
Organ Transplantation	Yes	$15 per confinement and $2 per outpatient visit (Services to identify donor limited to $25,000 per member)	$25 per confinement and $5 per outpatient visit (Services to identify donor limited to $25,000 per member)	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 synegenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. The Contractor shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, pancreas, and single lung transplants. The Contractor shall cover necessary procurement/donor related services. The Contractor is not required to cover transplant procedures determined to be experimental or investigational.
Outpatient Mental Health	Yes	$2 per visit	$5 per visit	*The Mental Health Parity and Addiction Act of 2008 mandates coverage for mental health and*

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
and Substance Abuse Services				*substance abuse treatment services. Accordingly, the Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance abuse treatment services.* The Contractor shall provide coverage to members, for mental health and substance abuse treatment services. Emergency counseling services, intensive outpatient services, day treatment, and substance abuse case management services are carved-out of this contact and shall be covered by the Department.
Community Mental Health Rehabilitative Services (CMHRS)	Yes			Effective December 1, 2018, the behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), including psychiatric residential treatment facilities (PRTFs), shall be covered under the MEDALLION 4.0 Program. The Department's BHSA will continue to provide these services for MEDALLION 4.0/FAMIS Members through the fee-for-service program until the services transition to MEDALLION 4.0.The Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001). CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.
Pap Smears	Yes	$0	$0	Contractor shall cover annual pap smears
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	Yes	$2 per visit	$5 per visit	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. The Contractor shall not be required to cover those services rendered by a school health clinic.
Physician Services *Inpatient physician care* *Outpatient physician visit in the office or hospital* *Primary Care* *Specialty care* *Maternity services*	Yes	 $0 $2 per visit $2 per visit $0 per visit	 $0 $5 per visit $5 per visit $0 per visit	Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.
Pregnancy-Related Services	Yes	$0	$0	Contractor shall cover services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy related services. No cost sharing at all will be charged to members enrolled in FAMIS MOMS.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Prescription Drugs *Retail up to 34-day supply* *Retail 35-90-day supply* *Mail service up to 90-day supply*	Yes	 $2 per prescription $4 per prescription $4 per prescription	 $5 per prescription $10 per prescription $10 per prescription	Contractor shall cover all medically necessary drugs for its members that by Federal or State law require a 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 required to cover prescription drugs prescribed by the outpatient mental health provider. 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 the copayment **plus** 100% of the difference between the allowable charge of the generic drug and the brand drug.
Private Duty Nursing Services	Yes	$2 per visit	$5 per visit	Contractor shall cover private duty nursing services only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN); must be medically necessary; 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. Private duty nursing services must be pre-authorized.
Prosthetics/Orthotics	Yes	$2 per item	$5 per item	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. add items listed in Handbook) for members. The Contractor shall cover medically necessary orthotics for members when recommended as part of an approved intensive rehabilitation program.
Psychiatric Residential Treatment Services	No			This service is non-covered under FAMIS.
School Health Services	Yes*			*Contractor is not required to cover school-based services provided by a local education agency or public school system. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies at school. School health services that meet the Department's criteria will continue to be covered as a carve-out service. The Contractor shall not be required to cover these services rendered by a school health clinic.
Second Opinions	Yes	$2 per visit	$5 per visit	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 outside the network, at no cost to the member. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.
Skilled Nursing Facility Care	Yes	$15 per confinement	$25 per confinement	Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Telemedicine Services	Yes			Contractor shall provide coverage for medically necessary telemedicine services. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. Currently the Department recognizes only physicians and nurse practitioners for medical telemedicine services and requires one of these types of providers at the main (hub) satellite (spoke) sites for a telemedicine service to be reimbursed. Additionally, the Department currently recognizes three telemedicine projects.
Temporary Detention Orders	No			Contractor is not required to cover this service. Coverage may be available through the State TDO program.
Therapy Services	Yes	$15 per confinement if inpatient $2 per visit outpatient	$25 per confinement if inpatient $5 per visit outpatient	Contractor shall cover the costs of renal dialysis, chemotherapy and radiation therapy, and intravenous and inhalation therapy.
Tobacco Dependence Treatment (i.e., Tobacco or Smoking Cessation) for Pregnant Women	Yes			Contractor shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.
Transportation	No			Transportation services are not provided for routine access to and from providers of covered medical services.
Well Baby and Well Child Care	Yes	$0	$0	Contractor shall cover all routine well baby and well childcare recommended by the American Academy of Pediatrics Advisory Committee, including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations. The following services rendered for the routine care of a well child: Laboratory services: blood lead testing, HGB, HCT or FEP (maximum of 2, any combination); Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered); Pure tone audiogram for age 3-5 (maximum of 1); Machine vision test (maximum of 1 covered). 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. Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

SUMMARY OF COVERED SERVICES – PART 4 – FAMIS SERVICES

Service	FAMIS Covered	Network Cost Sharing & Benefit Limits		Notes and Day Limitations
		<150%	>150%	
Vision Services *Once every 24 months:* *Routine eye exam* *Eyeglass frames (one pair)* *Eyeglass lenses (one pair)* *single vision* *bifocal* *trifocal* *contacts*	Yes	 $2 Member Payment $25 Reimbursed by Plan $35 Reimbursed by Plan $50 Reimbursed by Plan $88.50 Reimbursed by Plan $100 Reimbursed by Plan	 $5 Member Payment $25 Reimbursed by Plan $35 Reimbursed by Plan $50 Reimbursed by Plan $88.50 Reimbursed by Plan $100 Reimbursed by Plan	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, for all members, shall be allowed at least once every two- (2) years. The Contractor shall cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for members.
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	No			Contractor is not required to cover this service. However, the Contractor may cover services rendered in free-standing psychiatric hospitals to members up to nineteen (19) years of age as an enhanced benefit offered by the Contractor. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members.
Abortions	No			Contractor is not required to cover services for abortions.
Cost Sharing: *Annual Co-Payment Limit*		Calendar year limit: $180 per family	Calendar year limit: $350 per family	Plan pays 100% of allowable charge once limit is met for covered services. No cost sharing will be charged to American Indians and Alaska Natives.
FAMIS MOMS				Benefits are the same as those available under MEDALLION 4.0.

ATTACHMENT C - PROVIDER NETWORK REPORTING REQUIREMENTS

File Specifications

Provide the following information in a comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in the .csv file.

Field	Specifications
NPI/API	Required. 10 bytes numeric with leading zeros.
PCP Status	Required field. Must contain a valid value. Valid values are Y and N.
Provider Last Name	Required.
Provider First Name	Leave blank if provider is facility or business.
Address line 1	Required.
Address line 2	Optional.
City	Required.
State	Required.
Zip code	Required. 5 byte numeric with leading zeros.
Taxonomy Code	Required. Current taxonomy code values are listed on the official WPC site: www.wpc-edi.com/reference. See list below for the list of taxonomy codes that are used in Virgina provider adequecy analysis.
Phone Area Code	Required. NUM(3)
Phone Number	Required. NUM(7)
Phone Extension	Optional. NUM(4)
Evening Hours	Required. Indicates that the provider offers evening hours (after 5:00 p.m) for patient visits. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Weekend Hours	Required. Indicates that the provider offers weekend hours for patient visits. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Language 1	Optional. If provided, must use code values from the code set provided in 1.21 (Enrollment Broker File). CHAR(2)
Language 2	Optional. If provided, must use code values from the code set provided in 1.21 (Enrollment Broker File). CHAR(2)
Language 3	Optional. If provided, must use code values from the code set provided in 1.21 (Enrollment Broker File). CHAR(2)
American Sign Language	Required. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Accomodations	Required. Indicates that the provider's service facility 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. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Group Affiliation	Optional. CHAR(50)
Provider's Gender	Required. Valid values: M, F, U. Default to U if not available or not applicable. NUM(1)
Low Age Limit	Required. Identifies any age restrictions imposed by provider. This is the lowest patient age served by the provider. Default to 0 if unavailable. CHAR(3)
Upper Age Limit	Required. Identifies any age restrictions imposed by provider. This is the highest patient age served by the provider. Default to 120 if unavailable. NUM(3)
Gender(s) Served	Required. Identifies any gender restrictions imposed by provider, i.e. if the provider serves only Males, Females, or Both genders. Valid values: M, F, B. Default to B if not available. CHAR(1)
PCP Status	Required. Indicates that this provider meets the qualifications to serve as a Primary Care Physician for patients (as defined by the MCO). Valid values are Y and N. Default to N if not available. CHAR(1)

Field	Specifications
Accepting New Patients	Required. Indicates that the provider is accepting new Medicaid patients. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Cultural Competency	Required. Whether the health care professional or non-facility based network provider has completed cultural competence training. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Provider Web Site	Optional. Provider website/URL, if available.
Public Transport	Required. Whether the network provider is on a public transportation route. Valid values are: Y, N, and U. Default to U if not available. CHAR(1)
Specialized Training	Optional. For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use.
Contracted vs. LOI	Required. Indicate whether the MCO has a contract or letter of intent with this provider/ location. Valid values are: C = contracted, and L = letter of intent. CHAR(1)

Requirements

Include providers participating in Medicaid and FAMIS.

The complete provider file; i.e., all PCPs, specialists, hospitals, health systems, safety net, and subcontractor networks (this includes psychiatric, vision, pharmacy, etc.) must be submitted. The entire network should be in a single file submission, formatted as above; not separate files.

Include only network participating providers. Do not include any out of network providers in this file.

For providers with multiple service office locations, each office location must be listed on a different line.

Each provider and service location should be listed only once in the MCO's submission. Do not include multiple lines for the same provider and location with different taxonomy values. Provide the primary taxonomy code only.

The address provided should represent the provider's actual servicing address (not billing, mailing, or corporate). Do not submit P.O. boxes for the provider's servicing address.

Provider last name field must contain the valid individual or business name for the NPI/API provided. Do not use default values for the provider last name.

The following table shows the mapping of NPPES Taxonomy Codes to provider specialty that will be used for the evaluation of the MCO provider networks:

Specialty	Taxonomy
Allergy & Immunology	207KA0200X 207K00000X
Anesthesiology	207L00000X 207LC0200X 207LP2900X 207LP3000X
Colon and Rectal Surgery	208C00000X
Dermatology	207N00000X 207ND0900X 207ND0101X 207NP0225X 207NS0135X
Emergency Medicine	207PE0004X 207P00000X 207PH0002X 207PT0002X 207PP0204X 207PE0005X
Family Medicine	207QA0401X 207QA0000X 207QA0505X 207Q00000X 207QG0300X 207QH0002X 207QS1201X 207QS0010X
General Practice	208D00000X
Hospitalist	208M00000X

Specialty	Taxonomy
Internal Medicine	207RA0401X 207RA0000X 207RA0201X 207RB0002X 207RC0000X 207RC0001X 207RC0200X 207RE0101X 207RG0100X 207RG0300X 207RH0000X 207RH0003X 207RI0008X 207RH0002X 207RI0200X 207R00000X 207RI0011X 207RX0202X 207RN0300X 207RP1001X 207RR0500X 207RS0012X 207RS0010X
Medical Genetics	207SG0202X 207SG0201X
Neurological Surgery	207T00000X
Nuclear Medicine	207UN0901X 207UN0902X 207U00000X
Obstetrics & Gynecology	207VC0200X 207VF0040X 207VX0201X 207VG0400X 207VH0002X 207VM0101X 207VX0000X 207V00000X 207VE0102X
Ophthalmology	207W00000X 152W00000X
Oral Surgery	204E00000X
Orthopedic Surgery	207XS0114X 207XX0004X 207XS0106X 207X00000X 207XS0117X 207XX0801X 207XP3100X 207XX0005X

Specialty	Taxonomy
Otolaryngology	207YS0123X 207YX0602X 207Y00000X 207YX0905X 207YX0901X 207YP0228X 207YX0007X 207YS0012X
Pain Medicine	208VP0014X 208VP0000X
Pathology	207ZP0101X 207ZP0102X 207ZB0001X 207ZP0105X 207ZC0500X 207ZD0900X 207ZH0000X 207ZN0500X 207ZP0213X
Pediatrics	2080A0000X 2080P0006X 2080H0002X 2080N0001X 2080P0008X 2080P0201X 2080P0202X 2080P0203X 2080P0204X 2080P0205X 2080P0206X 2080P0207X 2080P0208X 2080P0210X 2080P0214X 2080P0216X 208000000X 2080S0012X 2080S0010X
Pharmacy	183500000X 3336C0002X 3336H0001X 332900000X
Physical Medicine and Rehabilitation	2081H0002X 2081N0008X 2081P2900X 2081P0010X 208100000X 2081P0004X 2081S0010X

Specialty	Taxonomy
Plastic Surgery	208200000X 2082S0099X 2082S0105X
Preventive Medicine	2083A0100X 2083T0002X 2083X0100X 2083P0500X 2083P0901X 2083P0011X
Psychiatry & Neurology	2084A0401X 2084P0802X 2084B0040X 2084P0804X 2084N0600X 2084D0003X 2084F0202X 2084P0805X 2084P0005X 2084N0400X 2084N0402X 2084P2900X 2084P0800X 2084P0015X 2084S0012X 2084V0102X
Radiology	2085B0100X 2085D0003X 2085R0202X 2085U0001X 2085N0700X 2085N0904X 2085P0229X 2085R0001X 2085R0203X 2085R0204X
Surgery	2086S0120X 2086S0122X 208600000X 2086S0105X 2086S0102X 2086X0206X 2086S0127X 2086S0129X
Thoracic Surgery	208G00000X
Transplant Surgery	204F00000X
Urology	2088P0231X 208800000X

Specialty	Taxonomy
Behavioral Health and Social Service Providers	101Y00000X 106H00000X 103T00000X 103TC0700X 104100000X 1041C0700X 101YM0800X 101YP2500X
Physician Assistants and Advanced Practice Nursing Providers	367A00000X 363L00000X 363LA2100X 363LA2200X 363LF0000X 363LP0200X 363A00000X 363AM0700X 363AS0400X 367500000X
Respiratory, Developmental, Rehabilitative and Restorative Service Providers	225X00000X 225100000X 227800000X 227900000X 231H00000X 235Z00000X
Acute Care Hospital	282N00000X
Clinical Medical Laboratory	291U00000X

Specialty	Taxonomy
Community Service Boards	251S00000X
Durable Medical Equipment Supplier	332BC3200X 332B00000X 332BX2000X
End-Stage Renal Disease Facility	261QE0700X
Federally-Qualified Health Centers (FQHC)	261QF0050X 261QF0400X
Health Department	261QP0904X 251K00000X
Home Health	251E00000X
Pharmacy	333600000X 3336C0003X 3336L0003X
Prosthetic Supplier	335E00000X
Rural Health Care Clinic (RHC)	261QR1100X
Skilled Nursing Facility	314000000X
Transportation	344800000X 341600000X 3416L0300X 347B00000X 343900000X 343800000X 344600000X
Urgent Care Center	261QU0200X

ATTACHMENT D – TECHNOLOGY STANDARDS

Requirement ID	Requirement
XXXX-TECH-STND-001	All the artifacts developed as part of the proposed Solution shall be compliant with CMS and HIPAA standards and requirements.
XXXX-TECH-STND-002	The Solution shall use rules based, table driven modular, and reusable components.
XXXX-TECH-STND-003	The Solution shall facilitate online, browser based web capabilities with no client component download(s) for all authorized end users including, but not limited to providers and members.
XXXX-TECH-STND-004	The Solution shall support functionality to interface with multiple entities for exchange of information.
XXXX-TECH-STND-005	The Solution shall comply with all current and future HIPAA standard Transactions and Code Sets (TCS) in place or mandated by the Commonwealth and CMS.
XXXX-TECH-STND-006	The Solution shall implement standard policies and practices to ensure the security and integrity of the information to be exchanged.
XXXX-TECH-STND-007	The Solution shall provide notification to the MES ISS Contractor of all changes to application program interface (API) on a timely basis.
XXXX-TECH-STND-008	The Solution shall provide standard and ad hoc reporting capabilities for all modules of the proposed solution which are accessed by Commonwealth end users and other stakeholders.
XXXX-TECH-STND-009	The Solution shall meet the Federal reporting requirements and performance standards as defined by CMS and CMS certification checklists as applicable.
XXXX-TECH-STND-010	The Solution shall implement and support a reporting repository with Web based access by authorized end users, including the ability to extract data to be used with desktop applications.
XXXX-TECH-STND-011	The Solution shall provide interoperability between DMAS defined components, modules, or Solutions as required to support the Contractor's Solution and DMAS.
XXXX-TECH-STND-012	The Solution shall allow users to select among several format types (e.g., PDF, Microsoft Excel, Microsoft Word) for any outputs produced. The output media types shall be role based or by individual end user(s).
XXXX-TECH-STND-013	The Solution shall implement relevant standards including, but not limited to NIEM, CAQH-CORE, HL7, and HIPAA for data interchange.
XXXX-TECH-STND-014	The Solution shall provide single sign-on (SSO) capability using Commonwealth standards for login and authentication. The Contractor's system shall include an end user authentication process that permits the end user to enter one (1) name and password to access multiple applications. This process authenticates the user for those applications they have access rights to and eliminates the need for further prompts when switching between applications during a session.
XXXX-TECH-STND-015	The Solution shall process all inbound and outbound files at a frequency as defined by the Commonwealth.
XXXX-TECH-STND-016	The Solution shall support and monitor the processing of all transaction files and notify the Commonwealth of all transactions which have not been processed successfully.
XXXX-TECH-STND-017	The Solution shall accept and apply interface data accurately 100% of the time.
XXXX-TECH-STND-018	The Solution shall reconcile errors identified during the processing of any transaction file and reprocess partner transactions within the agreed upon SLA.
XXXX-TECH-STND-019	The Solution shall comply with Commonwealth and Federal records management policies and retention schedules.
XXXX-TECH-STND-020	The Solution shall ensure archived data is retrievable, formatted to match the original intake document, and shows the changes during processing.
XXXX-TECH-STND-021	The Solution shall comply with all Commonwealth and Federal laws, grant requirements, rules, regulations, guidelines, policies, and procedures for destruction of records.
XXXX-TECH-STND-022	The Solution shall retain all records for both paper and electronic claims as per the Commonwealth and Federal guidelines.
XXXX-TECH-STND-023	The Solution shall comply with and align with Commonwealth Technology Standards.
XXXX-TECH-STND-024	The Solution for proposed interfaces to Commonwealth systems shall comply with or have approved exceptions to all applicable Commonwealth Data Standards as found at: http://www.vita.virginia.gov/oversight/default.aspx?id=10344 If not, please explain.

XXXX-TECH-STND-025	The Solution shall provide effective, interactive control and use with nonvisual means and provide 508 Compliance in accordance with the following standard regarding IT Accessibility and 508 Compliance: http://www.vita.virginia.gov/uploadedFiles/Library/AccessibilityStandard_GOV103-00_Eff_11-04-05.pdf (Refer to www.section508.gov and www.access-board.gov for further information) If yes, please describe how this functionality is achieved and include a completed Voluntary Product Accessibility Template (VPAT) with your proposal. (The VPAT template is located in APPENDIX C of the Accessibility Standard (GOV103-00)). If no, does your solution/application/product provide alternate accessibility functionality? Please describe.
XXXX-TECH-STND-026	The Solution shall comply with all current COV ITRM Policies and Standards, as applicable, found at: http://www.vita.virginia.gov/library/default.aspx?id=537? If proposed solution does not, please provide details that specify the Standard/Policy and how Contractor's solution does not comply.

ATTACHMENT E – SECURITY COMPLIANCE/AUDIT MANAGEMENT

Requirement ID	Requirement
XXXX-SSDR-SAD-001	The Solution shall support encryption at rest for all relational database items. The technical solution must be implemented as database encryption. DMAS must have control of the encryption keys,
XXXX-SSDR-SAD-002	The Solution shall require all relational database(s) to enforce Transport Layer Security (TLS 1.2 or above) for all incoming database connections.
XXXX-SSDR-SAD-003	The Solution requires a minimum of 256 bit encryption (AES preferred).
XXXX-SSDR-SAD-004	The Solution utilized to encrypt the database shall include security that contains encryption keys to be a minimum of 2048 bits.
XXXX-SSDR-SAD-005	The Solution utilized to encrypt the database requires methods used by relational databases to be FIPS-140-2 certified or higher.
XXXX-SSDR-SAD-006	The Solution utilized to encrypt the database requires methods used by relational databases to be common criteria certified.
XXXX-SSDR-SAD-007	The Contractor shall provide a System Security Plan (SSP) which will be in compliance with all State and Federal enterprise information security policies, standards, security initiatives, and regulations.
XXXX-SSDR-SAD-008	The Contractor shall provide a security solution which complies with VITA Information Security Standard Regulation SEC 501-09 or latest (SEC501-09 is updated annually and is based on NIST 800-53 v.4).
XXXX-SSDR-SAD-009	The Solution shall ensure that all data considered to be Protected Health Information (PHI) is secured while in transit and at rest (via encryption or an industry standard method of secure file transport). Data shall be stored in the continental United States.
XXXX-SSDR-SAD-010	The Contractor shall provide guest network connectivity from its offices and facilities during the life of the contract, at the Contractor's expense. This can be guest Wi-Fi or some other DMAS approved method. Requested guest accounts will be provisioned within twenty four (24) hours.
XXXX-SSDR-SAD-011	The Contractor shall collaborate and provide significant participation in support of the development and annual maintenance of its CMS System Security Plan (SSP) as required by CMS MARS-E v2.0.
XXXX-SSDR-SAD-012	The Solution shall provide the capacity to manage the creation of unique and permanent User ID's across multiple systems.
XXXX-SSDR-SAD-013	The Solution shall provide the capability for the provisioning of all MES accounts through the use of federated lists of tables.
XXXX-SSDR-SAD-014	The Solution shall have the functionality to allow for automated password resets using industry standard algorithms.
XXXX-SSDR-SAD-015	The Solution's password complexity shall require the use of all four of the following characteristics: Upper Case, Lower Case, Special Characters, and Numbers.
XXXX-SSDR-SAD-016	The Solution's passwords shall be a minimum of 12 characters in length and expire every 42 days as required by MARS-E v2.0 and VA IT SEC501 (latest).
XXXX-SSDR-SAD-017	The Contractor shall ensure the solution integrates with a central ICAM/SSO using web services.
XXXX-SSDR-SAD-018	The Contractor shall ensure the solution provides an authorization system and workflow for setting up user roles/access levels.
XXXX-SSDR-SAD-019	The Contractor shall provide coordination between role-based contractor solutions that include DMAS user roles and the central ICAM/SSO during implementation/setup of access control components.
XXXX-SSDR-SAD-020	The Contractor shall provide coordination between role-based contractor solutions which include DMAS roles and the central ICAM/SSO for external testing.
XXXX-SSDR-SAD-021	The Contractor shall provide coordination and support during the mapping of current roles (such as VAMMIS ACF2 roles) into applicable contractor solution roles for DMAS users.

Requirement ID	Requirement
XXXX-SSDR-SAD-022	The Contractor shall ensure the solution provides role-based security and audit capabilities relative to the ICAM/SSO.
XXXX-SSDR-SAD-023	The Contractor shall ensure the user role/access level identifiers are continually in synch with the authorization system.
XXXX-AUDIT-001 (OPTION A)	The Contractor shall provide DMAS, at a minimum, an annual report from its external auditor on effectiveness of financial internal controls. The report shall be compliant with the AICPAs Reporting on a Service Organizations Controls (SOC), Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall be a SOC 1 – *Report on Controls at a Service Organization Relevant to User Entities' Internal Control over Financial Reporting*, Type 2 Report. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiencies. The SOC 1, Type 2 audit reports must be provided to the DMAS Contract Administrator and the Internal Audit Division annually, no later than 30 days after the report is issued.
XXXX-AUDIT-001 (OPTION B)	The Contractor shall provide DMAS, at a minimum, an annual report from its external auditor on effectiveness of internal controls related to compliance or operations. The report shall be compliant with the AICPAs Attestation Standards, AT Section 101. The report shall be a SOC 2 – *Report on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, and Privacy,* Type 2 Report performed in accordance with the Attestation Standards AT101, Attest Engagements. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiencies. The SOC 2, Type 2 audit reports must be provided to the DMAS Contract Administrator and the Internal Audit Division annually, no later than 30 days after the report is issued.
XXXX-AUDIT-002 (OPTION A)	For each of its third-party service providers which provide a service that may impact the financial or program operations of DMAS, the Contractor must provide DMAS, at a minimum, an annual report from its external auditor on the effectiveness of financial internal controls. The report shall be compliant with the AICPAs Reporting on a Service Organizations Controls (SOC), Statement on Standards for Attestation Engagements (SSAE) No. 16, Reporting on Controls at a Service Organization. The report shall be a SOC 1 – *Report on Controls at a Service Organization Relevant to User Entities' Internal Control over Financial Reporting*, Type 2 Report. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiencies. The SOC 1, Type 2 audit reports must be provided to the DMAS Contract Administrator and the Internal Audit Division annually, no later than 30 days after the report is issued.
FMA-AUDIT-002 (OPTION B)	For each of its third-party service providers which provide a service that may impact the financial or program operations of DMAS, the Contractor must provide DMAS, at a minimum, an annual report from its external auditor on effectiveness of internal controls related to compliance or operations. The report shall be compliant with the AICPAs Attestation Standards, AT Section 101. The report shall be a SOC 2 – *Report on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, and Privacy,* Type 2 Report performed in accordance with the Attestation Standards AT101, Attest Engagements. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiencies. The SOC 2, Type 2 audit reports must be provided to the DMAS Contract Administrator and the Internal Audit Division annually, no later than 30 days after the report is issued.
XXXX-AUDIT-003	The Contractor shall provide DMAS, at a minimum, an annual report from a qualified, independent, external IT security Contractor for a Vulnerability Assessment and Network Penetration Test covering all Contractor and subcontractor networks that will access Commonwealth data and information.
XXXX-AUDIT-004	The Contractor shall provide DMAS, at a minimum, a quarterly report of the results of its quarterly vulnerability scans covering all Contractor and subcontractor networks that will access Commonwealth data and information.
XXXX-AUDIT-005	The Contractor shall provide the Department, at a minimum, a biennial report from an independent, external auditor on the Contractor's compliance with the Commonwealth IT Information Security Standard SEC 501-09 (or latest). The first report shall be provided within the first 6 months after the contract go live date. If any of these reports disclose security deficiencies, the Contractor shall include management's corrective action plans to remediate the deficiency. The report shall be developed utilizing the requirements established in Commonwealth IT Information Security Standard (SEC 501-09 or latest) and Commonwealth IT Security Audit Standard (SEC 502-02.3 or latest).

Requirement ID	Requirement
XXXX-AUDIT-006	The Contractor and its subcontractors shall provide network connectivity for visitors from DMAS, Federal, and Commonwealth 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 Commonwealth of Virginia Auditor of Public Accounts (APA) or any other authorized auditors as determined by DMAS.
XXXX-AUDIT-007	The Contractor shall produce robust audit trails and audit logs of all applications and engineering activities (including inquiry transactions) on the production systems. These audit logs will be kept available online, behind a front-end presentation toolset providing queries, reports, and analytics on any log selected. The system will be able to answer typical control questions required by COV SEC 501-09 and NIST 800-053 REV 4 (or latest) with online reporting. The DMAS Internal Audit Division and the Office of Compliance and Security shall provide the capability to access the audit logs directly without the Contractor's intervention. The logs shall be available to be reviewed by authorized Federal and COV auditors. Log retention shall be six (6) years.
XXXX-AUDIT-008	The Contractor shall establish policies, procedures, and practices to ensure there is appropriate internal monitoring of the audit logs and the established process produces documentation to evidence the monitoring effort.
XXXX-AUDIT-009	The Contractor shall provide DMAS, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General, the HHS CMS, the Auditor of Public Accounts, and any other State and Federal auditors, or any of their duly authorized representatives with access to Contractor facilities for the purposes of audit, review, or physical inspection of system assets and system security, and access to any books, annual reports, management's report on internal control over financial reporting, Service Organization Controls (SOC) audit reports, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors. Access to records includes any records which are stored offsite. Records shall be provided for review at no cost to the Department.
XXXX-AUDIT-010	The Contractor shall provide DMAS, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General, the HHS CMS, State and Federal auditors, or any of their duly authorized representatives, access to inspect, copy, and audit contractor documents, including, Virginia Medicaid-related claims, medical, and/or financial records maintained by the Contractor and its subcontractors.
XXXX-AUDIT-011	The Contractor shall retain all records and reports relating to this Contract for a period of six years after final payment are made under this Contract or in the event that this Contract is renewed six years after the final payment. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the end of said period, however, records shall be maintained for a period of six years following resolution of such action or longer if such action is still ongoing. Media Copies of the documents contemplated herein may be substituted for the originals provided that the 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.
XXXX-AUDIT-012	The Contractor shall provide DMAS with timely responses and corrective action plans (CAPs) for any audit or review findings, and shall ensure that any and all of its subcontractors also comply. In addition, the Contractor shall provide quarterly status updates for each CAP until the CAP is complete and the finding is remediated.
XXXX-AUDIT-013	The Contractor shall comply, and shall ensure any and all subcontractors comply with the following COV Information Security Standards (available on the VITA website) (or latest), which among other requirements includes development and or performance of risk assessments, system security plans, disaster recovery plans, continuity of operations plans, and security audits: • COV SEC 501-09 (or latest) IT Information Security Standard • COV SEC 502-02.3 (or latest) IT Security Audit Standard • COV SEC 514-03 (or latest) Removal of Commonwealth Data from Electronic Media Standard • COV SEC 520-00 (or latest) IT Risk Management Standard • COV SEC 525-02 Hosted Environment Information Security Standard (issued August 11, 2016).
XXXX-AUDIT-014	The Contractor shall not have the right to audit DMAS, or require that DMAS be audited.
XXXX-AUDIT-015	The Contractor shall provide Control Policy and Procedures required by the Agency to develop, disseminate, and review/update annually, formal documented procedures. The Contractor shall also provide a Security Roles-based Report that can be used as evidence to validate access control policy on an annual basis. (SEC501-09 Section 8.1.AC-1) (or latest).

Requirement ID	Requirement
XXXX-AUDIT-016	The Contractor shall provide Control Policy and Procedures to disable unneeded accounts in a timely manner as well as historical records of such actions. (SEC 501.9 Section 8.1-AC-2-COV 1.b) (or latest).
XXXX-AUDIT-017	The Contractor shall conduct and document a risk assessment of each IT system classified as sensitive at least once every three years. The risk analysis shall address all of the requirements in the Security Standard and include an analysis of encryption/decryption mechanisms pertaining to PHI data at rest or in transition. (SEC 501.9 Section 6.2) (or latest).
XXXX-AUDIT-018	The Contractor shall maintain and document a system for Risk Management which is compliant with the COV IT Risk Management Standard (SEC 520-00 or latest) published by VITA. The intent of this requirement is to ensure the Contractor establishes a risk management framework, setting a baseline for information risk management activities for the Contractor. These risk management activities include, but are not limited to, any regulatory requirements that the Contractor is subject to, information security best practices, and the requirements defined in this Standard. These risk management activities will provide identification of sensitive system risks, their associated business impact, and a remediation/recommendation strategy that will help mitigate risks to the Contractor's information systems and data and the Commonwealth's information systems and data. The Risk Management Framework aligns with the methods set forth by the National Institute of Standards and Technology (NIST) Framework for Improving Critical Infrastructure Cybersecurity.
XXXX-AUDIT-019	The Contractor shall process a documented request with supervisory approval to establish an account on IT systems. In addition, the Contractor shall notify the Agency System Administrator in a timely manner about termination and/or transfer of employees and contractors with access rights to IT systems and data. (SEC501.9 Section 8.1.AC-2 COV 2) (or latest).
XXXX-AUDIT-020	The Contractor shall provide and require encryption for the transmission of email and attached data that is sensitive relative to confidentiality. (SEC501.9 Section 8.16.SC-8-COV) (or latest).
XXXX-AUDIT-021	The Contractor shall, annually, support the Agency and review of user accounts and privileges. (SEC501-09 Section 8.1.AC-2(j)) (or latest).
XXXX-AUDIT-022	The Contractor shall provide evidence of document management practices for administering accounts. (SEC501 -09 Section 8.1 AC-2-COV) (or latest).

ATTACHMENT F – BUSINESS CONTINUITY AND DISASTER RECOVERY

Requirement ID	Requirement
XXXX-NFR-DR-001	The Contractor shall prepare and submit for Department approval a comprehensive Disaster Recovery Plan due to the Department on an annual basis and after a substantive change to the solution that would require revision to the DR Plan.
XXXX-NFR-DR-002	The Contractor shall provide back-up processing capability at a remote site from the primary site such that normal processing can continue in the event of a disaster or major hardware problem at the primary site. All operations at the remote back-up site will meet established contractual performance and SLA requirements.
XXXX-NFR-DR-003	The Contractor shall coordinate with and demonstrate to the Department the Contractor's disaster recovery capabilities in accordance with SLAs. The Contractor will include recovery of any new functionality implemented during the previous year.
XXXX-NFR-DR-004	The Contractor shall, in the event of a catastrophic (i.e. possibility of crimes, terrorism, hackers, intentional torts, human error, virus, etc.) or natural disaster, resume normal operational business functions at the earliest possible time in accordance with specified SLAs and according to the Department-approved disaster recovery plan.
XXXX-NFR-DR-005	The Contractor shall, in the event of other disasters caused by such things as criminal acts, human error, malfunctioning equipment, computer viruses, or electrical supply, resume normal business functioning at the earliest possible time, in accordance with SLAs.
XXXX-NFR-DR-006	The Contractor shall plan and coordinate disaster recovery activities with Department-approved business partners.
XXXX-NFR-DR-007	The Contractor shall coordinate with and demonstrate to the Department the Business Continuity and Contingency Plan every calendar year in conjunction with the annual disaster recovery demonstration.
XXXX-NFR-DR-008	The Contractor shall leverage and use the LAST environment as the Disaster Recovery site. The extent to which the primary site cannot be restored in accordance with SLAs, may determine that the recovery site be considered the new primary site.
XXXX-NFR-DR-009	The Contractor shall, upon notification by DMAS that the primary production site is deemed inoperable, execute the Disaster Recovery Plan.
XXXX-NFR-DR-010	The Contractor shall provide back-up network connectivity at both the primary Production and Disaster Recovery sites with the capacity to support the solution and its components.
XXXX-NFR-DR-011	The Contractor shall ensure that the DRP is available to Commonwealth and Federal auditors at all times.
XXXX-NFR-DR-012	The Contractor shall establish, in cooperation with DMAS a hierarchy of critical services and infrastructure to determine the order that services will be restored.
XXXX-NFR-DR-013	The Contractor shall maintain a DRP that provides for the recovery of critical services in accordance with SLAs upon the discovery of the service disruption, the declaration of a disaster or Production site becoming unsafe or inoperable.
XXXX-NFR-DR-014	The Contractor shall maintain or otherwise arrange for a disaster recovery site for its system operations in the event of a disaster that renders the Production site inoperable.
XXXX-NFR-DR-015	The Contractor shall modify the DRP, software installation procedures, and operational procedures as needed to reflect the changes implemented with new data sources, system changes, or any enhancements that will impact the disaster recovery capability.
XXXX-NFR-DR-016	The Contractor shall perform an annual review of the disaster recovery back-up site, procedures for all off-site storage and validation of security procedures.
XXXX-NFR-DR-017	The availability schedules and corresponding SLAs for the Production solution shall apply to the disaster recovery environment when fulfilling the Production role.
XXXX-NFR-DR-018	The Contractor's DRP test shall be performed, each year at no additional cost to DMAS. In the event the Contractor's test is deemed by HHS to be unsuccessful, the Contractor shall continue to perform the test at its expense until satisfactory results are received and approved by DMAS.
XXXX-NFR-DR-019	The Contractor shall develop, maintain, and submit to DMAS, in advance, all proposed off-site procedures, locations, and protocols for DMAS review and approval prior to implementation. The Contractor shall incorporate these items as components of the Disaster Recovery Plan (DRP).

Requirement ID	Requirement
XXXX-NFR-DR-020	The Contractor shall execute a disaster recovery test to demonstrate the capability of the Contractor to restore processing capability in accordance with the DRP and for all critical system components at a remote site. The DRP test shall be included as a part of Acceptance Testing. The length of the test shall be the amount of time that is necessary to recover from the disaster and provide proof that the recovery has been successfully completed.
XXXX-NFR-DR-021	The Contractor shall take all precautions to ensure that system interruptions in service, resulting from a Production hardware failure, data corruption or a disaster that renders the Contractor's primary computer facility unusable are avoided.
XXXX-NFR-DR-022	If the Production site becomes unavailable during the contract period, the Contractor shall be required to move operations to the disaster recovery site. In this event, the Contractor shall not be allowed to return to the original Production site without approval of DMAS.
XXXX-NFR-DR-023	The Contractor shall comply with all SLAs that are relevant to Disaster Recovery Requirements.
XXXX-NFR-DR-024	The Contractor's Disaster Recovery Plan shall adhere to Commonwealth and Federal laws, rules, regulations, and guidelines, will address recovery of functions, human resources and the technology infrastructure and shall include: ➢ Checkpoint/restart capabilities ➢ Retention and storage of back-up files and software ➢ Hardware back-up for the servers ➢ Hardware back-up for data entry ➢ Network back-up for telecommunications ➢ Telephone communications lines to the disaster back-up site ➢ Recovery prioritization list (hardware and software applications) ➢ Telecommunication Voice Switch
XXXX-NFR-DR-025	The Contractor's Disaster Recovery Plan shall include detailed procedures to address (but not be limited to) the following potential events: ➢ Natural disasters (e.g., earthquake, fire, flood, storms) ➢ Terrorist acts ➢ Power disruptions or power failure ➢ Computer software or hardware failures ➢ Computer shutdown due to hackers or viruses ➢ Significant compromises/degradation of performance ➢ Processing shutdowns
XXXX-NFR-DR-026	The Contractor shall coordinate with VITA to meet the minimum geographic offsite location requirement of 100 miles between the disaster recovery site and the production environment site.

ATTACHMENT G – DATA EXCHANGES

Requirement ID	Requirement
XXXX-IS-001	The Contractor shall facilitate the secure exchange of data with other applications in DMAS within the agreed upon SLA through synchronous real time web services and/or asynchronous services using Queues through an Integration service.
XXXX-IS-002	The Contractor shall have the ability to produce/consume SOAP, RESTful Web Services.
XXXX-IS-003	The Contractor shall have the ability to exchange files through secure file transfer protocol with other systems through an Integration service.
XXXX-IS-004	The Contractor shall conform to the responsibilities and expectations of an Integrated Supplier as described in the Managed Environment section in Exhibit H.
XXXX-EDI-001	For real-time submission, the Contractor shall ensure that the Unique ID that is assigned in the DMAS EDI Gateway will be tied to its backend process.
XXXX-EDI-002	For batch submissions, the Contractor shall ensure that the Unique File ID assigned in the DMAS EDI Gateway will be tied to its backend process.
XXXX-EDI-003	When connecting with the DMAS EDI Gateway, the Contractor shall ensure authorization and authentication is performed through the Commonwealth specified single sign-on system.
XXXX-EDI-004	The Contractor solution shall support all current and future applicable EDI standards, including but not limited to HIPAA transactions, versions, and code sets and all phases of CAQH/CORE operating rules.
XXXX-EDI-005	The Contractor shall ensure that data to support a HIPAA standard response is provided, including but not limited to the TA1, 999, 271, 277, 277CA, 820, and 834.
XXXX-EDI-006	The Contractor shall ensure all incoming and outgoing transaction data is logged and archived to support auditing, reporting, and other business needs.
XXXX-EDI-007	The Contractor shall provide archived data in response to a DMAS request in a timeframe to be determined based on the age of the data.
XXXX-EDI-008	The Contractor shall provide an automatic response when it is unable to process a real-time or batch transaction from the DMAS EDI Gateway.
XXXX-EDI-009	The Contractor shall ensure that all submitted transaction information metrics, including but not limited to (submitted timestamp, transaction size, user, IP, and port) are stored and accessible for problem resolution, reporting SLAs, and other business needs.
XXXX-EDI-010	The Contractor shall ensure an hourly EDI statistics email is sent to listed users.
XXXX-EDI-011	For real-time submission, the Contractor shall ensure unique UUID is assigned, and the ID is tied to the backend process.
XXXX-EDI-012	The Contractor shall ensure an alert is sent to the appropriate technical team regarding the system status.
XXXX-EDI-013	The Contractor shall ensure SLA reports are generated and include information such as amount of time it took to process the file, file rejection rate, and file acceptance rate.
XXXX-EDI-014	The Contractor shall ensure human readable format is produced for 999 and TA1.
XXXX-EDI-015	The Contractor shall ensure all the submitted file information is kept in the database for easy access (file submitted timestamp, file size, user, and so on).
XXXX-EDI-016	The Solution shall validate that a provider has identified a relationship with the service center and transaction ID as part of processing an EDI transaction.
XXXX-EDWS-001	All Contractors and their partners, with no exceptions, shall have to accommodate sharing of enterprise relationship diagram of their system, data dictionaries, and business and technical metadata with DMAS.
XXXX-EDWS-002	The Contractors shall provide resources and services that provide access to their transactional data both in real-time and batch.
XXXX-EDWS-003	The Contractors shall provide functions to translate their data into XML, JSON, SOAP, etc., for exchange as required by DMAS.
XXXX-EDWS-004	The Contractors shall adhere to the frequency of data-exchange as desired by DMAS.
XXXX-EDWS-005	Each Contractor shall assure data quality pertaining to the benchmarks set forth by DMAS.
XXXX-EDWS-006	Any and all products generated by the Contractor during the course of the MES and pertaining to the MES shall be shared with DMAS.
XXXX-XCHG-001	The Contractor shall have adequate resources to support the DMAS interfaces and the care management technology system described in the MEDALLION 4.0 Contract.
XXXX-XCHG-002	The Contractor shall demonstrate the capability to successfully send and receive interface files.

Requirement ID	Requirement
XXXX-XCHG-003	The Contractor shall conform to HIPAA compliant standards and all state and federal standards for data management and information exchange and must implement new versions as made available by HIPAA according to DMAS's needs and guidance.
XXXX-XCHG-004	The Contractor shall demonstrate controls to maintain information integrity.
XXXX-XCHG-005	The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DMAS for reconciliation processes.
XXXX-XCHG-006	The Contractor shall keep track of every encounter submission made through the State's Fiscal Agent during the month and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification as defined by DMAS.
XXXX-XCHG-007	The Contractor shall, in accordance with 42 C.F.R. § 438.606, deliver an Encounter Certification form signed by the Contractor's Chief Financial Officer, Chief Executive Officer or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor.
XXXX-XCHG-008	The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia.* 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*.
XXXX-XCHG-009	The Contractor's interface with DMAS must include receiving Medicaid participant enrollment information in HIPAA standard EDI X12 834 format.
XXXX-XCHG-010	The Contractor's interface with DMAS must the submission of encounter data in the HIPAA standard X12 Post Adjudication Standard 837I, 837P, and the NCPDP D.0 or Post Adjudication Standard formats.
XXXX-XCHG-011	The Contractor's interface with DMAS must include receiving monthly capitation payments in the HIPAA standard X12 820 format.
XXXX-XCHG-012	All Contractor staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner.
XXXX-XCHG-013	The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of the Contract.
XXXX-XCHG-014	The Contractor shall allow sufficient time for installation, configuration, and testing of the data line and associated equipment prior to production.
XXXX-XCHG-015	The Contractor shall be responsible for any expenses, including equipment, services, etc., required to establish and maintain connectivity between the Contractor and DMAS. It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of the Contract.

ATTACHMENT H - PROPRIETARY/CONFIDENTIAL INFORMATION IDENTIFICATION FORM

To Be Completed By Offeror and Returned With Your Technical Proposal

Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of § 2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected including the section of the proposal in which it is contained and the page numbers, and states the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must include only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. In addition, a summary of such information shall be submitted on this form. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable. If, after being given reasonable time, the Offeror refuses to withdraw such a classification designation, the proposal may be scored lower or eliminated from further consideration.

Name of Firm/Offeror:_____, invokes the protections of § 2.2-4342F of the *Code of Virginia* for the following portions of my proposal submitted on _____.
Date

Signature:_____ Title:_____

DATA/MATERIAL TO BE PROTECTED	SECTION NO., & PAGE NO.	REASON WHY PROTECTION IS NECESSARY

ATTACHMENT I - CERTIFICATION OF COMPLIANCE WITH PROHIBITION OF POLITICAL CONTRIBUTIONS AND GIFTS DURING THE PROCUREMENT PROCESS

For contracts with a stated or expected value of $5 million or more except those awarded as the result of competitive sealed bidding

I, _____, a representative of _____,
Please Print Name *Name of Bidder/Offeror*

am submitting a bid/proposal to _____ in response to
Name of Agency/Institution

_____, a solicitation where stated or expected contract value is
Solicitation/Contract #

$5 million or more which is being solicited by a method of procurement other than competitive sealed bidding as defined in § 2.2-4301 of the *Code of Virginia*.

I hereby certify the following statements to be true with respect to the provisions of §2.2-4376.1 of the *Code of Virginia*. I further state that I have the authority to make the following representation on behalf of myself and the business entity:

1. The bidder/offeror shall not knowingly provide a contribution, gift, or other item with a value greater than $50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.

2. No individual who is an officer or director of the bidder/offeror, shall knowingly provide a contribution, gift, or other item with a value greater than $50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.

3. I understand that any person who violates § 2.2-4376.1 of the *Code of Virginia* shall be subject to a civil penalty of $500 or up to two times the amount of the contribution or gift, whichever is greater.

_____
Signature

_____
Title

_____
Date

To Be Completed By Offeror and Returned With Your Technical Proposal

ATTACHMENT J - STATE CORPORATION COMMISSION FORM

Virginia State Corporation Commission (SCC) registration information: The Offeror
☐ is a corporation or other business entity with the following SCC identification number: _____
-OR-

☐ is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

☐ is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Offeror in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Offeror's out-of-state location)
-OR-

☐ is an out-of-state business entity that is including with this proposal an opinion of legal counsel which accurately and completely discloses the undersigned Offeror's current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the *Code of Virginia*.

****NOTE** >>** Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver): ☐

_____
Signature

_____
Title

_____
Date

To Be Completed by Offeror and Returned with Your Technical Proposal