

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Medallion 4.0
Managed Care Services Agreement



CONTRACT TO PROVIDE MANAGED CARE SERVICES
FOR THE MEDICAID and FAMILY ACCESS TO MEDICAL
INSURANCE SECURITY (FAMIS) PROGRAMS

JULY 1, 2021 – JUNE 30, 2022

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1. DEFINITIONS AND ACRONYMS

1.1 DEFINITIONS

Listed below are the Definitions, Acronyms, and Abbreviations used in this Contract. These terms and their corresponding definitions and acronyms were developed in accordance with Commonwealth of Virginia and Federal governing regulations. However, the following terms, when used in this Contract, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

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

“Access” As defined in 42 CFR § 438.320, access as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services).

“Accreditation” The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by an industry recognized accrediting agency, 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.

“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.

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

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

“Addiction and Recovery Treatment Services” (ARTS) – A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This includes: (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv)

intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); (vi) substance abuse case management; (vii) opioid treatment services; and (viii) peer recovery support services. Providers will be credentialed and trained to deliver these services consistent with ASAM’s published criteria and the Department’s medical necessity criteria and using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

“Administrative Dismissal”

1. 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; or
2. A member appeal dismissal made on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the Contractor.

“Adoption Assistance” A social services program, under Title XX of the Social Security Act, that provides the adoptive parents with the necessary assistance to adopt and care for the child who has special needs and who meets eligibility criteria. It is not intended to cover the full cost of raising the child. Rather, it supplements the resources of the adoptive parents.

“Adverse Action” For providers that have already rendered a service, a denial in whole or in part, of a service authorization; or the denial, in whole or in part, of payment for a service.

“Adverse Benefit Determination” For members, pursuant to 42 C.F. R. § 438.400, 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 to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and 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. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) is not an adverse benefit determination.

“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 as provided by Virginia Code § 32.1-276.7:1.

“Alternate Formats” Provision of enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading

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

“Ameliorate” To improve a condition or to prevent a condition from getting worse.

“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 or Managed Care Technical Manual.

“Appeal”

- 1) For members, in accordance with 42 CFR § 438.400, is a request to DMAS for a State fair hearing of a Contractor’s internal appeal decision to uphold the Contractor’s adverse benefit determination. After a member exhausts the Contractor’s one-step internal appeal process, the member may appeal to DMAS. Member appeals to DMAS shall be conducted in accordance with regulations at 42 CFR §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
- 2) For providers, is a request made by a provider (in-network or out-of-network) to review the Contractor’s reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the Contractor’s reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) with DMAS in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 *et seq.*, and Virginia Medicaid’s provider appeal regulations, 12 VAC 30-20-500 *et seq.*

“Assertive Community Treatment (ACT)” Intensive nonresidential treatment and rehabilitative mental health services provided in accordance with the fidelity model of ACT. Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients with serious mental illness (SMI) whose needs have not been well met by more traditional service delivery approaches.

“Assess” To evaluate an individual’s condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor’s observation of the individual.

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

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

“Balance Billing” When a provider bills a Medicaid enrollee for the difference between the provider’s charge and the allowed amount.

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

“Behavioral Health Services Administrator (BHSA)” An entity that is contracted to manage or direct a behavioral health benefits program. The BHSA is currently responsible for administering the Department’s behavioral health benefits for Medicaid recipients enrolled in Fee for Service and for Therapeutic Group Home Services and Treatment Foster Care Case Management for Medallion 4.0 members, including care coordination, provider management, and reimbursement of such behavioral health services.

“Behavioral Health and Substance Abuse Treatment Services (BHS)” An array of therapeutic and rehabilitation services provided in inpatient and outpatient psychiatric and community 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.

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

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

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

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

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

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

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

“Care Coordination” (also known as “Care Management) The Contractor’s responsibility of assessing and planning of services; linking the Member to services and supports; assisting the Member directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family individuals involved with the Member; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling.

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

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

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

“Children and Youth With Special Health Care Needs” or “CYSHCN” Children and youth with special needs that have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child’s age. These include, but are not limited to, the children in the eligibility categories of foster care and adoption assistance (aid category 076 and 072), youth who have aged out of the foster care system (Aid Category 70), children identified as Early Intervention (EI) participants, members identified as experiencing childhood obesity and others as identified through the Contractor’s assessment or by the Department.

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

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

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

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

“Common Core Formulary” A list of all drugs required to be covered by health plans, including those on the Preferred Drug List (PDL), for Medicaid members enrolled with fee-for-service, Medallion 4.0, and Commonwealth Coordinated Care Plus (CCC Plus) Managed Care programs. These drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria. Health plans may add drugs to the therapeutic drug classes on the DMAS PDL/Common Core Formulary but cannot remove drugs.

“Commonwealth Coordinated Care Plus (CCC Plus) Program” The Department’s mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from designated home and community-based services (HCBS) 1915(c) waivers.

“Community Service Board (CSB)” A citizens' board established pursuant to Virginia Code §37.2-500 and §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 “grievance” definition.

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

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

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

“Consumer-Directed (CD) Employee/Attendant” A person who is employed by an individual who is receiving services through the consumer-directed model or their representative to provide approved services (e.g., personal care), and who is exempt in Virginia from Workers’ Compensation.

“Consumer-Directed (CD) Services” Service (personal care) for which the individual or his representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) The Medicaid enrolled provider who is responsible for supporting the Member or his representative, as appropriate, providing employee management training, and completing ongoing review activities as required by DMAS.

“Contract” This signed and executed Medallion 4.0 program document resulting from the RFP, issued and awarded, including all attachments or documents incorporated by reference.

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

“Contractor” A managed care health plan selected by the Department and contracted by execution of this Contract to participate in the Medallion 4.0 program in accordance with the RFP award.

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

“Cost Avoidance” The application of a range of tools to identify and prevent inappropriate or medically unnecessary charges before they are actually paid. This may include service authorization, second surgical opinion, 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” Commonwealth of Virginia (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>.

“Cover Virginia” Virginia’s telephonic customer service center and online portal providing statewide eligibility information and application assistance for Virginia’s Medicaid, FAMIS, Plan First, Fee-for-Service, Department of Corrections, and other insurance options. Cover

Virginia's website www.coverva.org provides easy access to information about Virginia's Medicaid and FAMIS programs, including eligibility and how to apply. Staff at the Cover Virginia statewide customer service center at 1-855-242-8282 provide confidential application assistance and program information. Individuals can apply, report changes, or renew coverage through Cover Virginia.

“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.

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

“Cultural Competency” The ability of health care providers and health care organizations to understand and respond effectively to a patient's cultural health beliefs, preferred languages, health literacy levels and communications needs.

“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 Health Professions (DHP) – Agency that issues licenses, registrations, certifications, and permits to healthcare practitioner applicants that meet qualifications established by law and regulation. In addition to the Board of Health Professions, the following applicable boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Nursing, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, and Board of Social Work.

Department of Medical Assistance Services (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 MCO plan to another MCO.

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

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

“Early Intervention” or “EI” Services provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth through the day before the third birthday 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. Per 12 VAC 35-225-70 children are not eligible to receive EI services on or after their third birthday. Early intervention services provided in the child's natural environment to the maximum extent appropriate. EI services are covered by this Contract.

Early Intervention Assistive Technology Services - Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

Early Intervention Individualized Family Service Plan (IFSP) - A written plan developed by the member’s interdisciplinary team for providing early intervention supports and services to eligible children and families that: 1) Is based on evaluation for eligibility determination and assessment for service planning; 2) Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and 3) Is implemented as soon as possible once parental consent is obtained. The IFSP requires a physician signature for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). Medical necessity is established by the IFSP combined with physician certification and shall serve as the authorization for the identified early intervention services. No additional service authorizations shall be required for EI services.

“Early and Periodic Screening, Diagnostic, and Treatment” or “EPSDT” is a Federal law (42 CFR § 441.50 et seq.) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

- 1) EPSDT promotes the early and universal assessment of children’s healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member
- 2) EPSDT also compels state Medicaid agencies to cover for children, any additional health care services, products, or procedures that are coverable under the Federal

Medicaid program, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination. All medically necessary services require service authorization.

1. For more information on the EPSDT services visit:
<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>

“ED Care Coordination” Real-time communication and collaboration among hospital emergency departments, physicians, other health care providers, and health plan clinical and care management personnel to improve outcomes for populations with high utilization of EDs as required by state law through the Virginia Emergency Department Care Coordination Program.

“Electronic Visit Verification” or “EVV” An electronic system that provides “real time” monitoring of a service provision, verifies that service visits occur, and documents the precise times service provision begins and ends.

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

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

“Emergency Services” Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Placing the client’s health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; Serious impairment to bodily functions; or, Serious dysfunction of any bodily organ or part. [42 CFR §438.114 (a) (i-iii)]

“Employer of Record (EOR)” The individual who directs their own care and receives consumer-directed services from a CD attendant who is hired, trained, and supervised by the individual or the individual’s representative.

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

“Encounter Data” Data collected by the Contractor 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.

“Encounter Processing System (EPS)” The DMAS Encounter Processing Solution (EPS) is a component module of the overall Medicaid Enterprise System (MES). The EPS is designed to fulfill all DMAS encounter data collection and validation needs.

“Encounter Submission Calendar” The Department’s schedule for the Contractor to submit encounters.

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

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

“Enrollee” A Medicaid or FAMIS beneficiary who is currently enrolled in an MCO, used interchangeably with member in this Contract.

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

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

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

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

“Enrollment Period” The time that a member is enrolled in a Department approved MCO during which they may not dis-enroll or change MCOs unless dis-enrolled under one of the

conditions described in this Contract and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

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

“Every Reasonable Effort” This is Contractor-initiated action related to assessments, screenings, laboratory tests, immunizations, follow-up treatment or other services. Every reasonable effort shall include at a minimum a telephone call or mailed reminder either prior to the due date of each visit or upon learning that a visit has been missed and scheduling appointments for members. In the case of being notified of a missed appointment, a telephone call or mailed reminder for the missed appointment is required. In the case of EPSDT, if there is no response, a personal visit to urge the parent or guardian to take the child to his or her appointment is required.

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

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

“External Appeal” An appeal, subsequent to the Contractor’s appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions.

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

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

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

“FAMIS” 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. Per 12 VAC 30-141, FAMIS MOMS are not subject to exemption from MCO participation (e.g., for being hospitalized at the time of MCO enrollment).

“Federally Qualified Health Centers” or “FQHCs” Those facilities as defined in 42 CFR § 405.2401(b), as amended.

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

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

“Financial Relationship” As defined in 42 CFR § 438.320, a financial relationship is (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or (2) A compensation arrangement with an entity.

“Firewall” Software or hardware-based security system that controls the incoming and outgoing network traffic based on an applied rule set. A firewall establishes a barrier between a trusted, secure internal network and another network (e.g. the internet) that is not assumed to be secure and trusted. Firewall also includes physical security measures that establish barriers between staff, the public, work areas, and data to ensure information is not shared inappropriately or in violation of any applicable State or Federal laws and regulations.

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

“Formulary” A list of drugs that the MCO has approved. Prescribing some of the drugs may require service authorization. The Department has developed a Preferred Drug List (PDL) that shall be a subset of the Contractor’s formulary that includes all the preferred drugs from the Department’s Preferred Drug List (PDL).

“Former Foster Care Member” A former foster care youth is an individual who was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory and receiving Medicaid until discharge from foster care upon turning age 18 years or older, is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under Age 18 or SSI), and is under age 26 years. A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

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

“Fostering Futures” Virginia’s program that implements provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages 18 to 21. The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source.

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

“Full Credibility” As defined in 42 CFR § 438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ratio (MLR) with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR

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

“Grievance” In accordance with 42 CFR § 438.400, means an expression of dissatisfaction about any matter other than an “adverse action” or “adverse benefit determination.” Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s or provider’s rights.

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

“Health Care Services” All Medicaid and FAMIS services provided by an MCO under contract with the Department.

“Health Care Home (Formally Patient Centered Medical Home)” A patient centered health care delivery system option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions to support the “whole-person” across the lifespan.

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

“Health Insurance Premium Payment (HIPP) Program” A DMAS administered Medicaid related premium assistance program(s) that may reimburse part, or a participant’s entire share, of employer sponsored group health insurance premiums for members who have employer sponsored group health insurance available to them through their own or their family member’s employment. Eligibility criteria currently include, but are not limited to the following:

- a member must be enrolled in full coverage Medicaid (be found eligible to meet either the categorically needy or medically needy and found eligible for a fully covered group);
- the health plan must meet cost effectiveness evaluation;
- must be enrolled in a health plan that meets the definition of an a “qualified employer sponsored plan”; and
- must not be a plan with deductibles that are equal to or exceed IRS High Deductible Health Plan limits.

“Health Insurance Premium Program (HIPP) for Kids” HIPP program for those Medicaid members under the age of 19 who are eligible for or enrolled in “qualified employer-sponsored coverage.”

“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.

“Home and Community-Based Care Services” or “HCBS” A variety of home and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care.

“Homeless” In accordance with 42 U.S.C., 254b, a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing

who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

“Hospital or Health System” A facility that meets the requirements of 42 CFR § 482, as amended.

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

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

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

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

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

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

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

“Inquiry” An oral or written communication usually received by a Member Services Department or telephone helpline representative made by or on the behalf of a member that may

be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirements or materials received, etc.; 2) provision of information regarding a change in the member's status such as address, family composition, etc.; or 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

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

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

“Internal Appeal” A request to the Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of a Contractor's adverse benefit determination as defined in this Contract. The internal appeal is the only level of appeal with the Contractor and must be exhausted by a member or deemed exhausted according to 42 CFR § 438.408(c)(3) before the member may initiate a State fair hearing.

“Investigation” 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.

“Joint Legislative Audit and Review Commission (JLARC)” Conducts policy analysis, program evaluation, and oversight of state agencies on behalf of the Virginia General Assembly. The duties of the Commission are authorized by the Code of Virginia §30-58.1.

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

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

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

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

“Local Education Agency” A local public school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or the Virginia School for the Deaf and the Blind at Staunton.

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

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

“Managed Care Organization” or “MCO” An organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be

deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Medallion 4.0 members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 CFR § 438.116.

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

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

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

“Marketing” Any communication, from an MCO to a Medicaid or FAMIS beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's Medicaid or FAMIS product, or either to not enroll in or to disenroll from another MCO's Medicaid or FAMIS product. Marketing does not include communication to a Medicaid or FAMIS beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

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

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

“Material Adjustment” As defined in 42 CFR § 438.2, an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

“Medallion 4.0” A statewide mandatory Medicaid program, approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver, which utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. .

“(Medallion 4.0) Carved-Out Services” The subset of covered services which the Contractor shall not be responsible for covering under the program.

“(Medallion 4.0) Covered Services” The subset of covered services which the Contractor shall be responsible for covering under the program.

“Medicaid” Medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof.

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

“Medicaid Enterprise System” or “MES” The Department’s modernized technology system which will replace the current Medicaid Management Information System (MMIS).

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

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

“Medicaid Member” Any individual enrolled in the Virginia Medicaid program.

“Medical Loss Ratio (MLR) Reporting Year” As defined in 42 CFR § 438.8, a period of twelve (12) months consistent with the rating period selected by the Department.

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

“Medically Complex” Individuals who have a complex medical or behavioral health condition and a functional impairment or an intellectual or developmental disability.

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

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

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

“Member” A person eligible for Medicaid or CHIP/FAMIS who is enrolled with an MCO Contractor to receive services under the provisions of this Contract.

“Member Handbook” Document required by the Contract to be provided by the MCO to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, member eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, member services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

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

“Mental Health Case Management” Service to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services.

“Mental Health - Intensive Outpatient Services (MH-IOP)” Structured programs of skilled treatment services for adults and youth focused on maintaining and improving functional abilities through a time-limited, interdisciplinary approach to treatment.

“Mental Health - Partial Hospitalization Program (MH-PHP)” Standard, short-term, non-residential, medically-directed services for adult and youth members who require intensive, highly coordinated, structured and inter-disciplinary ambulatory treatment within a stable environment that is of greater intensity than Intensive Outpatient, Mental Health Skill Building, or Psychosocial Rehabilitation.

“Mental Health Parity and Addiction Equality Act” A federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

“Mental Health Professional” In accordance with the Virginia Department of Health Professions (DHP), a Mental Health Professional is a person who by education and experience is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual’s achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development. Refer to:

<https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2400.1/>.

“Medicaid Information Technology Architecture (MITA)” Initiative sponsored by the Center for Medicare and Medicaid Services (CMS) 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. 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” or “NPDB” The NPDB, maintained by the Health Resources and Services Administration, is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. OIG reports exclusions to the NPDB monthly. Although the NPDB includes unique identifiers, to protect sensitive information it is available only to registered users whose identities have been verified.

“National Provider Identifier” or “NPI” NPI is a national health identifier for all health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many

paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in this contract will be required to have and use an NPI.

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

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

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

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

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

“Notice” Means a written statement that meets the requirements of 42 CFR § 438.404.

“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.

“Office Based Opioid Treatment Providers” or “Preferred OBOTs” Deliver addiction treatment services to members with a primary diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for substance-related and addictive disorders, with the exception of tobacco-related disorders and non-substance-related addictive disorders, marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use, is seeking treatment for the use of, or is in active recovery from the use of alcohol or other drugs despite significant related problems. Services are provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020).

“Ombudsman” The independent State entity that will provide advocacy and problem-resolution support for 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 CFR § 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 effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within sixty (60) days of the open enrollment period shall remain in his or her current health plan selection until their next open enrollment effective date.

“Outcomes” As defined in 42 CFR § 438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

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

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

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

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

“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.

“Pass-Through Payment” Any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR §438.6(a) for services and enrollees covered under the contract; a sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.

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

“Person-Centered Planning” A process, directed by an individual or his or her family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired outcomes for the individual.

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

“Personal Care Provider” A provider that renders personal care services to an eligible member in order to prevent or reduce institutional care, or, in the case of Local Education Agency-based services, in order to allow the child to participate in a free and appropriate public education.

“Personal Care Services” Available through the EPSDT benefit and through Local Education Agency-Based Services for children under the age of 21. A range of support services necessary to enable the individual to remain at or return home rather than enter a nursing facility, or to participate in a free and appropriate public education. The services includes assistance with ADLs, IADLs, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition. Personal care services shall be provided by personal care aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model, by consumer-directed attendants under the CD model of service delivery, or as authorized by a student’s Individuals Education Program plan delivered via Special Education and Related Services.

“Pharmacy Benefit Manager (PBM)” An entity responsible for the provision and administration of pharmacy services.

"Pharmacy Benefits Management" The administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals.

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

“Plan First” The Medicaid fee-for-service family planning program. The purpose of this program is to reduce unplanned pregnancies, increase spacing between births, reduce infant mortality rates, and reduce the rates of abortions due to unintended pregnancies. Men and women not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS, who have income between 138% and less than or equal to 200 percent of the federal poverty level (plus a 5% disregard) and meet citizenship and identity requirements may be eligible for Plan First.

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

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

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

“Potential Member” A Medicaid member who is subject to mandatory enrollment in a given managed care program. [42 CFR § 438.10(a)]

“Psychiatric Residential Treatment Facilities” means the same as defined in 42 CFR 483.352 and are a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment.

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

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

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

Contractor authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the Contractor. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

“Prepaid Ambulatory Health Plan (PAHP)” An entity that:

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

“Prepaid Inpatient Health Plan (PIHP)” An entity that:

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

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

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

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

“Private Duty Nursing” Nursing care services available for children under age 21 under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

“Program Integrity” The process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities.

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

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

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

“Quality” As defined in 42 CFR § 438.320, as it pertains to external quality review, the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:

- (1) Its structural and operational characteristics;
- (2) The provision of services that are consistent with current professional, evidenced-based-knowledge;
- (3) Interventions for performance improvement.

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

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

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

“Quarters” Calendar quarters starting on January 1st, April 1st, July 1st, and October 1st.

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

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

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

“Reconsideration” A provider’s request for review of an adverse action as defined in this Contract. The Contractor’s reconsideration decision is a prerequisite to a provider filing an informal appeal to the DMAS Appeals Division.

“Remand” The return of a case by the DMAS hearing office to the Contractor MCO for further review, evaluation, and action.

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

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

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

“Rural Exception” A rural area as designated in the 1915(b) managed care waiver, pursuant to 1935(a)(3)(B) of the Social Security Act and 42 CFR § 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 CFR § 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.

“Safe Sleep Virginia” Virginia Department of Social Services program designed to educate parents and caregivers regarding the steps they can take to prevent infant sleep-related death and to emphasize simple practices all Virginians can employ to provide a safe and healthy environment for infants during sleep.

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

“Sentinel Event” An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence

would carry a significant chance of a serious adverse outcome. Such events are called “Sentinel” because they signal the need for immediate investigation and response.

“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).

“Serious Mental Illness” Used to refer to individuals ages 18 and older, who have serious mental illness diagnosed under the DSM in the following major diagnostic categories: schizoprenias and other psychotic disorders, bipolar disorders, and major depressive disorders.

“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.

“Service Authorization Request” A managed care member’s request for the provision of a service.

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

“Spread Pricing” The model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

“Stabilized” As defined in 42 CFR § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.

“State Fair Hearing” DMAS’ evidentiary hearing process for member appeals. Any adverse internal appeal decision rendered by the Contractor may be appealed by the member to DMAS’s Appeals Division. DMAS conducts evidentiary hearings in accordance with regulations at 42 CFR § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

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

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

“State Plan Substituted Services” (In Lieu of Services) – Alternative services or services in a setting that are not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services that are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). However, the Contractor shall not require a Member to use a state plan substituted service/“in lieu of service” as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

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

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

“Substance Exposed Infants (SEIs)” Infants who experienced prenatal exposure to alcohol, tobacco, or other controlled substances. SEIs shall include children born with Neonatal Abstinence Syndrome (NAS). SEIs/NAS infants require unique medical, behavioral health and care coordination services in order to reach optimum health outcomes.

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

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

“System for Award Management” or “SAM” or formerly “EPLS” The General Services Administration (GSA) maintains the SAM, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the SAM on parties they have debarred or suspended as described above; Office of Inspector General (OIG) sends monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the SAM. The SAM does not include any unique identifiers; it provides only the name and address of excluded entities. If SAM users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.

“Telehealth” The use of telecommunications and other electronic information exchange 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 used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance, and it is not restricted to modalities that involved real-time, two-way interaction (see “Telemedicine” below). Telehealth incorporates technologies such as telephone, facsimile machines, electronic, email systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

“Telemedicine” A service delivery model that uses real-time, two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the member at an originating site to an enrolled provider approved to provide telemedicine services at a distant (remote) site.

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

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

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

“Transmit” – Means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

“Trauma Informed Care” An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences (ACEs) have played in their lives. This approach also builds on member resiliency and strengths to address both the overall physical and emotional well-being of the individual.

“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.

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

- (1) Placing the patient’s health in serious jeopardy;
- (2) Serious impairment to bodily function;
- (3) Serious dysfunction of any bodily organ or part; or
- (4) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

“Value-Based Payment (VBP)” 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.

“Virginia Department of Health Office of Emergency Medical Services (OEMS)” The governing state agency ensuring ambulance companies maintain employee, vehicle compliance, and licensing requirements. If OEMS finds the ambulance company out of compliance, OEMS is the governing authority that takes action.

“Waste” The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified that the practice is inappropriate, may be considered fraud or abuse.

“Withhold Arrangement” Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

1.2 ACRONYMS

Acronym	Meaning
AA	Adoption Assistance
ABD	Aged, Blind, and Disabled Population
ACIP	Advisory Committee on Immunization Practice
ACT	Assertive Community Treatment
ADHD	Attention-Deficit/Hyperactivity Disorder
ANSI	American National Standards Institute
APIN	Administrative Provider Identification Number
AHRQ	Agency for Healthcare Research and Quality
ARTS	Addiction and Recovery Treatment Services
ASP	Application Service Provider
BAA	Business Associate Agreement
BBA	Balanced Budget Act of 1997
BHSA	Behavioral Health Services Administrator
BMI	Body Mass Index
BOI	Bureau of Insurance of the Virginia State Corporation Commission
CAD	Coronary Artery Disease
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations

CHF	Congestive Heart Failure
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare and Medicaid Services
CMS 1500	Standard Professional Paper Claim Form
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CORFs	Comprehensive Outpatient Rehabilitation Facilities
CPT	Current Procedural Terminology
CSB	Community Service Board
CY	Calendar Year
CYSHCN	Children and Youth with Special Health Care Needs
DBA	Dental Benefits Administrator
DBHDS	Department of Behavioral Health and Developmental Services
DESI	Drug Efficacy Study Implementation
DHHS	Department of Health and Human Services
DMAS	Department of Medical Assistance Services
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSP	Data Security Plan
DSS	Department of Social Services
EI	Early Intervention
EN	Enteral Nutrition
EOC	Evidence of Coverage
EPA	Environmental Protection Agency
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
EVV	Electronic Visit Verification
FAMIS	Family Access to Medical Insurance Security
FAMIS Plus	Another name for Children's Medicaid
FIPS	Federal Information Processing Standards
FOIA	Freedom of Information Act
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent
FTP	File Transfer Protocol
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
HCBS	Home and Community-Based Care Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome

IBNR	Incurred But Not Reported
ICF/IID	Intermediate Care Facility/Individuals with Intellectual Disabilities
IHCP	Indian Health Care Provider
ID	Identification
IDEA	Individuals with Disabilities Education Act.
IDEA – EIS	Individuals with Disabilities Education Act - Early Intervention Services
IEP	Individual Education Program
IFSP	Individual Family Service Plan
IMD	Institution for Mental Disease
LARC	Long Acting Reversible Contraception
LEA	Local Education Agency
LCSW	Licensed Clinical Social Worker
LDSS	Local Department of Social Services
LEIE	Listing of Excluded Individuals and Entities
LIFC	Low Income Families and Children
LSH	Long-Stay Hospital
LTAC	Long-Term Acute Care
MCHIP	Managed Care Health Insurance Plans
MCO	Managed Care Organization
MEL	Medicare Exclusions List
MH-IOP	Mental Health - Intensive Outpatient Program
MH-PHP	Mental Health - Partial Hospitalization Program
MHS	Mental Health Services
MMIS	Medicaid Management Information System (also known as VAMMIS)
MCTM	Managed Care Technical Manual
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NQTL	Non-quantitative Treatment Limitations
OB/GYN	Obstetrician and Gynecologist
OIG	Office of Inspector General
OSR	Operational Systems Review
OT	Occupational Therapy
PA	Prior Authorization (also known as Service Authorization)
PACE	Program of All-inclusive Care for the Elderly
Part C	Part C of the Individuals with Disability and Education Act (also known as Early Intervention)
PCP	Primary Care Provider
PDN	Private Duty Nursing
PHI	Protected Health Information
PIP	Physician Incentive Plan

PIRS	Patient Intensity Rating Survey
PMP	Prescription Monitoring Program
PMV	Performance Measure Validation
POC	Plan of Care
PSA	Prostate Specific Antigen
PT	Physical Therapy
QI	Quality Improvement
QIP	Quality Improvement Program
RFP	Request For Proposal
RHC	Rural Health Clinics
RN	Registered Nurse
RTF	Residential Treatment Facility
SA	Service Authorization (formally known as Prior Authorization)
SAM	System for Award Management (formally known as Excluded Parties List System)
SLP	Speech-Language Pathology
SPO	State Plan Options
SSI	Social Security Income
SSN	Social Security Number
TB	Tuberculosis
TDO	Temporary Detention Order
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
Title XIX	Medicaid
Title XXI	CHIP
TTY/TDD	Teletype/Telecommunication Device for the Deaf
UM	Utilization Management
U.S.C	United States Code
VAC	Virginia Administrative Code
VAMMIS	Virginia Medicaid Management Information System
VAN	Value Added Network
VPN	Virtual Private Network
VVFC	Virginia Vaccines for Children Program
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children.
XYZ	Any Named Entity

2. SCOPE OF CONTRACT

This Contract, by and between the Department of Medical Assistance Services (hereinafter referred to as the Department or DMAS) and the Contractor, is for the provision of managed care services to individuals enrolled in the Department's Medallion 4.0 Medicaid and FAMIS Programs, and any newly eligible populations as defined by the Governor, the General Assembly, and/or the Department. The period of this renewal Contract is from July 1, 2020

through June 30, 2021, with the option of four (4) remaining twelve month renewals. This Contract includes the program requirements and specifications as outlined in RFP 2017-03, this Contract, and the Managed Care Technical Manual. All Contracts and rates may be renewed annually as needed, subject to CMS approval pursuant to 42 CFR §438.6.

The Medallion 4.0 program, through the contracted MCOs, will be the vehicle through which the Department will ensure service delivery for the specified populations listed in Section 2.2. Medallion 4.0 includes the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for Virginia's Medicaid and FAMIS members. Under this Contract, the Contractor shall provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described, and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by this Contract.

2.1 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS

The documents listed herein shall constitute the entire Contract between the parties, and no other expression, whether oral or written, shall constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the Contract documents shall be resolved by giving legal order of precedence in the following order:

- Federal Statutes
- Federal Regulations
- Virginia §1915 (b) Managed Care Waiver
- Virginia Statutes
- Virginia Regulations
- Virginia State Plan for Medical Assistance Services
- FAMIS State Regulations
- Virginia State Child Health Insurance Program (CHIP) Plan
- Managed Care Contract, including all amendments and attachments including Medicaid Memos/Bulletins and relevant provider manuals, as well as the Managed Care Technical Manual and other technical manuals, as updated.
- Medallion 4.0 RFP 2017-03
- Medallion 4.0 RFP 2017-03 Proposal Response
- Medallion 4.0 Model Member Handbook

Any ambiguity or conflict in the interpretation of this Contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals.

Services listed as covered in any evidence of coverage or any member handbook shall not take precedence over the services required under this Contract or the State Plan for Medical Assistance. See Section 17.1 for additional sources of governing law.

2.2 COVERED POPULATIONS

Medallion 4.0 covers all Medicaid and FAMIS mandatory eligibility groups as well as various optional categorically needy and medically needy groups as defined in this contract. The Contractor agrees to provide services to the general populations as defined and outlined in

Federal and State regulations as well as this Contract. In addition, the Contractor agrees to provide services to any additional populations or services that the Department, Governor or General Assembly may deem appropriate. The Department reserves the right to transition populations and services into either CCC Plus or Medallion programs in the future. The Contractor shall work with the Department to ensure services are provided to the populations outlined below as well as ensuring that Departmental goals and focuses are met.

Pursuant to 12 VAC30-30-10, the current Medallion 4.0 population includes:

2.2.A Parents, Caretaker Relatives, and Dependent Children

Parents, other caretaker relatives, or dependent children with household income at or below a standard established by the state in 12VAC30-40-100 consistent with 42 CFR 435.110 and §§ 1902(a)(10)(A)(i)(I) and 1931(b) of the Social Security Act.

2.2.B Infants, Children, and Youth

Infants (0-3), children, and youth younger than the age of 18 years, or age 19 if still in school, with household income at or below standards based on this age group, consistent with 42 CFR 435.118 and §§ 1902(a)(10)(A)(i)(III), (IV) and (VIII); 1902(a)(10)(A)(ii)(IV) and (IX); and 1931(b) of the Act.

2.2.C Pregnant Women

Women who are pregnant or postpartum with household income at or below a standard established by the Commonwealth in [12VAC30-40-100](#), consistent with 42 CFR 435.116 and §§ 1902(a)(10)(A)(i)(III) and (IV), 1902(a)(10)(A)(ii)(I) and (IX), and 1931(b) of the Act. Individuals qualifying under this eligibility group shall be pregnant or postpartum as defined in 42 CFR 435.4. The Contractor shall update its maternal care systems to identify and track members enrolled in an expansion aid category who become pregnant. This data will be included in existing maternal care reporting submitted to the Department on a monthly basis as specified in the MCTM.

2.2.D Children and Youth with Special Health Care Needs (CYSHCN)

Children and youth with special health care needs up to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in foster care and adoption assistance (aid categories 076 and 072), youth who have aged out of the foster care system (aid category 70), children identified as Early Intervention (EI) participants, members identified as experiencing childhood obesity and others as identified through the Contractor's assessment or by the Department. The Contractor must develop and maintain policies and procedures for identifying children and youth with special health care needs. These policies and procedures should be submitted to the Department upon creation and thereafter when changed or upon request by the Department.

2.2.E Foster Care

The Contractor shall work collaboratively with the Department in meeting the requirements of the Virginia Health Care Oversight and Coordination Plan, the provision of health care services

as outlined in the VDSS Five Year State Plan for Child and Family Services, and the VDSS Child and Family Services Manuals for children in foster care.

The Contractor shall participate in mandatory case management collaboration regarding children in foster care and adoption assistance. Additionally, the Contractor shall establish a process to notify youth in foster care who are approaching age seventeen (17) of the programs that provide continued health care coverage, specifically former foster care and Fostering Futures. The Contractor shall assist in care coordination during this transitional period.

The Contractor agrees to adhere to all additional reporting requirements related to the foster care and adoption assistance population, as outlined in the Managed Care Technical Manual.

a. Foster Care Transition Planning

The Contractor shall develop and maintain transition of care policies and procedures for enrollees who are transitioning out the child welfare system from Aid Category 76 to Aid Category 70. The policies and procedures shall include provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation. If the services are not covered by Medicaid, the Contractor shall inform the enrollee, or their authorized representative, of available community programs that may be able to meet their needs and make the necessary referrals, as needed.

The Contractor shall start transition planning one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system or immediately upon notification that an enrollee has achieved permanency status. The Contractor shall assist the member with all aspects of the eligibility determination process to ensure transition to Aid Category 70.

2.2.F Medicaid Expansion Population

Pursuant to this Contract, the Medicaid Expansion population includes adults age nineteen (19) through sixty-four (64) who are not eligible for Medicare coverage or for a mandatory coverage group, and whose income does not exceed 138% of the Federal Poverty Level, including individuals in aid categories 100, 101, 102, and 103.

a. Medically Complex Determination

On their Medicaid applications, individuals included in the Medicaid Expansion population who are already enrolled in a limited benefit program or who are members of certain selected populations will self-identify (attest) as either “medically complex” or “non-medically complex.” Members of other selected populations may be presumed to be medically complex without having to self-identify. Members who attest to being medically complex are presumed to be medically complex. Likewise, members who attest to being non-medically complex are presumed to not be medically complex.

These presumptions can be rebutted by the results of part 1 of a MCO Member Health Screening (MMHS) administered to the member. The Contractor shall administer both parts of the MMHS to all covered individuals in the Medicaid expansion population

within 90 days of their enrollment with the Contractor. Refer to Section 8.6.A for further details regarding the medically complex determination and the MMHS.

Members who attest to non-medically complex will initially be enrolled in the Medallion 4.0 program and will be assigned an MCO using the process described in Section 6.3.B.

2.2.G FAMIS

Details pertaining to FAMIS and FAMIS MOMS members are detailed in Attachment XIV, *FAMIS Addendum*.

2.2.H New Populations

The Contractor agrees to provide services to any newly eligible populations as defined by the Governor, General Assembly, and/or the Department. As appropriate, the Department shall create a distinct contract amendment with relation to rate setting and any changes in program requirements in the event of the addition of newly eligible population groups.

2.3 MEMBER THIRD-PARTY LIABILITY

2.3.A Comprehensive Health Coverage

Medicaid members, identified by 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. However, members who obtain Medicare after Medallion 4.0 enrollment shall be dis-enrolled and subsequently enrolled in CCC Plus.

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.

Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department, and annually via a cost recovery report. The Contractor must have a vendor for identifying TPL members and shall notify the Department on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage, and if there is any change in a member’s primary insurance. The Contractor shall instruct its vendor to review potential TPL for all of its covered members. The Contractor’s timely claims filing requirement shall be no shorter than two years (730 days) for the resolution of TPL claims with providers. 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. A file layout, along with turnaround time to DMAS, will be specified in the MCTM.

2.3.B Workers' Compensation

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

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

2.3.C Estate Recoveries

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

2.3.D Other Coverage

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

Members with these other resources shall remain enrolled in the MCO. The Contractor shall notify the Department or its designated agent on a monthly basis of any members identified during that past month that are discovered to have any of the above coverage types, including members identified as having trauma injuries. The Contractor shall provide the Department with all encounter/claims data associated with care given to members who have been identified as having any of the above coverage.

2.4 COMMITMENT TO DEPARTMENT GOALS AND INITIATIVES

The Contractor shall work collaboratively with the Department as directed on any and all Department goals and initiatives.

2.5 DEPARTMENT OVERSIGHT

The Department reserves the right to review the Contractor's policies and procedures and determine conditions for formal notification to the Department of situations involving quality of care.

During the conduct of contract monitoring activities, the Department may assess the Contractor's compliance with any requirements set forth in this Contract and in the documents referenced herein. The Department reserves the right to audit, formally and/or informally, for compliance with any term(s) of this Contract, for compliance with the laws and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of any term(s) of this Contract. The right to audit under this section exists for ten (10) years from

the final date of the contract period or from the date of completion of any audit, whichever is later. Records must be maintained in a searchable electronic format.

The Department shall be responsible for the administration of this Contract. Administration of the Contract shall be conducted in good faith within the resources of the State, but in the best interest of the members. The Department shall retain full authority for the administration of the Medicaid and FAMIS programs in accordance with the requirements of Federal and State laws and regulations. See Section 16.2 regarding conflicts between the Department's administration of the Medicaid program and the Contractor's policies and its subcontractor's contracts.

2.6 RESPONSIVENESS TO THE DEPARTMENT

The Contractor must acknowledge receipt of the Department's written, electronic, or telephonic requests for assistance, including case management evaluation requests and requests to change MCO (good cause as outlined in Section 6.3.D of this Contract), involving members or providers within one (1) business day in instances where the member's health condition requires and in all other instances no later than two (2) business days of receipt of the request from the Department. The Contractor's acknowledgement must include a planned date of resolution. A detailed resolution summary advising the Department of the Contractor's action and resolution shall be rendered to the Department in the format requested. The Department's requests for case management services and/or requests for the Contractor to contact the member/provider must occur within the time frame set forth by the Department.

The Department's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Department, must be given priority by the Contractor and completed in accordance with the instructions from the Department. The Department shall provide guidance with respect to any necessary deadlines and resolution requirements, including dates of resolution. A resolution summary, as described by the Department, shall be submitted to the Department.

3. MEDALLION 4.0 REQUIREMENTS TO DO BUSINESS

3.1 LICENSURE AND SOLVENCY

The Contractor shall obtain and retain at all times during the period of this Contract a valid license issued with "Health Maintenance Organization" Lines of Authority by the State Corporation Commission and comply with all terms and conditions set forth in the *Code of Virginia* §§ 38.2-4300 through 38.2-4323, 14 VAC 5-211-10 et seq., §38.2-5800 through 38.2-5811 and any and all other applicable laws of the Commonwealth of Virginia, as amended. A copy of this license shall be submitted with the signature page at each annual contract renewal.

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

3.2 CERTIFICATION

Pursuant to § 32.1-137.1 through § 32-137.6 *Code of Virginia* , and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services delivered. A copy of this certification shall be submitted with the signature page at each annual contract renewal.

3.3 ACCREDITATION

As specified in 42 CFR § 438.332, the Contractor must obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA). The Contractor must report to the Department any deficiencies noted by NCQA within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest. Denial or revocation of NCQA accreditation status or a status of “Provisional” may be cause for the Department to impose remedies or sanctions as outlined in Sections 10 and 16 of this contract, to include suspension of this contract, depending upon the reasons for denial by NCQA.

Any health plan that is new to Virginia Medicaid that has been approved by the Department and is seeking NCQA accreditation for its Virginia Medicaid line of business must agree to adhere to NCQA standards while working toward accreditation based on the most current version of NCQA Health Plan Accreditation Standards, and meet a timeline of milestones set by the Department as a condition of operation.

3.3.A Milestones for New Managed Care Organizations

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

1. EQRO Comprehensive onsite review at least annually, at dates to be determined by the Department.
2. Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to Virginia Medicaid/CHIP members).
3. Obtain NCQA accreditation status of at least Accredited within 36 months of the onset of delivering care to members.

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

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

The Contractor must adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Standards for Members’ Rights and Responsibilities,

Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and CAHPS survey.

3.4 QUALIFIED HEALTH PLAN REPORTING

If the Contractor offers a qualified health plan (QHP) certified by the Federal Health Insurance Marketplace under the Affordable Care Act, the Contractor shall notify the department by August 1st of each contract year and annually thereafter the localities in which the contractor offers a QHP or the localities they will no longer be participating in. All letters submitted to members who have income under 150% of the Federal Poverty Level must be reviewed by DMAS prior to submission to members in an effort to facilitate Medicaid enrollment. The Contractor shall encourage these members to update their records to facilitate their Medicaid enrollment.

3.5 OWNERSHIP AND CONTROL INTEREST

In accordance with Federal regulations contained in 42 CFR §§ 455.100 through 455.106, 42 CFR § 438.604(a)(6), 42 CFR § 438.608(c)(2) and 42 CFR § 438.610 the Contractor shall disclose all of the following for the Contractor's owner(s) and managing employee(s), including, but not limited to:

- Information on ownership and control (42 CFR § 455.104);
- Name, address, date of birth, and Social Security Number of any managing employee;
- Information on whether a person or corporation with an ownership or control of five percent (5%) or more interest is related to another person with ownership or control interest in the health plan as a spouse, parent, child or sibling (42 CFR § 438.604(a)(6); 42 CFR § 455.104(b)(2); 42 CFR § 438.608(c)(2)).
- Information related to business transactions (42 CFR § 455.105); and,
- Information on persons convicted of crimes against Federally related health care programs (42 CFR § 455.106).
- The contractor must submit the tax identification number of any corporation with an ownership or control interest in the MCO and any subcontractor in which the MCO has a 5% or more interest.
- Information of any other disclosing entity in which an owner of the Contractor has an ownership or control interest.

The Contractor shall provide the required information using the Disclosure of Ownership and Control Interest Statement (CMS 1513), included as part of the Contractor Specific Contract Terms and Signature Pages, annually at the time of Contract signing. All disclosures must also be made in the timeframe and manner specified in accordance with 42 CFR§455.104.

Additionally, the Contractor shall submit this completed form upon request to the Department within thirty- five (35) calendar days of the Department's request. The Department will review the ownership and control disclosures submitted by the Contractor and any of the Contractor's subcontractors in accordance with 42 CFR §§ 438.602(c) and 438.608(c). Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, sanction as described in Section 10 of this Contract, and/or termination of this Contract by the Department.

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

The Contractor shall conduct monthly checks for all of the Contractor's owners and managing employees against the Federal List of Excluded Individuals and Entities (LEIE) database. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

Federal database checks shall be consistent with the requirements at 42 CFR § 455.436. The Contractor shall confirm the identity and determine the exclusion status of its subcontractors, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor/subcontractor through routine checks of Federal databases.

3.6 ORGANIZATIONAL STRUCTURE

The Contractor shall provide the Department with an organizational chart showing the staffing and lines of authority for the key personnel to be used. The organizational chart should include:

- The relationship of service personnel to management and support personnel
- The names of the personnel and the working titles of each, and
- Any proposed subcontractors including management, supervisory, and other key personnel.
- It is recommended that these organizational charts also reflect any current internal reporting structures.

3.6.A Company Background History

The Contractor shall submit annually an updated company background history that includes any awards, major changes (such as entering or leaving another State Medicaid Program), or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors. This report must be submitted electronically.

3.6.B Virginia Based Operations

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

a. Access to Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, at any time, access to the Contractor's premises, subcontractor's premises, or the premises of the Contractor's network providers to inspect, audit, monitor or otherwise evaluate the performance of the Contractor, subcontractor, or network provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. Further, duly authorized agents or representatives of the State or Federal Government, shall have the right to audit and inspect any books or record of the Contractor or its subcontractor pertaining to: the ability of the Contractor to bear the risk of financial losses and services performed or payable amounts under the Contract. In the

event “right of access” is requested under this section, the Contractor, subcontractor, or network provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Contractor’s or subcontractor’s activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

3.6.C Dedicated Project Director and Project Manager

The Contractor shall have a dedicated Virginia Medallion 4.0 Project Director and dedicated Project Manager located in an operations/business office within the Commonwealth of Virginia. The Contractor’s Project Director and Project Manager are expected to attend all meetings required 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 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 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.

3.6.D Medical and Behavioral Health Leadership Staff

The Contractor’s Virginia-based location shall also include a dedicated full-time Virginia-licensed Medical Director/Chief Medical Officer, Virginia-licensed Behavioral Health/Addiction Recovery Treatment Clinical Director, and Care Coordination Manager able to perform comprehensive oversight and comply with all requirements covered under this Contract.

3.6.E Compliance Officer

Pursuant to 42 CFR § 438.608 (a)(1)(ii), the Contractor shall designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors. Pursuant to 42 CFR § 438.608 (a)(1)(v), the Contractor shall establish effective lines of communication between the Compliance Officer and the Contractor’s employees.

Lastly, pursuant to 42 CFR § 438.608, the Compliance Officer and Regulatory Compliance Committee shall coordinate with the Department on any fraud, waste, or abuse case.

3.6.F Provider Relations Staff

The Contractor shall have a Provider Network Manager responsible for network development, recruitment, credentialing, and management. The Contractor's provider relations staff must be located within the geographic region where the Contractor operates. The Contractor's regional provider relations staff shall work with providers, including face-to-face when necessary, to ensure that appropriate and accurate information is collected during credentialing process. The Contractor shall also ensure that this provider information is accurately reflected in the Contractor's provider directory, including but not limited to information on the provider's cultural competency, disability accessibility and open panels.

3.6.G Program Integrity Lead

The Contractor shall designate a PI Lead who will represent the Contractor and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, pre- and post-claim edits, PA/SA review, and any other fraud activities and outcomes. This individual must also attend all scheduled meetings of the Department's Quarterly Program Integrity Collaborative. If the PI Lead is unable to attend the PI Collaborative, the Contractor must notify the Department prior to the meeting and identify an alternative representative who will be in attendance. The Contractor must be aware and actively involved with State, Federal, and CMS initiatives of Program Integrity.

3.6.H Encounter Data Manager

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

3.6.I CYSHCN Care Coordinator

The Contractor shall designate a care coordinator who shall be responsible for ensuring that children identified as CYSHCN receive assessments, and medical, dental, and behavioral health visits in the timeframe outlined in this contract. The coordinator also shall be responsible for handling any inquiries or concerns related to this population. The coordinator shall be trained on all aspects related to the population.

Care coordinators may have a "blended" caseload comprised of members in more than one sub-population to meet business operational needs or provide transition of care for members.

3.6.J Key Personnel Changes

To promote continual effective communications, the Contractor must notify the Department of changes in key staff positions, particularly the Chief Executive Officer (CEO), President (corporate or Commonwealth business), Contract Administrator, Chief Financial Officer (CFO), Chief Medical Director/ Officer (CMO), Pharmacy Director, Medical Management Director, Member Services/Operations Manager, Information Technology staff, Quality Improvement Manager, Project Executive, Compliance Manager/Director, Compliance Officer, Program Integrity Lead, Encounter Data Manager, Behavioral Health Director, and anyone key to the Contractor's operations per the timelines listed below. Reporting requirements are as specified in the MCTM. The notification requirement also applies to specific program or project leads

assigned to participate in or serve on the Department’s Meetings and/or Board, as referenced in Section 3.6.

Departure:	The Contractor must provide notification to the Department within five (5) calendar days from receipt of formal written <i>notice</i> of departure
New Hire/Internal Promotion:	The Contractor must provide notification, a resume, and an updated organizational chart to the Department within five (5) calendar days of the start date.

In addition, the following information is to be reported annually and also within five (5) calendar days when individuals either leave or are added to these key positions.

a. Resumes

The Contractor shall provide the Department with resumes for any key positions within five calendar (5) days of a staffing change, or at the Department’s request. Resumes, limited to two (2) pages, shall include qualifications, experience, and relevant education and training.

3.6.K Department Authority to Remove Staff

The Department reserves the right to direct the Contractor to remove any staff from this Contract when the Department determines the removal to be in the best interest of the Contract and the Commonwealth.

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

3.7 CHANGES TO CONTRACTOR ORGANIZATIONAL STRUCTURE AND OPERATIONS

Any changes to Contractor organizational structure and operations, that have significant impact, as deemed by the Department, on Virginia Medicaid shall require notification to the Department. The Contractor shall ensure, at a minimum, the following:

1. Uninterrupted services and ongoing adequate access to care and choice for members.
2. The ability to maintain and support the Contract requirements including the commitments in the proposal submitted to DMAS during the procurement process, as modified by the contracting process with DMAS.

3. Major functions of the Contractor's organization, as well as DMAS programs, are not adversely affected.
4. The integrity of a fair, competitive DMAS procurement process for Managed Care contracts.

The Contractor shall submit notice to the Department, no less than 30 days in advance, for review and approval of the following:

1. Significant changes in operations, contracting, or to a change from the original Request for Proposal (RFP).
2. Organizational changes or major decisions affecting Medicaid business in Virginia or other states.
3. Contractor and subcontractor changes and terms directly related to the delivery of healthcare to Medicaid members, including, but not limited to:
 - PBM and specialty pharmacy
 - Transportation
 - Information management
 - TPA arrangements
 - Claims payment vendor
 - Medical management
 - Utilization management
 - Care coordination/case management
 - Program Integrity
 - Fraud Waste and Abuse
 - Specialty services
 - Marketing and outreach
 - Provider contracting services
 - Value Based Purchasing
 - Actuarial Services
 - Quality Improvement
 - Data Management
 - Financial Management
 - Provider Relations and Network Management
 - Member Materials
 - Compliance

DMAS may offer open enrollment to the members assigned to the Contractor should a significant Change in Organizational Structure that impacts Virginia Medicaid occur, as determined by the Department.

A Change in Organizational Structure may require a Contract amendment.

3.8 PROPOSED ACQUISITION AND PURCHASE/SALE OF HEALTH PLAN

The Department requires review of any proposed acquisition or purchase of an existing Medicaid health plan. The proposed acquisition must benefit both the Commonwealth and the Department and must assure minimal disruption to Medicaid members and providers. As part of the review

process, the Contractor shall submit notice to the Department, not less than 30 days in advance or upon availability, for review and approval of the following:

- A letter of intent which describes the purpose and manner of the sale, including the acquisition plan, method and terms (e.g. stock or asset transfer);
- A proposed effective date, copies of BOI and VDH approval, and NCQA certification;
- A detailed description of the parent/acquiring company to include health insurance history and experience, Medicaid managed care experience (including state Medicaid recommendations and sanctions, if any);
- A project plan including completion of any network development, information technology changes and requirements, and communications;
- An organizational chart indicating the retention of current and key personnel, as well as any staff changes;
- A list of the acquisition/implementation team at the MCO with their title and role on the team including a project lead;
- Profit and enrollment projections;
- Any additional information requested by the Department, including Acquisition/Purchase Requirements as outlined in the MCTM.

The Department will send a notice to members at the Contractor's expense notifying them of changes and shall review all member and provider correspondence relating to the merger/acquisition prior to its disbursement by the Contractor.

The Department will review and respond to the Contractor regarding the Notification and submission of the Acquisition/Purchase Requirements. An acquisition or purchase/sale may require a Contract amendment. The Department may consider waiving specific requested requirements upon written request from the Contractor.

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

3.8.A NCQA Notification Requirements

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

3.9 READINESS REVIEW AND ANNUAL REQUIREMENTS FOR REVIEW

Prior to the execution of this contract, and annually thereafter the Department and/or its duly authorized representative will conduct comprehensive readiness review(s) which will include a minimum of one site visit. This review may be conducted prior to enrollment of any members in the MCO, prior to the renewal of the Contract, prior to the Contract being amended to add newly covered populations or aid categories, and anytime thereafter upon the Department's request and at the Department's discretion. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled members.

The review will document the status of the MCO with respect to meeting program standards set forth in the BBA, federal regulations, and this Contract, as well as any goals established by the Department.

During the Readiness Review, the Department may make a determination that the Contractor is not able to perform any or all of its obligations under this Contract. The Department reserves the right to deny participation in some or all areas of the Commonwealth for the Medallion 4.0 program if the Contractor fails the Readiness Review within the timeframe specified. The readiness review activities will be conducted by the Department's External Quality Review Organization (EQRO), and/or by a multidisciplinary team appointed by the Department.

The scope of the readiness review(s) will include, but not be limited to; review and/or verification of: network provider composition and access; staffing; content of provider agreements; policies and procedures consistent with the Medallion 4.0 contractual standards; pregnancy and complex care management programs; EPSDT plan; CYSHCN plan; financial solvency; and information systems performance and interfacing capabilities. The Contractor agrees to meet any expansion criteria as may be required by the Department. The readiness review(s) will assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

In the instance where there is a change to the contract terms that does not affect one or more of the elements above, and when the Department has previously conducted a readiness review on the non-impacted element(s), the Department has the discretion to deem that the previously conducted readiness review for non-impacted items is sufficient to meet readiness requirements.

The Department will provide the Contractor with a summary of the findings, as well as areas requiring remedial action. No individual shall be enrolled into the Contractor's health plan prior to the Department making an initial determination that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

3.10 DEPARTMENTAL MEETINGS

The Contractor shall participate in meetings with the Department of Medical Assistance Services as required by the Department. These include DMAS Managed Care Advisory Committee, MCO Workgroup, Quality Collaborative, Quarterly CFO, Compliance Collaborative, Program Integrity, CMO and Pharmacy Director, ARTS Workgroup, or any other groups as necessary or when requested to do so by the Department. In-person attendance is expected unless otherwise noted by the Department.

3.10.A Meetings with State Government Agencies

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

4. PROVIDER NETWORK MANAGEMENT

The Contractor is required to establish a network of providers. The Contractor must maintain its own provider network processes, separate from other managed care organizations, and maintain distinct recruitment, credentialing, and contracting, reviews, policies, and processes. The

Contractor must establish, maintain, and monitor its network in accordance with this Contract and any and all applicable Medicaid Rules and Regulations at the State and Federal level, as well as the Department's policies. The Contractor may terminate, suspend, sanction, and/or educate providers according to the terms described in its agreements with its network providers, including but not limited to "for cause" terminations, such as access, program integrity, or quality of care issues, as well as "not-for-cause" or "at-will" terminations under authority granted by this Contract. The Contractor is not required to offer providers appeal rights except as specified in Section 12.3, 12.4, 12.5, and 12.7 in cases of denied authorization/reimbursement and/or reduced reimbursement. The Contractor is permitted to offer additional types of provider appeal rights at the MCO-level of review only. Network providers may not appeal termination decisions to the Department. The Contractor is required to report on all terminations and credentialing failures to the Department as specified in the MCTM.

4.1 NETWORK ADEQUACY STANDARDS

The Contractor's network shall meet or exceed Federal standards in 42 CFR §438.68 and 42 CFR §438.206, as well as the full scope of access standards described in Section 4.6, Access to Care Standards. The Contractor shall regularly assess and certify through submission of quarterly reports to the Department the adequacy of its provider network and notify the Department of any major initiatives or changes to program design (e.g., expanded benefits). Refer to the Medallion 4.0 Network Requirements Submission Manual (NRSM) for network reporting format requirements. When identified, the Contractor shall report any network deficiencies as soon as possible and no later than within five (5) business days and request an exemption by completing the Medallion Network Exemption Request Form for any circumstance whereby the Contractor is unable to meet the Department's network time and distance standards. Such a request may be granted only in circumstances where there exists a shortage of the number of providers in a specialty practicing in the region (i.e., provider shortage area). The Contractor's request for exemption shall also identify the Contractor's strategy (for its enrolled members) for ensuring timely access to care for all contract covered services. The Department will review and reserves the right to request changes to the provider network, which must be completed within specified timeframes.

The Contractor shall contract with a broad range of providers to meet the complex needs of its members. Services shall be delivered in the most integrated setting possible while offering opportunities for active community living and workforce participation. The Department shall be the sole determiner of the Contractor's network sufficiency. The Department, as part of the program development cycle, will set network adequacy for new population group expansions. These standards shall be considered as operational guidelines.

4.2 PROVIDER NETWORK COMPOSITION

4.2.A Network Establishment & Maintenance

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

- The anticipated Medallion 4.0 and FAMIS enrollment in each region;

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

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

b. Behavioral Health Network

The Contractor shall monitor and assure that the Contractor’s behavioral health network is adequate (in terms of service capacity and specialization) to serve child, adolescent, and adult populations timely and efficiently for all BHS services covered by the Contractor. The Department will assess the MCO’s inpatient and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

c. MHS Network Development Plan

The Contractor’s MHS network shall ensure sufficient Member access to high quality service providers with demonstrated ability to provide evidence based treatment services that consist of person centered, culturally competent and trauma informed care using a network of high quality, credentialed, and knowledgeable providers in each level of care within the access to care and quality of care standards as defined by the Department.

d. NEMT Provider Network

The Contractor shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. The Contractor shall have a sufficient network of NEMT providers (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the Contractor to provide NEMT services in accordance with the requirements of the Contract. The Contractor’s NEMT network shall include sufficient number of providers qualified to provide the following modes of transportation: emergency and non-emergency air ambulance, emergency and non-emergency ground ambulance, public transit, stretcher vans, wheelchair vans, mini-vans, sedans, taxis, transportation network companies (TNCs) and volunteer drivers. The Contractor shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements for access to care standards as described in this Contract.

4.2.B Notification to the Department

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

4.2.C Admission Privileges

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

4.3 NETWORK PROVIDER FILE SUBMISSIONS

4.3.A Enrollment Broker and Other DMAS Contractors

The Contractor shall submit, to the Department for the Enrollment Broker and other DMAS Contractors, a complete network provider file at least sixty (60) days prior to the effective date of the Contract. A complete file for the Enrollment Broker will be submitted to the Department each week. Details on the quality measures and details on the reporting structure and template can be found in the MCTM.

4.3.B Complete Provider File to Department

In accordance with 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2) the Contractor shall submit documentation to the state, in a format specified by the state, to demonstrate that it offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area and demonstrates that the Contractor maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the Contractor's service area. The Contractor shall submit to the Department a complete provider file quarterly, or on a more frequent basis, as requested by the Department. The Network Requirements Submission Manual (NRSM) version 1.1 details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department.

4.3.C Network Sufficiency Determined by the Department

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

4.3.D Network Provider Classes

The following provider classes will be utilized for the Department’s network analysis. The Contractor will provide its Medallion 4.0 and FAMIS membership with sufficient access to the following provider classes, but is not required to contract with each subtype so long as the members have access to these categories. Health care provider taxonomy codes for these provider classes are provided in the MCTM and will be used to assess network adequacy.

Acute Care Hospital	Orthopedic Surgery
Allergy & Immunology	Otolaryngology
Anesthesiology	Pain Medicine
Behavioral Health and Social Service Providers	Pathology
Clinical Medical Laboratory	Pediatrics
Colon and Rectal Surgery	Pharmacy
Community Service Boards	Physician Assistants and Advanced Practice Nursing Providers
Dermatology	Physical Medicine and Rehabilitation
Durable Medical Equipment	Plastic Surgery
Early Intervention	Preventive Medicine
Emergency Medicine	Prosthetic Supplier
End- Stage Renal Disease Facility	
Family Medicine	Psychiatry & Neurology
Federally-Qualified Health Centers (FQHC)	Radiology
General Practice	Respiratory, Developmental, Rehabilitative and Restorative Service Providers
Health Department	Rural Health Care Clinic (RHC)
Home Health	Skilled Nursing Facility
Hospitalist	Substance Abuse Treatment
Internal Medicine	Surgery
Medical Genetics	Thoracic Surgery
Neurological Surgery	Transplant Surgery
Nuclear Medicine	Transportation
Obstetrics & Gynecology	Trauma-informed Care
Ophthalmology	Urgent Care Center
Oral Surgery	Urology

4.4 PROVIDER NETWORK DATA REQUIREMENTS

In accordance with 42 CFR § 438.242(b)(2-3), the Contractor shall collect and maintain 100% of all provider characteristics including those providers in the Contractor’s or sub-contractor’s network where the Contractor has incurred a financial liability on services furnished or denied to enrollees and:

- Submit complete, timely, reasonable, and accurate provider network data to the Department daily, prior to the Contractor’s submission of encounters, and in the form and manner

specified by the Department. The Department will use this provider file submission for Medallion 4.0 MCO assignments and encounter processing. The first submission shall be sent sixty (60) days prior to the Department's program implementation. Standard formats, required data elements, and other submission requirements shall be detailed in the Medallion PSF113 Guide;

- Submit a complete Enrollment Broker file, which includes the Contractor's provider network list in the Department's approved electronic specified format noted in the Managed Care Technical Manual sixty (60) calendar days prior to the effective date of the Contract. An updated file with all of the changes to the network shall be submitted to the Department weekly thereafter or more frequently, if needed, during any program expansions (e.g., upon adding additional populations to the Medallion 4.0 program). The Department sends these files to the Department's contracted Enrollment Broker as data supplied to the Virginia Managed Care website and the Medallion 4.0 smartphone application.
- Submit to the Department a complete provider network file on a quarterly basis, or on a more frequent basis as requested by the Department for network analysis. The Medallion 4.0 Network Requirements Submission Manual (NRSM) & Methodology details the required provider reporting data elements. Additional required elements to be included in this provider file may be identified by the Department.

4.5 PROVIDER RECRUITMENT AND SELECTION

In accordance with 42 CFR §§438.12 and 438.214, the Contractor shall implement written policies and procedures for selection and retention of network providers. The Contractor shall submit its policies and procedures in accordance with the Managed Care Technical Manual.

4.5.A Adequate Resources

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

4.5.B Panel Participation Prohibited

The Contractor shall not require as a condition of participation/contracting with providers in the Medallion 4.0 network a provider's terms of panel participation with other MCOs.

4.5.C Out-of-State Providers

A Contractor licensed in Virginia may include, in its provider network, providers that are located in other states. The Contractor may also utilize non-participating in-state and out-of-state providers who are not enrolled as Virginia Medicaid/ FAMIS providers.

4.6 PROVIDER LICENSING AND CERTIFICATION STANDARDS

Each Contractor must have the ability to determine whether providers are licensed by the State and have received proper certification or training to perform medical and behavioral health services contracted for under this Contract. The Contractor's standards for licensure and

certification shall be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or employment contracts. The Contractor shall be able to demonstrate upon request by the Department that its network providers are credentialed as required under 42 CFR § 438.214.

4.6.A Credentialing/Recredentialing Policies and Procedures

The Contractor shall utilize provider credentialing and re-credentialing standards outlined by NCQA for network development and maintenance. The Contractor shall implement written policies and procedures for credentialing and recredentialing of acute, primary, behavioral health, ARTS, and EI network providers. These policies and procedures shall comply with Federal standards at 42 CFR § 438.214, the most recent NCQA standards, and State standards described in 12 VAC 5-408-170. In addition, consistent with 42 CFR §438.12, the Contractor's credentialing standards shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

In accordance with NCQA credentialing and re-credentialing requirements, the Contractor shall have the proper provisions to determine whether providers are licensed by the Commonwealth and are qualified to perform the services in accordance the provisions required in this Contract. The Contractor's re-credentialing 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 providers under contract with the subcontractor are qualified to perform the services covered under this contract. See Section 5.2, Subcontractor Management & Monitoring, for additional requirements unrelated to credentialing.

The Contractor shall ensure all orders, prescriptions or referrals for items, or services for Members originate from appropriately licensed providers. The Contractor shall credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to Medicaid and FAMIS members.

The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The Contractor shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers), this includes program integrity-related and adverse actions as outlined in the Managed Care Technical Manual.

4.6.B Credentialing of Behavioral Health Providers

The Contractor's Community-Based Mental Health and ARTS providers (public and private) shall meet any applicable DBHDS certification and licensing standards. Behavioral health and ARTS providers shall meet the Department's qualifications as outlined in 12 VAC 30-130-5000, et.al. and the Department's most current behavioral health provider manuals, including the Mental Health Services, mental health clinic, and psychiatric services provider manuals found at: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

4.6.C Credentialing of Early Intervention Providers

Provider qualification requirements for early intervention are described at 12VAC30-50-131 and 12VAC35-225 et seq., in Appendix G of the DMAS Early Intervention Provider Manual, and the DBHDS Practice Manual.

The Contractor shall develop and maintain a network of early intervention providers, certified by DBHDS, with sufficient capacity to serve its members in need of EI services. Early intervention providers shall be reflected in the Contractor’s networks. The Contractor’s EI network shall be sufficient in all disciplines to provide assessments and ongoing services in accordance with Federal timelines and DMAS program requirements. Early intervention providers shall be contracted with or have memorandum of agreement with the local lead agency for the catchment area in which the member resides.

The providers must be certified by DBHDS to provide Early Intervention services. Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as Service Coordinators.

4.6.D Mental Health Services Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed providers as defined in 12VAC30-60-143 and 12VAC30-60-61, and the provider manuals and supplements. The Contractor shall verify that the registration requirements for peer recovery specialists and qualified mental health professionals are met as directed by the Department of Health Professions in accordance with all applicable regulations.

The Contractor shall allow for the billing methods by each MHS Level of Care as defined by the Department and detailed in the table below:

Mental Health Services	Billing Method	Urban Rate Per Unit	Rural Rate Per Unit
Mental Health Intensive Outpatient Services (MH-IOP)	CMS-1500 or UB	N/A	N/A
Mental Health Case Management	CMS-1500	N/A	N/A
Therapeutic Day Treatment (TDT) for Children	CMS-1500	N/A	N/A
Mental Health Partial Hospitalization Program (MH-PHP)	CMS-1500 or UB	N/A	N/A
Crisis Intervention	CMS-1500	\$30.79	\$18.61
Assertive Community Treatment (ACT)	CMS-1500	N/A	N/A
Mental Health Skill-building Services (MHSS)	CMS-1500	\$91.00	\$83.00
Intensive In-Home	CMS-1500	N/A	N/A
Psychosocial Rehab	CMS-1500	N/A	N/A
Crisis Stabilization	CMS-1500	\$89.00	\$81.00
Behavioral Therapy Program	CMS-1500	N/A	N/A

Mental Health Peer Recovery Support Services – Individual	CMS-1500	N/A	N/A
Mental Health Peer Recovery Support Services – Group	CMS-1500	N/A	N/A

4.6.E Provider Enrollment into Medicaid

In order to comply with 42 CFR 438.602(b)(1) and (b)(2), 42 CFR § 438.608(b), and 42 CFR § 455.100-106, 42 CFR § 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Virginia Medicaid members, including providers participating in a managed care organization (MCO) provider network, are required to be screened and enrolled with DMAS.

The Provider Services Solution (PRSS), managed by the contracted modular vendor, is Virginia’s web-based Medicaid provider enrollment system. The Contractor must integrate their information systems with PRSS to assure a smooth transition to meet 21st Century Cures Act requirements.

Upon implementation of PRSS, the Department will screen, enroll, and periodically revalidate all MCO network providers per the requirements of the 21st Century Cures Act. This requirement applies to all individuals and entities who provide services of any type to members, including but not limited to: health care providers; pharmacies; ordering, referring, or prescribing providers’ and providers who do not participate in Medicaid fee-for-service (FFS_ but are network providers through a MCO or their subcontractor(s).

The Contractor must require all network providers to be enrolled in the Virginia PRSS prior to finalizing the contracting and credentialing process with the provider.

The Contractor must have policies and procedures that ensure in- and out-of-network providers can verify enrollment in the Contractor’s plan prior to treating a patient for non-emergency services.

a. Provider Enrollment Verification

The Contractor must have policies and procedures that ensure in-and out-of-network providers can verify enrollment in the Contractor’s plan prior to treating a patient for non-emergency services. The Contractor must provide, within five (5) business days of the date on which the Contractor receives the enrollment report from the Department, enrollment verification by telephone or by another timely mechanism.

4.6.F Reimbursement of New Provider Applicants

In accordance with § 38.2-3407.10:1 of the Code of Virginia, the Contractor shall establish reasonable protocols and procedures for reimbursing new provider applicants, within thirty (30) calendar days of being credentialed by the carrier, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. At a minimum, the protocols and procedures shall:

1. Apply only if the new provider applicant's credentialing application is approved by the Contractor;
2. Permit reimbursement to a new provider applicant for services rendered from the date the new provider applicant's completed credentialing application is received for consideration by the Contractor;
3. Apply only if a contractual relationship exists between the Contractor and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
4. Require that any reimbursement be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan.

4.6.G Excluded Entities/Service Providers

The Contractor shall require its providers and subcontractors to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 CFR § 455 Subpart B and E.

The Contractor shall comply with the requirements detailed at 42 CFR § 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 non-Medicaid enrolled providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and re-credentialing.

The Contractor shall obtain Federally required disclosures from all non-Medicaid enrolled network providers and applicants in accordance with 42 CFR 455 Subpart B and 42 CFR § 1002.3, as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. The Contractor shall screen all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc. The information shall be obtained through provider enrollment forms and credentialing and re-credentialing packages. The Contractor shall maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DMAS in accordance with this Contract and relevant state and Federal laws and regulations.

The Contractor shall conduct monthly checks and shall require subcontractors to conduct monthly checks to screen non-Medicaid enrolled providers for exclusion, using the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. The Contractor shall also check the DMAS provider file or conduct its own checks against the Federal exclusion files (named above) to ensure that any of its network providers who are "Medicaid enrolled" providers remain enrolled with DMAS.

The Contractor's screening process shall also include: verifying licenses, conducting revalidations at least every five years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as

required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by subcontractors and providers.

The Contractor/Subcontractor shall terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled. The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

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 should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov/>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered.

4.7 ACCESS TO CARE

4.7.A Choice of Provider Standard

The Contractor shall provide members with a choice of at least two (2) providers for each type of service listed below:

- PCP (primary care provider), adult and pediatric
- OB/GYN
- Specialist, adult and pediatric
- Behavioral health (mental health and substance use disorder), adult and pediatric
- Pharmacy

The Contractor shall provide members with at least one (1) provider for each type of service listed below in accordance with time and distance standards specified in section 4.7.B below or where an exception is granted by the Department as described in Exceptions to Access Standards Section 4.7.C. of this Contract:

- Hospital (general)

4.7.B Member Travel Time and Distance Standards

In accordance with 42 CFR 438.68(b)(1), the Contractor shall ensure that the travel time and distance standards described in this section are met. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours).

The Contractor shall contract with a sufficient number of providers and facilities to ensure that at least 80 percent of its members within a county can access primary care within the time and distance standards described below. In addition, travel time and distance for all other providers in which the member travels to receive covered benefits shall not exceed the standards below for at least 75 percent of its enrolled members.

Member Time & Distance Standards		
Standard	Distance	Time
Urban		
<ul style="list-style-type: none"> • PCPs • Other Providers including Specialists 	15 Miles 30 Miles	30 Minutes 45 Minutes
Rural		
<ul style="list-style-type: none"> • PCPs • Other Providers including Specialists 	30 Miles 60 Miles	45 Minutes 75 Minutes

4.7.C Exceptions to Access Standards

In accordance with 42 CFR §438.68 (d)(1), the Contractor may request an exception to the standards described in this section where there is a shortage of the provider type(s) practicing in a given locality and/or region. The Contractor’s exception request shall include a detailed action plan for network improvement with actionable and measurable goals, and related milestones for coming into compliance. The Contractor’s action plan shall also explain how the Contractor will ensure that members receive timely access to care including in any instance where an exception is granted by the Department. The Contractor shall monitor and work to improve access to any provider types in which the Department grants an exception on an ongoing basis and shall report findings to DMAS per the action plan approved by DMAS. DMAS also reserves the right to establish different time and distance standards in future Contract revisions. Also refer to Section 4.1 Network Adequacy Standards.

4.7.D Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to members under this Contract in the same manner as they provide those services to all non-Medicaid and non-FAMIS members, including those with limited English proficiency or physical or mental disabilities. Additionally, in accordance with 42 CFR § 438.206 (c)(1)(ii), the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members if the provider serves only Medicaid and/or FAMIS members.

4.7.E Member Access to Reasonable Accommodations and Accessible Equipment

In accordance with 42 CFR 438.206(c)(3), the Contractor must ensure that all network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

4.7.F Member-to-PCP Ratios

As a means of measuring accessibility, the Contractor must have:

- At least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 members.
- At least one (1) full-time equivalent (FTE) pediatric PCP for every 1,500 members under the age of eighteen (18).

No PCP may be assigned members in excess of these limits, except where mid-level practitioners are used to support the PCP’s practice.

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

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

4.7.G Inpatient Hospital Access

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

4.7.H Twenty Four-Hour Coverage

The Contractor shall maintain adequate provider network coverage to serve the entire eligible population in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week. The Contractor shall refer members seeking care after regular business hours to an appropriate physician or the emergency department for potentially emergent conditions. This may be made via a recorded message.

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

4.8 APPOINTMENT STANDARDS

4.8.A Appointment Standards and Member's Health Condition

The Contractor must arrange to provide care as expeditiously as the member's health condition requires. Members cannot be billed for missed appointments. The Contractor shall arrange care according to each of the following appointment standards:

Emergency Services

Emergency services shall be made available immediately upon the member's request.

Urgent Medical Conditions

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

Routine Primary Care Services

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

4.9 MATERNITY CARE APPOINTMENT STANDARDS

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

- **First trimester**
Appointments shall be scheduled within seven (7) calendar days of request.
- **Second trimester**
Appointments shall be scheduled within seven (7) calendar days of request.
- **Third trimester**
Appointments shall be scheduled within three (3) business days of request.
- **High Risk Pregnancies**
Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

4.10 EMERGENCY SERVICES COVERAGE

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

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

4.11 MEDICAL HELP LINE ACCESS STANDARDS

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

4.12 CONTINUED NETWORK ADEQUACY FOR MEDICAID EXPANSION POPULATION

The Contractor shall report to DMAS monthly regarding the maintenance of network adequacy for the Medicaid Expansion population. Refer to the MCTM for further details.

5. PROVIDER ENGAGEMENT

The Contractor shall establish and maintain a formal provider engagement function, which shall include recruitment and retention of providers along with ongoing troubleshooting and education for contracted providers. The Contractor must give written notice of the reason for its decision when it declines to include an individual or groups of providers in its provider network. In all

contracts with network providers, the Contractor must use a documented process and follow NCQA's uniform credentialing and re-credentialing policy that addresses the health care services the provider is licensed to provide including acute care, primary care, behavioral health services, and substance use disorder.

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

Annually, the Contractor shall develop and submit a plan outlining its efforts in provider engagement. At a minimum, the plan should include recruitment, retention, education, training, and communication. In an effort to ensure ongoing improvements in provider relations, the Contractor shall also conduct an annual survey to assess provider satisfaction, including at a minimum: satisfaction with enrollment, communication, education, complaint resolution, claims processing and reimbursement, care coordination, and utilization management. The Contractor agrees to alter and or update the survey as requested by the Department.

The Contractor must receive approval by DMAS prior to providing any communication to their provider network that includes information pertaining to Federal and State laws, regulations or policies regarding the Medicaid or Children's Health Insurance Programs.

5.1 PROVIDER CONTRACTING

The Contractor shall enter into written agreements with providers to ensure the provision of all covered services as outlined in this contract. When contracting with providers, the Contractor shall have the authority to develop alternative and varying contractual models and relations, and incentives outside of the fee-for-service structure. The Contractor must submit a copy of all base provider agreements to the Department for review and approval.

5.1.A Provider Agreements

The Department has sole discretion to approve, modify and approve, or deny network provider agreement templates used under this Contract. The Department may, at its sole discretion, impose any conditions or limitations on its approval of an agreement as it deems appropriate. As it deems appropriate, the Department may consider factors to protect the interests of the Commonwealth and its members, including but not limited to, the proposed provider's past performance.

The Contractor shall submit new network provider agreement templates at least thirty (30) days prior to their effective date for review, and upon request thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of members is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed.

Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days. The Department reserves the right to require the Contractor to modify any provider agreement templates as the Department deems necessary or based on changes in Federal or State laws or regulations.

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

- (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid Agreement) with the Department of Medical Assistance Services.
- No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Agreement.
- Any conflict in the interpretation of the Contractor's policies and MCO-Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos/bulletins, notices, and provider manuals.

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

a. Special Provisions For Certain Provider Agreements

Provider agreements with private providers of Community Mental Health Rehabilitative Services- the MHS providers are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.

Provider agreements with Virginia Community Services Boards (CSBs) shall include provisions that allow the CSB to bill under the facility NPI for qualifying practitioners in accordance with DMAS guidelines. Such guidelines apply to:

- a. Psychiatric services - CSBs can provide outpatient services as described under the Psychiatric Services Manual, Chapter 2, where qualifying providers are not required to operate under the physician-directed model for all services. CSBs have the option to can also bill as a mental health clinic in a for physician-directed modelservices. The specific requirements for physician-directed services are described in the Psychiatric Services Mental Health Clinic manual, Chapter 2.
- b. Community Mental Health Rehabilitative Services- the CSBs are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.

5.1.B Anti-Discrimination

Pursuant to Section 1932 (b)(7) of the SSA, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of

such license or certification. Additionally, consistent with 42 CFR § 438.214(c), provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include an individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision as prescribed by 42 CFR § 438.12(a)(1).

This Section shall not be construed to prohibit the Contractor from including providers only to the extent necessary to meet the needs of the organization's members; or from using different reimbursement amounts; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor. [42 CFR § 438.12(b)]

5.1.C Provider Identification Numbers (NPIs)

In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the Contractor must require each provider to have a unique identifier in accordance with the system set up under 1173(b) of the Act, including physicians, and must require that providers use these identifiers when submitting data to the Contractor.

The Contractor shall ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. Monthly, the Department produces a provider file that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider identification number for the claim and service date. The Contractor will make best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

5.2 SUBCONTRACTOR MANAGEMENT & MONITORING

The Contractor may enter into subcontracts for the provision or administration of any or all covered or enhanced services, consistent with 2 CFR § 200.331. Subcontracting does not relieve the Contractor of its responsibilities to the Department or members under this Contract. The Department shall hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor's actions and/or providers shall also be considered actions and/or providers of the Contractor, as prescribed by 42 CFR §§ 438.230(b)(1) and 438.3(k).

The Contractor must ensure that subcontractors and providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. The Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs.

The Contractor shall give the Department at least 30 calendar days advanced written notice prior to the termination of any subcontractor agreement. At a minimum, such notice shall include the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, and any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan upon request, 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 provider(s).

5.2.A Review Requirements for Subcontractors

All subcontractors must ensure the level and quality of care required under this Contract. Subcontracts for administrative and medical services in the areas of care management, planning, finance, reporting systems, administration, quality assessment, credentialing/re-credentialing, utilization management, member services/call center, claims processing, or provider services must be submitted to the Department at least thirty (30) calendar days prior to their effective date. This includes subcontracts for transportation, vision, behavioral health, pharmacy, or other providers of service. The Contractor shall submit a list of all such subcontractors and the services each provides annually to the Department, or upon request, making note of any changes to subcontracts or subcontractors. See the Managed Care Technical Manual for details.

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this Contract. Subcontracts which require the subcontractor to be responsible for the provision of covered services must include the terms set forth in the Managed Care Technical Manual and for the purposes of this Contract, a subcontractor that is a party to such a contract shall be considered both a subcontractor and a network provider. The Contractor shall adhere to subcontractor specific restrictions found herein. Please note that the use of a Third Party Administrator triggers additional requirements under Section 5.2.C.

5.2.B Delegation and Monitoring Requirements

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

- a. All subcontracts shall be in writing;
- b. Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations including applicable sub-regulatory guidance and contract provisions;
- c. Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor;
- d. Subcontracts shall provide that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract;
- e. Subcontracts shall specify that if the Department, CMS, or the DHHS Inspector General determine that there is reasonable possibility of fraud or similar risk, the Department, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the subcontractor at any time;
- f. Subcontracts shall state that the right to audit by the Department, CMS, the DHHS Inspector General, the Comptroller General or their designees will exist through ten (10) years of the final date of the contract period or from the date of completion of any audit, whichever is later;

- g. Subcontracts shall clearly state that the subcontractor must comply with member privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E; and
- h. Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate and ensure all information necessary for the reimbursement of any outstanding Medicaid claims is supplied promptly.

Monitoring Requirements

- a. The Contractor shall perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements.
- b. The Contractor shall perform a formal performance review of all subcontractors at least annually.
- c. The Contractor shall monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, member and provider identification numbers, dates of service, diagnosis and procedure codes, etc.
- d. The Contractor shall monitor the subcontractor's provider enrollment, credentialing, and re-credentialing policies and procedures to assure compliance with Federal disclosure requirements as outlined in this Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally-funded health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federally-related health care programs as described in this Contract.
- e. As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement and shall require the subcontractor to take appropriate corrective action.

5.2.C Use of Third Party Administrator (TPA)

The Contractor may utilize subcontracts with third party administrators (TPAs) for the purpose of processing claims, "back office", and other purely administrative functions. All contracts between the Contractor and its chosen TPA must be submitted to the Department for initial approval ten (10) days prior to execution, and then annually or upon amendment thereafter.

5.2.D Firewalled Staff & Facilities

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a Third Party Administrator (TPA) for additional services beyond those referenced in Section 5.2.C, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. Contractors and TPAs must provide assurances that all service level agreements with the Department will be met or exceeded.

Contractor staff must be solely responsible to the single health plan entity contracted with the Department.

5.3 PROVIDER EDUCATION AND TRAINING

The Contractor shall submit annually a comprehensive plan to ensure that all providers receive proper education and training regarding the Medallion 4.0 program to comply with this Contract and all applicable Federal and State requirements. In this submission, the contractor must include a copy of all provider training manuals and calendars for review and approval by the Department. 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.

At a minimum, the Contractor shall develop educational and training programs that cover the following topics or issues:

- All Medallion 4.0 covered services, carved-out and enhanced services, policies, procedures, and any modifications to these items;
- Eligibility standards, eligibility verification, and benefits;
- The role of the enrollment broker regarding enrollment and disenrollment;
- Special needs of members in general that may affect access to and delivery of services, to include, at a minimum, transportation needs;
- Enrollee rights and responsibilities;
- Grievance and appeals procedures;
- Procedures for reporting fraud, waste, and abuse;
- References to Medicaid manuals, memoranda, and other related documents;
- Payment policies and procedures;
- Billing instructions which are in compliance with the Department's encounter data submission requirements; and,
- Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

The Contractor shall submit annually a comprehensive plan to ensure that all providers qualified to provide EPSDT services have access to proper education and training regarding the EPSDT benefit to comply with this Contract and all applicable Federal and State requirements. In this submission, the contractor must include a copy of all provider training manuals and calendars for review and approval by the Department. The Contractor's EPSDT educational and training program will include the required topics:

- Overview of the EPSDT benefit
- Eligibility criteria
- EPSDT screenings
- Diagnostic services
- Treatment services, including EPSDT Specialized Services
- Referrals
- Clinical trials
- Required services to support access
- Beneficiary outreach and communication

- Medical necessity
- Service authorization
- Utilization controls
- Secondary review
- Intersection of EPSDT and HCBS waivers
- Notice and appeals
- Provider manuals

The Contractor will ensure EPSDT-specific training materials are updated no less than every two (2) years or on an as needed basis if the Contractor determines the provider is non-compliant with EPSDT Federal and State requirements.

5.4 PROVIDER SERVICES

5.4.A Provider Call Center

The Contractor agrees to maintain and staff a toll-free provider call center to respond to questions, concerns, inquiries, and complaints. The call center shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues and shall operate in accordance with this section and Section 5.9 of this contract. Further, the call center shall be adequately staffed with qualified personnel who are trained to accurately respond to provider questions, including questions and concerns that are specific to the Virginia Medallion 4.0 program.

For a period of at least twelve (12) months following implementation in each Medallion 4.0 region, the contractor shall implement a dedicated queue to assist providers with enrollment, service authorizations, or reimbursement questions or issues. The Contractor shall ensure that providers are appropriately notified about how to access the dedicated queue for assistance. Such period may be extended as determined necessary by the Department.

5.4.B Monitoring by the Contractor

The Contractor shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

The Contractor shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall include, at a minimum, a secured voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor shall return all messages on the next business day.

5.4.C Emergency Department Assistance Line

The contractor shall have in place a specific process for hospitals electing to refer patients with non-urgent/emergent conditions to alternative settings for treatment. This process shall allow the Emergency Department (ED) staff to 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 Contract may elect to utilize the 24/7 nurse triage line for this purpose. The total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting, as well as the referred-to resource, shall be tracked and reported as outlined in the Managed Care Technical Manual.

5.4.D Provider Satisfaction Survey

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

5.5 PROVIDER PAYMENT PROCESSING

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 CFR §§ 447.45, 447.46, 438.60, and Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered members who are enrolled with the Contractor. The Contractor must ensure that the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment. 42 CFR § 447.45 defines timely processing of claims as:

- Adjudication (pay or deny) of ninety percent (90%) of all clean Medallion 4.0 claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all Medallion 4.0 clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 CFR § 447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

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 Contractor shall ensure that members maintain balance billing protections.

The Contractor shall ensure Early Intervention, ARTS, and MHS providers are paid no less than the current Medicaid FFS rate. The Contractor shall have prior approval from DMAS before implementing an alternative payment arrangement or value-based payment that revise the payment method for MHS, ARTS, and Early Intervention Services such that the payment rate could be less than the current Medicaid FFS rate, such as a shared risk arrangement.

The Following exceptions shall apply:

- Clean claims from Mental Health Services providers, ARTS and early intervention providers shall be processed within fourteen (14) calendar days of receipt of the clean claim. The Contractor shall notify the Department forty-five (45) days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations. Any expenses incurred by the Department or its contractors to adapt to the Contractor's claims processing operational changes (including, but not limited to costs for site visits) shall be borne by the Contractor.
- The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least sixty (60%) percent of claims received from providers are submitted electronically.
- The Contractor must pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the *Code of Virginia*. Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

5.6 PROVIDER TERMINATION

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

- Procedures to provide a good faith effort to give written notice of termination of a contracted provider. Notice to the enrollee must be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. ~~within 15 calendar days after receipt or issuance of the termination notice~~ to each member who received his or her primary care from, or was seen on a regular basis by the terminated provider. [42 CFR § 438.10(f)(1)]
- Procedures to provide a good faith effort to transition PCP panel members to new PCPs at least thirty (30) calendar days prior to the effective date of provider termination;
- Procedures for the reassessment of the provider network to ensure it meets access standards established in its Contract;
- Procedures for notifying the Department within the time frames set forth in this Contract; and

- Procedures for temporary coverage in the case of unexpected PCP absence (e.g., due to death or illness).

5.6.A Notice to the Department

The Contractor shall notify the Department regarding provider terminations as set forth in this Contract and the Managed Care Technical Manual as follows:

- In advance of, or within, at least thirty (30) business days of a contract termination that could reduce Member access to care, and at least thirty (30) business days prior to implementing any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider where the termination, pending termination, or pending modification could reduce Member access to care;
- In advance of, or within five (5) business days where the provider termination would create any network deficiencies whereby the Contractor is unable to meet the Department's network time and distance standards;
- As soon as possible and no later than within forty-eight (48) hours for suspected or actual fraud or abuse;
- Immediately upon receipt of notice regarding the termination of any contracts with hospitals and health systems; and,
- As soon as possible and no later than twenty-four (24) hours upon receipt of notice, including notice to the appropriate authorities for any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license.

5.6.B Reporting on Termination of Community Mental Health Services Providers

In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, and effective July 1, 2021, the Contractor must report to the Department on a quarterly basis on the termination of MHS providers. At a minimum, the report must include:

- 1) The number of providers in their network and their geographic locations;
- 2) The total number of provider terminations by year since fiscal year 2018 and the number terminated with and without cause;
- 3) The localities the terminated providers served; and
- 4) The number of Medicaid members the providers were serving prior to termination of their provider contract.

See MCTM for full reporting requirements.

5.7 PHYSICIAN INCENTIVE PLAN

The Contractor may, at its discretion, operate a physician incentive plan only if:

- No single physician who is not practicing as part of a physician group is put at financial risk for the costs of treating a member that are outside the physician's direct control;
- No specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Member; and,

- The applicable stop/loss protection, member survey, and disclosure requirements of 42 CFR Part 417 are met.

The Contractor shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR §§ 417.479, 422.208, and 422.210, as well as compliance with Section 1903(m)(5)(B)(ii) of the Social Security Act; 42 CFR 438.700(b)(6); 42 CFR 438.726(b); 42 CFR 438.730(e)(1)(i) which requires DMAS to deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS based on the state’s recommendation, when the MCP fails to comply with the requirements for PIPs.

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

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

Additionally, the contractor shall submit the Physician Incentive Plan annually to the Department.

PIP topics are as follows:

- Clinical: Timeliness of Prenatal Care (HEDIS measure)
- Nonclinical: Tobacco Use Cessation in Pregnant Women (based on Medical Assistance with Smoking and Tobacco Use Cessation HEDIS measure)

The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Department that results from the Contractor’s or any of its subcontractors’ failure to comply with the requirements governing physician incentive plans at 42 CFR §§ 417, 434 and 1003; however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Members in the Contractor’s plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of the Department, that it has made a good faith effort to comply with the cited requirements.

The Contractor shall report annually, and upon request, whether services not furnished by physician/group are covered by PIP or incentive arrangement that includes withhold, bonus, capitation, and percent of withhold or bonus, if applicable. The report shall also include the requirements in section 42 CFR § 438.6, the percentage of the Contractor’s network providers participating in a physician incentive plan, value-based purchasing arrangements, and/or gain sharing arrangements.

In accordance with 42 CFR 438.10(f)(3); 42 CFR 438.3(i), the Contractor shall make available PIPs to members upon request.

5.8 PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS

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

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment and
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

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

5.9 PROVIDER INQUIRY PERFORMANCE STANDARDS & REPORT

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

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

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

5.10 PROVIDER ADVISORY COMMITTEE

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

conduct on-site reviews of the membership of this committee, as well as the committee's activities annually.

5.11 CONTRACTOR REFERRAL RESPONSIBILITIES

5.11.A Referral Requirements

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

- Establish referral mechanisms to link members with providers and programs not covered through Medallion 4.0 or Medicaid.
- Establish relationships with key state partners and community-based partnerships
- Maintain a current list of providers, agencies, and programs and provide that list to members who have needs for those programs; and
- Refer members to the Department for carved-out and excluded services pursuant to Section 8.5 of this Contract.
- Refer members to the Department who are transitioning to residential treatment.

In accordance with 42 CFR§ 457.1201, the Contractor shall guarantee that it will not avoid costs for services covered in this Contract by referring enrollees to publicly supported health care resources.

5.11.B Relationships with Key State Partners

The Contractor must work to establish relationships with the Department's key partners and stakeholders. The Contractor shall work to 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. Key partners and stakeholders of particular interest that are listed below:

- 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);
- Community-based partnerships (as outlined below);
- Providers (primary, specialty and acute care, community-based organizations, health systems, MHS, Early Intervention);
- Associations (provider associations, advocacy associations);
- Social Supports (community care coordination models, others);
- Other Contractors that are part of the Medallion 4.0 program (e.g., enrollment broker).

Community-Based Partnerships

The Contractor shall work to establish community-based partnerships, which may include Community Services Boards (CSBs), Local Lead Agencies (LLAs) for early intervention, Local Health Departments, Federally Qualified Health Centers (FQHCs), and Rural Health Centers (RHCs).

The Contractor must submit to the department an annual report detailing all efforts to engage key partners and establish community-based partnerships, in accordance with the Managed Care Technical Manual.

5.11.C Availability of Other State Programs and Services

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

- Head Start - The Head Start program is authorized under the Head Start Act, 42 U.S.C. § 9831 et seq., as amended;
- Lead Environmental Investigation - The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels.
- Connection for Children Program – A Virginia Department of Health program consisting of a statewide network of centers for children and youth with special health care needs (CYSHCN). These centers provide leadership in the enhancement of specialty medical services, care coordination, medical insurance benefits evaluation and coordination, management of the CYSHCN Pool of Funds, information and referral to CYSHCN resources; family-to-family support, and training and consultation with community providers on CYSHCN issues.

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

6. MEMBER ELIGIBILITY, ENROLLMENT, AND GENERAL RESPONSIBILITIES

6.1 GENERAL

6.1.A Enrollment Determination

The Department shall have sole responsibility for determining the eligibility of a member for Medallion 4.0 programs and services. The Department 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. The Contractor shall enroll and provide coverage for members as determined by the Department. In accordance with 42 CFR §438.3 (d)(1) the Contractor shall accept new enrollments from individuals in the order in which they apply without restriction, up to the limits set forth in Section 6.2.C of this Contract.

Medicaid Enrollment Broker

At least monthly, the Enrollment Broker will share with the Contractor data that its agents have regarding reasons for enrollment and disenrollment (via the Plan Change Report).

CoverVA

The Department has contracted with a firm that will provide many of the eligibility and administrative services for the FAMIS and Medicaid programs. CoverVA will facilitate enrollment in FAMIS and Medicaid, through a telephone call center, applications processing,

eligibility determinations, MCO enrollment for FAMIS members, cost-sharing monitoring, reporting, and multiple electronic interfaces. The Contractor shall designate a CoverVA liaison to assist members with MCO-related issues.

DMAS Initial Enrollment Notice

When determined eligible, DMAS shall send a letter to the individual stating that he/she is being enrolled into the Medallion 4.0 program and that he/she may pre-select a health plan.

This initial notification letter includes:

- The Member's default MCO assignment;
- Information on how to contact the Enrollment Broker;
- A "call by" date (on or before the 18th of the month) prior to the MCO effective date for the Member to make his/her health plan selection;
- An explanation that if the Member does not call the Enrollment Broker by the "call by" date, the Member will be enrolled with a default MCO, and provides the default MCO enrollment effective date.

6.1.B Contractor Responsibilities

The Contractor shall accept assignment for any eligible Member. 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.

The Contractor shall refer Members and Potential Members who inquire about Medallion 4.0 eligibility or enrollment to the Department's Enrollment Broker, although the Contractor may provide factual information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker.

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

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

The Contractor shall notify the Member of his or her enrollment in the Contractor's plan in accordance with requirements described in the Contractor's *Member Communications and Enrollment Materials*.

The Contractor shall notify the Department within two (2) business days upon learning that a Member meets one or more of the Medallion 4.0 exclusion criteria. The Contractor shall report to the Department any Members it identifies as incarcerated within two (2) business days of knowledge of the incarceration.

The Contractor shall not discriminate against, or use any policy or practice that has the effect of discriminating against, individuals eligible to enroll on the basis of health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability as specified in 42 CFR§ 438.3 (d)(3-4).

Additionally, the Contractor shall not discriminate in disenrollment and re-enrollment against individuals on the basis of health state or need for health care services as specified in 42 CFR 438.3(q)(4).

6.1.C Coverage for Services

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or loss of eligibility, except for specially manufactured DME that was prior authorized by the Contractor and certain payments using DRG Methodology, as detailed in Section 15.9. However, in cases where disenrollment is anticipated, the Contractor is responsible for the authorization and provision of all services covered under this Contract until notified of the disenrollment by the Department or its designated agent.

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

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

6.1.D Capitation Payments

The Contractor shall be entitled to a capitation payment for the member based on the recoupment/reconciliation procedures in Section 15.8 and the Managed Care Technical Manual. The Contractor shall not be entitled to payment during any month subsequent to status change determination. Capitation payments already paid by the Department for months beyond the month in which the event occurred shall be repaid to the Department in accordance with the provisions of this Contract.

6.1.E Effective Periods

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

All dis-enrollments are effective 11:59 p.m. on the last day of enrollment. If the disenrollment is the result of a plan change, it is effective the last day of the month. If the disenrollment is the result of any exclusion, it may be effective any day during the month.

6.2 ENROLLMENT

6.2.A Eligibility for Enrollment

The member will lose Medallion 4.0 eligibility upon occurrence of any of the following events:

- Death of the member;
- Cessation of Medicaid/FAMIS eligibility;
- Members that meet at least one (1) of the exclusion criteria listed in Section 6.2 of this Contract. The Department shall determine if the member meets the criteria for exclusion;
- Transfer to the Commonwealth Coordinated Care Plus Program;
- Transfer to an eligibility category not included in this Contract; or,
- Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

6.2.B Enrollment Exclusions

The Contractor shall cover all eligible members, with the exception of excluded members as defined in 12 VAC 30-120-370 B. The Department shall have sole responsibility for determining the program exclusion for these individuals. When individuals no longer meet the exclusion criteria, they shall be required to re-enroll in the Medallion 4.0 program. Members enrolled with a MCO that subsequently meets one or more of these criteria during MCO enrollment shall be excluded from MCO participation as appropriate by the Department. The Department shall, upon new state or federal laws, regulations, or Department policy, exclude other members as appropriate.

When a member for whom services have been authorized, but not provided as of the effective date of exclusion or disenrollment is excluded or dis-enrolled from the Contractor's plan and from Medallion 4.0, the Contractor shall provide to the Department or the relevant PCP the history for that member upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

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

- **Inpatient Members in State Mental Hospitals****Members who are approved by the Department as inpatients in Long-Stay Hospitals:** The Department recognizes two facilities as long-stay hospitals: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]), nursing facilities, or intermediate care facilities for the intellectually disabled.
- **Spend Down:** Members who are placed on spend-down by the Department of Social Services.
- **Home and Community-Based Waivers:** Members who are participating in home and community based Waiver Programs.
- **Commonwealth Coordinated Care (CCC) Plus:** Members who are enrolled in the CCC Plus program.
- **Outside Area of Residence:** Members, other than students, who continuously 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 another MCO.
- **Hospice:** Members who receive hospice services in accordance with Department criteria.

- **HIPP:** Members with insurance purchased through the Health Insurance Premium Payment Program.
- **Limited Life Expectancy:** Members who have been assigned to the Contractor but whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion 4.0. Requests must be made during the assignment period.
- **Inpatient Members in Hospitals At Enrollment:** Members who are inpatients in hospitals, other than those listed in 5.2.A and above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within thirty (30) calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage.
- **Birth Injury Fund:** Members who are enrolled in the Virginia Birth-Related Neurological Injury Compensation Program, commonly known as the Birth Injury Fund.
- **Limited Eligibility Period:** Members who have an eligibility period that is less than three (3) months.
- **Retroactive Eligibility:** Members who have an eligibility period that is only retroactive.
- **PACE:** Members who are enrolled in the Program of All-Inclusive Care for the Elderly (PACE) benefit.
- **Dual Eligible:** Members who are enrolled in both Medicare and Medicaid.
- Residents in Nursing Facility Operated by the Veterans Administration
- **Plan First Family Planning:** Members who are enrolled in the Plan First benefit.
- **FAMIS Select:** FAMIS Select is a voluntary component for families that have access to health insurance through their employer.
- **Medically Complex Individuals:** Individuals who are included in the Medicaid Expansion population and meet the definition of medically complex or are presumptively medically complex.

6.2.C MCO Enrollment Limit by Region

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 at 70% or below. However, the enrollment cap may be exceeded due to member-choice assignment changes, for transition of care, or other reasons as the Department deems necessary.

6.2.D Delay of Enrollment Due to Member Hospitalization

Members who are inpatients in hospitals, other than those listed in Section 6.2 of this Contract, at the scheduled time of Managed Care enrollment or who are scheduled for inpatient hospital stay or surgery within thirty (30) calendar days of the enrollment effective date are restricted from enrollment with the MCO until the first day of the month following discharge, as set forth in 12 VAC 30-120-370 B.

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

6.3 MCO ASSIGNMENT

6.3.A Intelligent Assignment

All eligible members, except those meeting one of the exclusions shall be enrolled in Medallion 4.0. The Contractor will accept assignment for any eligible member as specified in 42 CFR§ 438.3(d)(1). The effective date of enrollment shall be designated by the Department.

In accordance with 12 VAC 30-120-370 and 42 CFR §438.3(d)(1), the Department will assign each member to an MCO using a set of hierarchical assignment algorithms.

The Department may establish alternate or contingent enrollment strategies as allowed by federal waiver requirements which support transition of enrollment for new and existing populations and health plans into and from managed care. The Department reserves the right to revise the assignment methodology, as needed based upon the Department's sole discretion.

The Department reserves the right to revise this process, as needed. Members will be assigned to MCOs through system algorithms, congruent with State conflict of interest safeguards described in 1932(d)(3) of the Social Security Act. The following hierarchical assignment process will be used during routine business months:

1. Member was previously enrolled with a currently contracted MCO;
2. Member has family member(s) who is currently enrolled with a contracted MCO;
3. Member's PCP (based on available claims history) participates with a currently contracted MCO;

All remaining members (cases) who do not meet one of the above criteria will be equitably distributed between the currently contracted MCOs.

The assignment algorithm for expansion populations is as follows:

- Member has family member(s) who is currently enrolled with a contracted MCO.
- All remaining members (cases) who do not meet the above criteria will be equitably distributed between the currently contracted MCOs.

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

All assignments are prospective. There shall be no retroactive enrollment in managed care, except as necessary to establish coverage for the contractually-required birth month plus two period on newborns who are born to a mother that is enrolled in a participating MCO on the date of birth.

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

6.3.B Member Choice

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

At the time a member is assigned, an assignment letter will be generated by the Department, either confirming the pre-selected MCO or assigning the member to an MCO for enrollment. The letter will also include the enrollment broker phone number, information about the Medallion 4.0 smartphone application, a link to the Medallion 4.0 website, and instructions to contact the toll-free managed care helpline number to select an available MCO, or for assistance with questions. At that time, the member may call the enrollment broker to select a different MCO. Members are encouraged to exercise their selection choice.

The MCO shall be responsible for generating a plan membership package that includes the membership card, provider directory, and member handbook.

A member may elect to change health plans during the first ninety (90) calendar days following the effective date of enrollment for any reason. Any such change of plan shall be effective no later than the first day of the second month after the month in which the member requests disenrollment. This ninety (90) day grace period during which a member may change MCOs without cause applies to the member's initial period of enrollment.

Following their initial ninety (90) day enrollment period, members (except those classified as foster care or adoption assistance) shall be restricted to their health plan selection until the open enrollment period for their locality, unless dis-enrolled under one of the conditions described in Section 6.2 and pursuant with Section 1932 (a)(4)(A) of Title XIX.

6.3.C Open Enrollment

On an annual basis, the Department will notify members of their ability to change plans at the end of their enrollment period at least sixty (60) days before the end of that period. Those members who do not choose a new MCO will have an additional thirty (30) days from the effective date of enrollment to choose an MCO. Enrollment selections will be effective no later than the first day of the second month following the month in which the member makes the request for the change in plans. MCOs that have contractual enrollment limits shall be able to retain existing members who select them and shall be able to participate in open enrollment until contractual limits are met. Open enrollment for members of the Medicaid Expansion population (aid categories 100, 101, 102, and 103) aligns with the Federal Health Insurance Marketplace timeframe (November and December open enrollment period for a January 1 effective date).

To enable members to make informed choices related to their coverage, by October 1 the Contractor shall have posted a copy of their January 1 formulary, a finalized list of enhanced services, and updated provider directories to the member website. The posted documents can continue to be updated as needed over time, and accordingly should be labeled that they are subject to change.

6.3.D MCO Change for Cause

The member may dis-enroll from any contracted health plan to another at any time, for cause, as defined by the Department. Members shall have the right to dis-enroll from the Contractor's plan

to another Plan pursuant to 42 CFR § 438.56, as amended, or § 1903 (m)(2) A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements.

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 dis-enroll 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 dis-enroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR § 438.56(d)(2) and 12 VAC 30-120-370.

Pregnant women, who are in their third trimester of the pregnancy, may request good cause exemption to temporarily return to fee-for-service if the provider is enrolled in Medicaid FFS but not covered under any health plan. In order to be considered for good cause exemption, pregnant members shall obtain an attestation from a physician or nurse practitioner (including Certified Nurse Midwives and other Nurse Practitioners), within the third trimester, that no diagnoses are present which could increase the risk of adverse outcomes for mother or baby.

The Department will respond to “cause” requests, in writing, within fifteen (15) business days of the Department’s receipt of the request. In accordance with 42 CFR §§ 438.56(e)(1)-(2) and 438.3 (q) , if the Department fails to make a determination by the first day of the second month following the month in which the member files the request, the disenrollment request shall be considered approved and effective on the date of approval.

In accordance with 42 CFR §§ 438.3(q)(5);438.56 (c)(1); and 438.56 (c)(2), a member has the right to dis-enroll from the Contractor’s plan without cause once every twelve (12) months; upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period; when the Department imposes intermediate sanctions on the Contractor, if the member moves out of the services area, if the Contractor does not cover the services the member seeks, because of moral or religious objections; and if the enrollee needs related services to be performed at the same time, and not all related services are available within the provider network and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

Upon disenrollment, the Contractor shall notify each member in writing of their disenrollment and the effective date of disenrollment. Upon receipt of an inquiry, the Contractor should provide instructions for the dis-enrolled member to contact the Department of Social Services (DSS) with any questions regarding Medicaid eligibility. With respect to the disenrollment of newborns specified in 6.4.A, the Contractor should inform mother/parent/guardian that in order to continue the newborn’s eligibility, the mother/parent/guardian must go to DSS to obtain a Medicaid identification number for the newborn.

Provision of an enhanced service that is a service qualifying for an exclusion from Medallion 4.0 Managed Care shall not be the sole basis for dis-enrollment from and MCO.

As specified in 42 CFR § 438.56(b)(2), the Contractor may not request disenrollment because of: an adverse change in the member's health status; the member's utilization of medical services; the member's diminished mental capacity; or the member's uncooperative or disruptive behavior resulting from his or her special needs.

6.4 SPECIAL POPULATIONS

6.4.A Newborns

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

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

If this Contract is terminated in whole or in part by the Contractor, the Contractor shall continue coverage for the MCO newborn until the child is enrolled with another MCO in the Department's MMIS, or until the end of the "birth month plus two" period, whichever is earlier. Any medically necessary claims for an MCO newborn may not be denied by the MCO for any reason during the "birth month plus two (2)" period, including, but not limited to, lack of service authorizations for newborn services, timely filing issues as a result of delayed or incorrect enrollment of the newborn, medically necessary services received out of MCOs service area, or medically necessary services received from out-of-network providers.

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

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

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

Contractor shall have written policies and procedures governing the identification of MCO newborns by their network providers. The Contractor must ensure that the newborn has a Medicaid or FAMIS ID number before sixty (60) days.

The Contractor shall have the following responsibilities to ensure newborns receive a Medicaid or FAMIS ID number before the end of the birth month plus two period:

MCO Responsibilities:

1. Conduct outreach to pregnant women to track births including contacting mom at hospital once notified of the birth.
2. Submit newborn information monthly on the Live Births Report (MCTM 1.6.5).
3. Review the first 834 sent postpartum and identify newborns without Medicaid or FAMIS IDs.
4. Conduct outreach to the parents/guardians of newborns without Medicaid or FAMIS IDs.
5. Review the second 834 sent postpartum and the E213 Live Births Report.
6. If newborns are not included on second 834 or are listed on the E213 Live Births Report, complete the CoverVA electronic DMAS E-213 form available at <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderLogin>. Newborns may be enrolled as a result of deliveries by mothers covered by emergency Medicaid.
7. The notice of action will include the newborn's 12-digit Medicaid identification number and the parents/guardians will receive the daily letter that includes managed care enrollment information.

DMAS Responsibilities:

1. Upon receipt of the Live Births Report, DMAS staff research the information for two months.
2. After the second 834 sent postpartum, newborns identified without a Medicaid or FAMIS number will be forwarded to each MCO via the E213 Live Births Report.

The Contractor must also encourage contracted hospitals to submit enrollment information for newborns via the streamlined online enrollment process through the Medicaid provider web portal at <https://www.viriniamedicaid.dmas.virginia.gov/>.

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

The Contractor shall provide coverage for newborns enrolled in their health plan but the mother is not a member. Examples include newborns of mothers enrolled in CCC Plus or mothers covered by Emergency Medical Certification for labor and delivery only. These newborns are enrolled into managed care prospectively and are not subject to the birth month plus two coverage requirement.

6.4.B Foster Care & Adoption Assistance Children and Youth

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

- For decisions regarding the foster care member’s medical care, the MCO shall work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance member’s medical care, the MCO shall work directly with the adoptive parent;
- The social worker shall be responsible for all changes to MCO enrollment for children in foster care. The adoptive parent shall be responsible for all changes to MCO enrollment for children in adoption assistance. An enrollment change can be requested at any time; Coverage shall not be limited to emergency services and must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area;
- The MCO must work with DSS and the foster parent(s) or adoptive parents in all areas of care coordination;
- For decisions regarding the medical care of former foster care or Fostering Futures members (AC 070), the Contractor shall work directly with the former foster care members;
- The former foster care or Fostering Futures members (AC 070) shall be responsible for all changes regarding their MCO enrollment;
- Members in foster care and adoptions assistance are not restricted to their health plan selection following the initial ninety (90) day enrollment period.

a. Foster Care Requirements

As part of the initial and routine contact and assessment for members in foster care, the Contractor is encouraged to support the efforts of the LDSS social worker and/or the foster care parents to ensure that members in foster care receive both a PCP and a dental visit within thirty (30) days of plan enrollment, unless their social worker attests that they have recently seen a provider within ninety (90) days prior to enrollment. In the event that the member has seen a PCP and/or a dentist prior to enrollment, and the provider(s) is not in-network, the Contractor will ensure the member is established with an in-network PCP and/or Smiles for Children dentist for future ongoing care.

The Contractor shall report monthly to the Department any barriers identified in contacting and/or providing care to members in foster care. The Barrier Report will provide the Department with information to assist the Contractor in resolving the barriers reported. Refer to the Managed Care Technical Manual for Barrier Report specifications.

6.4.C Medicaid Expansion Population

The Department will transition individuals who are members of the Medicaid expansion population as described above in Section 2.2.E into the Contractor’s managed care programs based on the following assignment algorithm:

- If the expansion Member has a child in Managed Care, the member will be enrolled in the same MCO as the child.
- If the Member does not have a child in Managed Care, the member will be randomly assigned an MCO.
- Members will have 90 days to make an active choice until the next expansion open enrollment period.

6.5 MEMBER PRIMARY CARE PROVIDERS (PCP)

6.5.A PCP Assignment

The Contractor must have written policies and procedures for assigning its members to a PCP. The Contractor must submit any changes or modifications to these policies and procedures to the Department at least thirty (30) calendar days prior to implementation. Changes and modifications must be approved by the Department.

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

The Contractor must notify the member in writing, on or before the first effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

6.5.B Member Choice of PCP

In accordance with 42 CFR §§438.3(l), the Contractor shall offer each member covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the extent that open panel slots are available pursuant to travel time and distance standards described in Section 4.6.B.

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

Members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines must be permitted to choose or change from at least two (2) PCP providers. Pursuant to 42 CFR § 438.52 the Contractor must ensure that limitations, on all members who qualify under the rural resident exception, to change between primary care providers (PCP) can only be as restrictive as the limitations on disenrollment from the MCP as requested by the enrollee in accordance with 42 CFR §438.56(c).

6.5.C Providers Qualifying as PCP

Providers that qualify as PCPs include:

- Pediatricians;
- Family and General Practitioners;
- Internists;
- Obstetrician/Gynecologists;
- Specialists who perform primary care functions within certain provider classes, care settings, or facilities. This includes, but is not limited to Federally Qualified Health

Centers, Rural Health Clinics, Health Departments, Free Clinics, and other similar community clinics;

- Indian Health Providers, (as defined in this Contract), if participating in the network as a primary care provider with the capacity to provide such services, or;
- Other providers approved by the Department.

The Contractor shall have in place procedures for ensuring access to needed services for these members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

Children with special health care needs may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children for whom the PCP is a specialist receive EPSDT services, including immunizations and dental services.

6.5.D Indian Health Service (IHS) Providers

The Contractor must permit any member who is identified as an Indian to receive health care services from a participating Indian Health Provider, to choose covered services from that Indian Health Provider (as defined in this Contract), and if that Indian Health Provider participates in the network as a primary care provider, to choose that Indian Health Provider as his/her PCP, as long as the provider has capacity to provide the services as described in Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5) and Section 1932(d)(3) of the Social Security Act and 42 CFR §438.14(b)(3) The Contractor must also permit an out-of-network IHCP to refer an Indian member to a network provider under 42 CFR §438.14(b)(6).

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

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

7. MEMBER OUTREACH AND MARKETING SERVICES

7.1 GENERAL REQUIREMENTS

For the purposes of this Contract, Marketing Materials and Services as defined shall apply to members who may or may not be currently enrolled with the Contractor. All Contractors may utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf. Marketing and outreach activities shall not be included in the capitation payment rate to MCOs and shall not be a reimbursable expense to the MCOs. The Contractor shall comply with

all Department guidelines issued in relation to enhanced outreach activities for the Medicaid Expansion effort.

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

7.1.A Adequate Written Descriptions to Members

Offer its plan to members and provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for members to make an informed decision about enrollment. Pursuant to 42 CFR§ 438.104(b)(iv) the Contractor may not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

7.1.B Annual Marketing Plan

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

7.1.C Materials in Advance of Events

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

7.2 MARKETING AND INFORMATIONAL MATERIAL REQUIREMENTS

The Contractor shall submit all new and/or revised marketing and informational materials, to include apps, video and web-based media, and social media platforms, to the Department before their planned launch and/or distribution. The Department will approve, deny, or ask for modifications to the materials in writing within thirty (30) days of the date of receipt by the Department. The Contractor should not assume no response equals approval. Once approved by the Department the Contractor must use the approved version of all materials, any deviations must be resubmitted to the Department for review and approval. The Contractor must ensure that any and all marketing material, including the plan and materials once approved are accurate and do not mislead, confuse, or defraud the intended recipients or the Department. Any Contractor found to be using misleading, uncorrected, or altered marketing materials or methods shall be subject to sanctions by the Department.

7.2.A Flesch Readability Scores

The Contractor must ensure that all marketing and informational materials shall set forth the Flesch readability scores of forty (40) or better (at or below 12th grade reading level) and certify compliance therewith (See Section 7.8 “Communication Standards”).

7.2.B Sanctions

The Contractor shall be subject to fines or sanctions if it conducts marketing activities that are not approved in writing by the Department. The Contractor shall also be subject to fines or sanctions for any marketing materials or methods that are found to be inaccurate, misleading, confusing, or defrauds the intended recipients or the Department.

7.2.C Use of Electronic and Social Media

The Contractor shall submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Contractor shall also provide the Department with a description of any efforts to reach members through various social media platforms, including Facebook, Twitter, Instagram, SnapChat, and YouTube. The Contractor shall submit to DMAS all electronic addresses of all social media and video platforms as well as smartphone applications used for the Medallion 4.0 Program. The Department will not be required to review and approve electronic communications regarding unforeseen circumstances that may require action on behalf of the Contractor or members (i.e. office closings due to inclement weather, power outages, etc).

7.3 DISTRIBUTION OF MARKETING MATERIALS

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

7.4 PERMITTED MARKETING AND OUTREACH ACTIVITIES

The Contractor may engage in the following promotional activities:

7.4.A General Public

Notify the general public of the Medallion 4.0 program in an appropriate manner through appropriate media, including social media, throughout its enrollment area.

7.4.B Through the Department

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

7.4.C Pre-Approved Mail Campaigns

Pre-approved mail campaigns through the Department or its agents to regions of potential members and parents or guardians of potential members and pre-approved informational

materials for television, radio, and newspaper dissemination.

7.4.D Potential Member Request

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

7.4.E Community Sites

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

7.4.F Health Awareness/Community Events

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

7.4.G Health Screenings

Health screenings may be offered by the Contractor at community events, health awareness events, and in wellness vans. The Contractor shall ensure that receives a screening (1) is instructed to contact his or her PCP if medical follow-up is indicated and (2) receives a printed summary of the assessment information to take to his or her PCP. The Contractor is encouraged to contact the member's PCP directly to ensure that the screening information is communicated.

7.5 WELLNESS AND MEMBER INCENTIVE PROGRAMS REPORT

The Contractor shall, on an annual basis and in the manner detailed in the Managed Care Technical Manual, provide the Department with a report that summarizes all of the Contractor's wellness and member incentive programs that encourage active participation in health and wellness activities to both improve member health and control costs.

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

7.5.A Promotional Items or "Giveaways"

Offers of free, non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of \$50.00 to any prospective member or family for marketing purposes are permissible. Such items must be offered to all prospective members for marketing purposes whether or not the prospective member chooses to enroll in the Contractor's plan. The Contractor is encouraged to use items that promote good health behaviors, e.g., toothbrushes or immunization schedules.

7.5.B Member Healthy Incentives

The Contractor is allowed to offer non-cash incentives to their enrolled members for the purposes of retaining membership in, and/or rewarding healthy behavior (e.g., compliance with immunizations, prenatal visits, or participating in disease management, HEDIS or HEDIS-related measures/activities, etc.). These incentives shall be limited to \$25.00 for individual “giveaways” as stated in item “h.” above unless an approved exception is made by the Department within its discretion. Gifts of this type cannot exceed \$100.00 in any fiscal year to any one individual. For raffles or prize drawings, only one (1) special incentive drawing a year per health plan in excess of \$100.00 will be allowed. The prize has to be health related. Contractors are required to keep a database to ensure that giveaways (including gift cards) do not exceed \$50.00 per member per contract year. Incentives must be made available in equal amount, duration, and scope to the Contractor’s membership in all localities served. This incentive shall not be extended to any member not yet enrolled in the Contractor’s plan. The Contractor must submit all incentive award packages to the Department for approval prior to implementation. Non-cash incentives may include gift cards. The Contractor must have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash.

7.6 PROHIBITED MARKETING AND OUTREACH ACTIVITIES

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

7.6.A Certain Informational Marketing Activities

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

7.6.B “Cold-Call Activities”

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

7.6.C Direct Mailing

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

7.6.D Home Visits/Direct Marketing or Enrollment

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

7.6.E Financial Incentives

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

7.6.F Prospective Member Marketing

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

7.6.G Improper Use of DMAS Eligibility Database

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

7.6.H Targeting on Basis of Health Status

Engaging in marketing activities which target prospective members on the basis of health status or future need for health care services, or which otherwise may discriminate against members eligible for health care services. The Contractor may, however, direct marketing to its members about its programs for specific health status.

7.6.I Contacting Members After Disenrollment Date

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

7.6.J Marketing a Rebate or Discount

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

7.6.K DSS Offices

No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department of Medical Assistance Services. The Contractor may collaborate with local DSS agencies on mutually identified initiatives, subject to DMAS approval.

7.6.L Statements of Endorsement (Government)

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

7.6.M Enroll to Keep Benefits

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

7.6.N Renewal of Medicaid Benefits/Reason for Disenrollment

Health plans may not solicit reason for disenrollment from members leaving the Contractor's plan.

7.6.O Influence Enrollment

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

7.6.P Direct Marketing to Any Child Under Nineteen (19) Years of Age

Direct marketing to those under nineteen (19) years of age that is not expressly approved in advance by the Department.

7.7 COMMUNICATION STANDARDS

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity as detailed in 42 CFR § 440.262. The Contractor shall have mechanisms in place to help members and potential members understand the requirements and benefits of their plan as specified in 42 CFR § 438.10(c)(7).

The Contractor is required to provide all written materials for members and potential members in an easily understood language and format as specified in 42 CFR § 438.10(d)(6)(i). Additionally, under 42 CFR § 438.10(d)(6)(ii)-(iv), the Contractor is required to:

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

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

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

As set forth in 42 CFR § 438.10(d)(3), the Contractor must make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks,

appeal and grievance notices, and denial and termination notices available in languages other than English when five percent (5%) of the Contractor's enrolled population in any given Medallion 4.0 region 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 region. Per 42 CFR § 438.10(d)(1), the prevalent non-English languages spoken by the members and potential members in the State and each MCO service are to be identified by the Department and provided to the Contractor.

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

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

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

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

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

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

All enrollment, disenrollment, and educational documents and materials made available to members by the Contractor must be submitted to the Department for its review at start-up, upon revision, and upon request unless specified elsewhere in this Contract. The Contractor's Medicaid Expansion Member Materials must be pre-approved by the Department before being

made accessible to the public. The Contractor must submit its Member materials to the Department for review and approval thirty (30) days prior to initial posting and thirty (30) days prior to any substantive changes being made.

7.7.A Member Notification

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

- Oral interpretation is available for any language, and how to access those services;
- Written translation is available in prevalent languages and how to access those services;
- Auxiliary aids and services are available upon request at no costs for members with disabilities and how to access those services.

Additionally, under 42 CFR §438.10(c)(4)(ii), the Contractor is required to use Department developed member notices. A model notice template is available on the Medallion 4.0 website at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

7.8 NEW MEMBER MATERIAL REQUIREMENTS

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

7.8.A Required Membership Materials

The Contractor shall notify the Member of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the required membership materials. At a minimum, the required new member materials shall include:

a. A Welcome/Introduction Letter

b. Member Identification (ID) Card

Based upon information provided by DMAS to the Contractor in the 834 enrollment file, the Contractor shall provide to each Member a Member Identification Card prior to the Member's enrollment effective date.

The Contractor shall mail all Member ID cards as expediently as possible, but no later than five (5) business days of receipt of the mid-month 834 file, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

The Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the Member identification cards.

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

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

1. Name of the Member;
2. Member's Medicaid or FAMIS identification number;
3. Member's Contractor identification number;
4. Name and address of the Contractor;
5. Telephone number to be used to access after-hours non-emergency care;
6. Behavioral health and ARTS crisis line number (if different);
7. Instructions on what to do in an emergency;
8. Any other information needed to process claims;
9. Telephone contact information for the Smiles For Children program.

The Contractor shall submit and receive approval of the identification card from the Department prior to production of the cards. The Contractor may, but is not required to, create a separate identification card for the Medicaid Expansion population.

The Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the member's Medicaid or FAMIS identification number, first/last name, incorrect address, and correct address, if available.

c. Member Notifications

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

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

d. Formulary Information

The Contractor shall make available to members all pertinent formulary information or a separate notice on how to access this information online and how to request a hard copy.

7.8.B Network Provider Directory

The Contractor shall make available a Provider Directory, or a separate notice on how to access this information online and how to request a hard copy.

a. Content of Provider Directory

In accordance with 42 CFR § 438.10(h)(1)(i)-(viii), the provider directory must include, at a minimum, the following information for all providers in the Contractor's provider network:

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

b. Maintenance and Distribution

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

- a. Update information in its paper directory at least monthly;
- b. Update information in its online and printed directories no later than thirty (30) calendar days after receipt of provider updates;
- c. Provide either a copy, or a separate notice about how to access this information online or request a hard copy, to all new members and annually thereafter;
- d. When there is a significant change to the network, the Contractor shall send a special mailing to members;
- e. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 CFR §438.10;

- f. Consistent with 42 CFR § 438.10(f)(1), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all members who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified; and,
- g. Include written and oral offers of such provider and pharmacy directory in its outreach and orientation sessions for new members.
- h. Make available on the Contractor's website in a machine readable file and format per 42 CFR §438.10(h).

7.8.C Member Handbook

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

7.9 MAILING REQUIREMENTS FOR MEMBER ID CARDS AND NEW MEMBER PACKETS

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

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

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

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

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

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

7.10 MEMBER HANDBOOK

In accordance with 42 CFR § 438.10, the Contractor shall develop a Member Handbook that includes all required elements as defined in this Contract and in the Department-developed Medallion 4.0 model Member Handbook template (available on the Medallion 4.0 website). The Contractor's handbook shall include information about the amount, duration, and scope of benefits available under this contract in sufficient detail to ensure that members understand the benefits to which they are entitled and how to effectively use the managed care program.

The Contractor shall submit a copy of the Member Handbook to the Department for approval sixty (60) calendar days prior to distribution. The Department will respond within thirty (30)

calendar days of the date of the Department's receipt of the request. The Contractor must update the Member Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or a red-lined handbook showing before and after language. The red-lined document may be submitted on paper or electronically.

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

Any handbook changes must be approved by the Department prior to dissemination to members and shall be submitted to the Department at least sixty (60) calendar days prior to planned use. The Department will respond to changes within thirty (30) calendar days of the date of the Department's receipt of the request. If the Department has not responded to the Contractor within thirty (30) days from receipt of the Member Handbook, the Contractor may proceed with its printing schedule. The Contractor may choose to either update the Member Handbook along with other Annual Deliverables by September 30 at 11:59pm, or notify the Department by that date of another scheduled time within the Contract year for submission of the annual Member Handbook update to allow Departmental resources to be allocated for review.

If the Contractor prints and distributes a version of the handbook that was not approved by the Department, the Contractor will be required to amend and redistribute to its entire member population within thirty (30) days. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Department.

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

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

The Contractor shall modify the member handbook utilizing the model handbook guidance provided by the Department that should include, but not be limited to, the additional benefits provided to members included in the Medicaid Expansion population and the medically complex screening process. The Contractor may, but is not required to, create a separate member handbook for the Medicaid Expansion population.

7.10.A Member Handbook Contents

The Contractor shall utilize the Department's model member handbook template and ensure that the handbook includes all content as outlined in the template and prescribed by 42 CFR §438.10.

The Contractor's Member Handbook shall reflect a copy of the member rights (as referenced in this Contract) as provided at open enrollment. Under 42 CFR § 438.10(g)(2), the Handbook must provide information that enables the member to understand how to effectively use the managed care program. The Handbook shall include, at a minimum, the following information:

- The Member Handbook must include instructions advising members about EPSDT and how to access such services. [42 CFR § 438.10 (g)(2)]
- The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (CoverVA, 1-855-242-8282).

7.10.B Member Eligibility

- a. Effective date and term of coverage.
- b. Terms and conditions under which coverage may be terminated.

7.10.C Procedures to be Followed if the Member Wishes to Change MCOs

7.10.D Choosing or Changing a PCP

- a. Information about choosing and changing PCPs and a description of the role of Primary Care Providers. [42 CFR § 438.10 (g)(2)(x)]

7.10.E Making Appointments and Accessing Care

- a. A description of appointment-making procedures and appointment access standards.
- b. A description of how to access all services including specialty care and authorization requirements.
- c. The role of the PCP and the Contractor in directing care.

7.10.F Member Rights

- a. Includes the member rights and responsibilities listed in Section 7.11 of this Contract. [42 CFR §§ 438.10 (g)(2)(ix) and 438.100(b)(2)(i)-(vi)]

7.10.G Member Services

- a. A description, including the amount, duration, and scope of all available covered services, as outlined in Section 8 of this Contract, including preventive services, and an explanation of any service limitations, referral and service authorization requirements, and any restrictions on the member's freedom of choice among network providers. The description shall include the procedures for obtaining benefits, including family planning services from out-of-network providers. [42 CFR § 438.10 (g)(2)(iii)-(iv)]
- b. A description of the enhanced services that the Contractor offers.
- c. An explanation that the Contractor cannot require a member to obtain a referral before choosing a family planning provider. [42 CFR § 438.10 (g)(2)(vii)]
- d. Instructions on how to contact Member or Customer Services of the Contractor and a description of the functions of Member or Customer Services.
- e. Notification that each member is entitled to a copy of his or her medical records and instructions on how to request those records from the Contractor.
- f. Instructions on how to utilize the after-hours Medical Advice and Customer Services Departments of the Contractor. [42 CFR § 438.10 (g)(2)(v)]

- g. A description of the Contractor’s confidentiality policies.
- h. Advice on how enrolled members may acquire services that are covered under Medicaid, but not under this contract, including home and community based care waiver services as applicable. A description of these services, including how they may be accessed, is provided as Attachment I.

7.10.H Emergency Care

- a. The telephone number to be used by members for assistance in obtaining emergency care.
- b. The definition of an emergency using the “prudent layperson” standard, a description of what to do in an emergency, instructions for obtaining advice on getting care in an emergency, the fact that service authorization is not required for emergency services, and the fact that the member has the right to use any hospital or other setting for emergency care. Members are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911. [42 CFR § 438.10 (g)(2)(v)]
- c. A description of how to obtain emergency transportation and other medically necessary transportation.
- d. How to appropriately use emergency services and facilities.
- e. Information indicating that emergency services are available out-of-network without any financial penalty to the member.
- f. Definition of and information regarding coverage of post-stabilization services in accordance with 42 CFR § 422.113(c) as described in Section 8 of this Contract.
- g. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this Contract.

7.10.I Member Identification Cards

- a. A description of the information printed on the identification card, including the Medicaid/FAMIS ID number.
- b. A description of when and how to use the identification card.

7.10.J Member Responsibilities

- a. A description of procedures to follow if:
 - The member’s family size changes;
 - The member’s address changes;
 - The member moves out of the Contractor’s service area, (where the member must notify the DSS office regarding change of address and must notify the Contractor for assistance to receive care outside of the Contractor’s service area until the member is dis-enrolled);
 - He or she obtains or has health coverage under another policy or there are changes to that coverage.
- b. Actions the member can make towards improving his or her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor. [42 CFR §§ 438.10 (g)(2)(ix) and 438.100(b)(3)]
- c. Information about advance directives, such as living wills or durable power of attorney, in accordance with 42 CFR §§ 489.102, 422.128, and 438.6(i)(1).

- d. Notification of any co-payment in accordance with Section 8.1.A, if applicable, the member will be required to pay.
- e. Information regarding the member's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid.

7.10.K MCO Responsibilities

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

7.10.L Grievances and Appeals [42 CFR Part 438.10 Subpart F]

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

- a. The availability of assistance in the filing process.
- b. The toll-free numbers that the member can use to file a grievance or an appeal by telephone.
- c. A description of the continuation of benefits process as required by 42 CFR § 438.420 and information describing how the member may request continuation of benefits, as well as information on how the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
- d. The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (Managed Care Helpline, 800-643-2273, Fraud 800-371-0824 and 888-323-0587).

7.10.M Interpretation and Translation Services

- a. Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42 CFR § 438.10(c)-(d)]
- b. A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services. [42 CFR § 438.10(c)-(d)] As the size of the Contractor's non-English speaking member population attains the threshold specified in Section F for translation of the member handbook into a language other than English, the Contractor shall be responsible for such translation as required by Section 7. Some of this information may be included as inserts in or addenda to the Member Handbook. As the member handbook is translated into other languages, the Contractor shall provide a language appropriate copy to all such non-English speaking members.
- c. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments. [42 CFR § 438.10(d)]

7.10.N Program Referral and Service Changes

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

7.10.O MCO Plan Formulary

While not required to be contained within the member handbook, under Section 8.7 of this Contract, in accordance with 42 CFR §§438.10(h) and 438.10(i)(1)-(3), the Contractor shall make available in electronic or paper form, the following information about its formulary:

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

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

7.11 MEMBER RIGHTS

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

At a minimum such member rights include the right to:

7.11.A Receive Information

Receive information in accordance with 42 CFR § 438.10 as described in Section 5 and Section 8 of this Contract.

7.11.B Respect

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

7.11.C Information on Available Treatment Options

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

7.11.D Participate in Decisions

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

7.11.E Be Free From Restraint/Seclusion

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

7.11.F Request/Receive Medical Records

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

7.11.G Free Exercise of Rights

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

7.11.H Health Care Services

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

7.12 MEMBER ADVISORY COMMITTEE

In accordance with 42 CFR §438.110, the Contractor shall establish a Member Advisory Committee that will provide regular feedback to the Contractor on issues related to Medallion program management and member care. The Contractor shall ensure that the Member Advisory Committee (1) meets at least twice annually and (2) is comprised of a reasonably representative sample of the Medallion members, or other individuals representing members. The Contractor shall include, within their Member Advisory Committees, a mechanism for feedback on the Contractor's programs related to maternal, child, and women's health. The Department reserves the right to review and approve Committee Membership.

7.13 ADVANCED DIRECTIVES

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

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

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

Under 42 CFR § 438.3(j)(1) and (2), the Contractor must maintain written policies and procedures on advance directives for all adults receiving medical care by or through the Contractor. Additionally, the Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive. Further, in accordance with 42 CFR §489.102(a)(5) the Contractor shall educate staff concerning their policies and procedures on advance directives.

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

7.14 CULTURAL COMPETENCY

The Contractor must demonstrate cultural competency in its dealings, both written and verbal, with members and providers.

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

7.15 MEMBER SERVICES

7.15.A Member Services Call Center

The Contractor agrees to maintain a toll-free Member Services Call center to be responsible for the following:

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

7.15.B Call Center Components

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 Medallion 4.0 program. It is the Contractors' responsibility to maintain up to date and accurate program specific information for call center staff to reference at all times.

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.

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

- General customer service (available 8:00am - 8:00pm, seven (7) days a week. Alternative technologies may be used after 8:00 pm, on Saturdays, Sundays, and State of Virginia holidays);
- Provider services and coverage determinations (available 8:00am - 6:00pm, Monday through Friday);
- Nurse triage/nurse advice line (available 24 hours per day; 7 days per week);
- Behavioral health crisis line (available 24 hours per day; 7 days per week);
- Care coordination support (available 24 hours per day; 7 days per week);
- 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.

7.15.C Specific Standards

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

a. Call Recording Technology

The Contractor shall record one hundred percent (100%) of incoming calls to its member and provider helplines using up-to-date call recording technology. Call recordings must be searchable by provider NPI, Member ID Number # (if available) and date and time of the call. Recordings will be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call.

b. Abandonment Rate & Call Center Statistics

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

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

c. Interactive Voice Response (IVR)

For the initial call to the call center(s), the Contractor may employ an answering service or use an interactive voice response (IVR) system to route calls. The Contractor's IVR system shall provide an option for crisis or emergency calls and direct the caller immediately to an appropriate representative. These calls, when transferred from the initial IVR, shall not go to another answering service or IVR.

The Contractor shall ensure that any line that receives crisis or emergency calls must be staffed by appropriate clinical staff. If the Contractor determines that the call is not an emergency, the caller may be informed the line is reserved for emergencies only and the caller may be transferred back through the standard phone line for assistance from the next available representative.

7.16 OUTREACH TO MEDICAID EXPANSION POPULATION

The Contractor shall comply with all Department guidelines issued in relation to enhanced outreach activities for the Medicaid Expansion effort.

7.16.A Outreach to Homeless Population

The Contractor shall collaborate with the Department to develop referral and assistance policies and procedures that identify homeless members enrolled in the Contractor's managed care program and provide them with information on community services.

7.16.B Services for Justice-Involved Members

The Contractor shall collaborate with the Department to develop policies and procedures for the screening and provision of care for Medicaid members who have been identified as recently released from a correctional facility or local/regional jail. These policies and procedures should address the following: 1) assisting the member with accessing care and/or community supports as needed, 2) partnering with community resources to facilitate referral networks, and 3) developing reports that include methods for identifying and removing barriers to care and addressing additional needs expressed by the member. Plans, policies, and procedures will be submitted annually to DMAS for approval according to specifications in the MCTM.

7.17 MEMBER EDUCATION PROGRAM

The Contractor must develop, administer, implement, monitor, and evaluate a program to promote health education services for its new and continuing members, as indicated below. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch total readability score of forty (40) or better (at or below a 12th grade education level). (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

The Contractor shall maintain a written plan for health education and prevention that is based on the needs of its members. The Contractor shall submit a health education and prevention plan to the Department sixty (60) calendar days prior to signing original contract, ten (10) business days prior to any published revision, and within ten (10) business days of receiving a request. At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual, or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Department prior to implementation.

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

8. BENEFIT SERVICE REQUIREMENTS AND LIMITS

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase, or otherwise make available all services required under this Contract to all of its members. (A chart summarizing covered services, carved-out services, and non-covered services is provided in Attachment I to this Contract.) Please note that the Contractor must permit any member who is identified as an Indian to receive health care services from a participating Indian Health Provider, to choose covered services from that Indian Health Provider (as defined in this Contract). Contractor should adhere to all special payment terms found in Section 15, Financial Statements, Information, Reporting and Payments.

8.1 GENERAL PROGRAM INFORMATION

8.1.A Cost-Sharing

In accordance with Federal regulations at 42 CFR § 447.56 and by the Department's directive, the Contractor shall not impose any cost-sharing for Medicaid services. Cost sharing requirements for the FAMIS program are detailed in Attachment XIV.

8.1.B Coverage of Authorized Services

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

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

If the authorized service is an inpatient stay, the financial responsibility shall be allocated as follows:

- For per diem provider contracts, reimbursement will be shared between the Contractor and either the Department or the new MCO. In the absence of a written agreement otherwise, the Contractor and the Department or the new MCO shall each pay for the period during which the member is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment.
- For DRG provider contracts, in accordance with Section 15, the Contractor is responsible for paying the full inpatient hospitalization (admission to discharge), including for any member actively enrolled in the MCO on the date of admission, regardless of the members' disenrollment from the MCO during the course of the inpatient hospitalization.

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

8.1.C Modification in Scope of Covered Services During a Contract Year

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

8.1.D Utilization Management/Authorization Program Description

The Contractor shall authorize, arrange, coordinate, and provide to members all medically necessary covered services as specified in this Contract in accordance with amount, duration, and scope of coverage rules described in the attached Medallion 4.0 Coverage Chart. Service authorizations for pharmacy must not exceed one year in duration, and for all other services must not exceed two (2) years in duration.

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

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

The Contractor shall work with the Department and the other contracted MCOs to establish review criteria and to study the scope of underutilization for children. The study shall include the following components:

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

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

In accordance with 42 CFR § 438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's medical, behavioral health, and supports needs. Additionally the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §

438.910(d) and 438.3(n)(1). In accordance with 42 CFR § 438.210(c), the Contractor shall notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. In accordance with 42 CFR §438.915, in the case of denial by the Contractor of reimbursement or payment for services for mental health or substance use disorder benefits, the reason for denial must be made available by the MCO to the member. Notices must meet the requirements outlined in Section 7 of this Contract.

The following timeframes for decision requirements apply to service authorization requests, per 42 CFR § 438.210:

a. Standard Authorization Decisions

For standard authorization decisions, the Contractor shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if (1) the member or the provider requests extension or (2) the Contractor justifies to the Department upon request that the need for additional information per 42 CFR §438.210(d)(1)(ii) is in the member's interest.

b. Expedited Authorization Decisions

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

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

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

The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Reference Section 8.7 for provisions regarding authorizations for prescription drugs and Section 8.2.E for provisions regarding authorizations for MHS services.

c. Extending Timeframe for Service Authorization Decision

In accordance with 42 CFR § 438.404(c)(4), if the Contractor meets the criteria set forth for extending the timeframe for standard authorization decisions consistent with 42 CFR § 438.210(d)(1)(ii), it must:

- Give the Member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and,
- Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d. Service Authorization Data Requirements

The Contractor shall:

1. Collect and maintain 100% of all service authorization data for services authorized, pending, or denied for members.
2. Ensure that service authorization data includes utilization data for all claims associated with services provided pursuant to the specific authorization.
3. Submit complete, timely, reasonable, and accurate service authorization data to the Department no less than weekly, and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in the MCTM.

e. UM Requirements for Mental Health Parity

At initial contract, annually, upon revision (if any) and upon request, the Contractor shall submit all applicable policies and procedures to the Department for review and approval regarding its UM program. The policies and procedures shall include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. In accordance with 42 CFR § 438.210, the Contractor's UM program must ensure consistent application of review criteria for authorization decisions and must consult with the requesting provider when appropriate. The program shall demonstrate that members have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the members.

8.1.E Medical Necessity

The Contractor shall cover medically necessary services, as defined in this Contract, and in accordance with 42 CFR § 440.230, State Plan for Medical Assistance (State Plan), the Family Access to Medical Insurance Security Plan as amended and as further defined by written Department policies (including agreements, statements, provider manuals, Medicaid memorandums/bulletins, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures.

The actual provision of any service is subject to the professional judgment of the Contractor's providers as to the medical necessity of the service, except in situations in which the Contractor must provide services ordered by the Department pursuant to an appeal from the Contractor's grievance process or an appeal directly to the Department by a member or for emergency services as defined in this Contract. Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness and the application of EPSDT criteria (for those under age twenty-one (21)). Disputes between the Contractor and members about medical necessity may be appealed to the Department by the member or the member's representative, in accordance with the Appeals requirements specified in Section 12.

At a minimum, medical necessity guidelines, program specifications and service components for services must be submitted to the Department 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. In accordance with 42 CFR §438.915, the Contractor must make medical necessity criteria for mental health and SUD benefits available to any member, potential enrollee or contracting provider upon request.

The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Coverage decisions that depend upon prior authorization and/or concurrent review to determine medical necessity must be in accordance with industry practice and shall be supervised by qualified medical professionals and completed within a reasonable period of time after receipt of all necessary information. The Contractor shall assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions.

8.1.F Coordination of Care Provisions

a. General

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

b. Care Coordination Staffing Requirements

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 Contractor shall establish care coordination staffing ratios that ensure compliance with all required care coordination activities required under this program. 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 this Contract. The Contractor must maintain an adequate ratio of care coordination staff to population as illustrated in the chart below:

Medallion 4.0 Care Coordination Staffing Ratios by Populations		
Medallion 4.0 Target Populations	Vulnerable Subpopulations	
Required Care Coordinator Ratio	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.

The Contractor shall ensure that care coordinators working with foster care, former foster care and adoption assistance members have specific competencies to address those program needs, respectively, as outlined by the Department. The Contractor shall comply with all care coordination reporting requirements as outlined in the Managed Care Technical Manual and requested by the Department.

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

The Contractor must ensure that 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 this Contract. The Department reserves the right to revise care coordinator ratios for additional populations, as appropriate. The Department may, at its discretion, consult with the Contractor regarding any changes to care coordinator ratios.

c. Primary Care

In accordance with 42 CFR §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.

d. Coordination/Prevention of Duplicate Services

The Contractor’s system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities and must comply with 42 CFR 438.208(b)(4) by submitting care

coordination activity by member to the state in a monthly report to prevent duplication of services as specified in the MCTM.

e. HIPAA, Member Privacy, and Health Records

The Contractor shall ensure that the process utilized to coordinate the member's care complies with member privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E, to the extent applicable.

Under 42 CFR § 438.208(b)(6), the Contractor shall ensure that each provider furnishing services to the member maintains and shares a member health record in accordance with professional standards.

f. Clinically Qualified Providers

The Contractor's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The Contractor shall submit to the Department prior to signing the initial contract, upon revision or on request, referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

g. Communication for Members with Disabilities

The Contractor shall require their contracted providers to ensure that members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.

h. List of Referral Sources

The Contractor shall develop and maintain a list of referral sources which includes community agencies, state agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, MCOs shall provide discharge planning and/or coordination with long-term care service providers for members who are being enrolled in home and community based care waivers or nursing facilities to assure continuity of care.

i. Coordination Procedures

In accordance with 42 CFR§ 438.208(b), the Contractor must implement procedures to coordinate:

- The services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
- The services the Contractor furnishes to the member with the services the member receives from any other MCO;
- The services the Contractor furnishes to the member with the services the member receives in fee-for-service Virginia Medicaid;

- The services the Contractor furnishes to the member with the services the member receives from community and social support providers.

j. Case Management

The Contractor shall provide case management to its membership. Case management shall be provided through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise. The Contractor shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor, as outlined in section 3.6.D of this contract. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Medicaid members' case management needs at all times. In accordance with 42 CFR § 438.66, the Contractor must submit medical management committee reports and minutes to the Department.

k. Case Management for Foster Care and Adoption Assistance Members

The Contractor shall coordinate the unique needs of members in foster care and adoption assistance through the provision of trauma-informed case management services. These services will be provided by a professional licensed in a behavioral health discipline, including those trained in trauma informed care. Case management staff are encouraged to have competencies in child placement services through both a legal and behavioral health lens and trauma-informed clinical practice.

Case management services shall be provided for every member in foster care and shall include navigating their unique logistical needs. To ensure the best utilization of care, the Contractor shall provide case management services that include outreach and education on medical and behavioral health benefits and the services provided by the Contractor for foster care parents. Care coordination for members in foster care shall be done in conjunction with the Contractor's case management staff, the Department, foster care case workers at Local Departments of Social Services and the foster care parents, as applicable. The Contractor shall also complete a health assessment for each member in foster care in accordance with the standard set forth in this contract.

The Contractor shall provide coverage for trauma-informed therapeutic counseling services for members in foster care and adoption assistance and their families, as requested by adoptive families. The Contractor shall ensure that case management staff have access to referrals for local trauma-informed therapy services as available and applicable depending on region. Case managers coordinating care for members in adoption assistance shall provide resources to support adoptive families to the extent needed and as requested by the adoptive parents.

The Contractor shall coordinate with LDSS on new Post-Adoption Case Management (PACM) Services for members in adoption assistance. PACM will provide families with 12 months of case management services after the finalization of an adoption from foster care. Families will automatically be referred to PACM by the VDSS Adoption Negotiator and families may start services right away or they can enroll at a later date when needed.

I. Assessments

In accordance with 42 CFR§ 438.208(b)(3), the Contractor shall make every reasonable 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. The Contractor shall make subsequent attempts to conduct an initial screening of each new member's needs if the initial attempt to contact the member is unsuccessful.

8.1.G Transition of Care Provisions

The Contractor shall develop transition of care policies and procedures to ensure interruptions in covered services do not occur for enrollees. The policies and procedures must include the information below. During the time period set below, the Contractor agrees to maintain the enrollee's current providers at the Medicaid FFS rate and honor service authorizations 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 thirty (30) calendar days, or where services are authorized, for the duration of the service authorization or thirty (30) calendar days, whichever comes first. During the thirty (30) day transition 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 30 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 transition 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 30-day period, the Contractor shall choose one for the enrollee. The Contractor shall offer single-case agreements to providers who are not willing to enroll in the Contractor's provider network.

The Contractor shall provide a continuity of care period of 30 days for new populations such as the Medicaid Expansion populations, including those with out-of-network providers in accordance with the requirements in this Contract.

The Medicaid Expansion population shall maintain their MCO enrollment when they transition between the CCC Plus Program and the Medallion 4.0 program without being enrolled in Fee-For-Service Medicaid. As stated above, continuity of care for transitions between Fee-For-Service and MCO's or between MCO's is 30 days.

The Contractor must honor any Fee-For-Service authorizations before enrolling members of the Medicaid Expansion population in the Contractor.

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 transition 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.

a. Pharmaceutical Services

For pharmaceutical services, the Contractor shall ensure that Members can continue treatment of medications prescribed or authorized by DMAS or another Contractor (or provider of service) for at least thirty (30) calendar days or through the expiration date of the active service authorization including service authorizations approved by DMAS' Drug Utilization Review (DUR) Board. This would not preclude the health plan from working with the Member and his or her treatment team to resolve polypharmacy concerns. Additionally, at the time of enrollment, if a Member is receiving a prescription drug that is not on the Contractor's formulary or PDL, that member shall be permitted to continue to receive that drug, if medically necessary.

8.1.H Complex Care Management Programs Minimum Requirements

The Contractor must have, at a minimum, complex care management programs that focus on identifying and improving the health status of members diagnosed with the following conditions:

1. Respiratory Conditions such as Asthma & Chronic Obstructive Pulmonary Disease (COPD) (pediatrics and adults),
2. Heart disease, including Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF),
3. Diabetes (pediatrics and adults),
4. Mental/Behavioral Health conditions,
5. Cancer,
6. Children and Youth with Special Health Care Needs

a. Complex Care Management Plan Submission to the Department

The Contractor must submit to the Department, on September 30th of each contract year, a document outlining the approach taken to address individuals with the conditions listed above. The Complex Care Management Plan must include the following elements:

1. A description of how the Contractor identifies the members with the identified focus conditions,
2. A description of any predictive modeling techniques employed by the Contractor,
3. A description of how success is measured in the program (HEDIS outcomes and non-HEDIS outcomes), and other measures that may include such things as: member

- satisfaction, decreased utilization of avoidable, inappropriate, and/or unnecessary services such as hospital readmissions, unsuitable emergency department use, preventable hospitalizations related to the chronic disease(s) at issue, etc.,
4. A description of how and why the program has or has not been successful under that definition, and
 5. A description of any successful measures employed by the Contractor in another state (Commercial or Medicaid lines of business), and a brief justification as to whether these measures could be successfully utilized by the Commonwealth.

8.1.I Required Reform Initiatives

The Contractor shall report to the Department efforts to promote appropriate utilization of hospital emergency department services. This may include incentives the Contractor provides to primary care practices that provide night and weekend hours and same-day appointments, advanced levels of care management for those exhibiting high utilization of emergency services, use of the ED Care Coordination encounter alerts, and shared care coordination plans by MCO care coordinators to identify frequent ED utilizers and address their needs. Refer to the MCTM for all applicable reporting criteria.

8.1.J Moral or Religious Objections

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

a. Information Requirements

The Contractor must furnish information about the services it does not cover, subject to DMAS approval:

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

8.1.K Notification to the Department of Sentinel Events

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

8.1.L Out-of-Network Services

- a. The Contractor shall cover, pay for, and coordinate all care that it has pre-authorized and provided out of its established network. Out-of-network claims must be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the Contractor and the provider of services.
- b. The Contractor shall cover and pay for emergency and family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract.

- c. The Contractor shall cover, pay for, and coordinate care rendered to members by out-of-network providers when the member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract.
- d. The Contractor shall cover and pay for services furnished in facilities or by practitioners outside the Contractor's network if the needed medical services or necessary supplementary resources are not available in the Contractor's network.
- e. The Contractor must provide out-of-network coverage for any of the following circumstances:
 - a. When a service or type of provider (in terms of training, experience, and specialization) is not available within the MCO's network,
 - b. Where the MCO cannot provide the needed specialist within the contract distance standard of more than thirty (30) miles in urban areas or more than sixty (60) miles in rural areas,
 - c. For members other than those residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the Contractor must provide out-of-network coverage for up to thirty (30) days to transition the member to an in-network provider when a provider that is not part of the MCOs network has an existing relationship with the member, is the member's main source of care, and has not accepted an offer to participate in the MCOs network,
 - d. When the type of provider needed and available in the MCOs network does not, because of moral or religious objections, furnish the service the member seeks,
 - e. When the Department determines that the circumstance warrants out-of-network treatment.

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

- a. When a provider is not a part of the Contractor's network, but is the main source of a service to the member, provided that:
 - i. The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type;
 - ii. If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider within thirty (30) days (after being given the opportunity to select a provider who participates);
- b. The member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

8.1.M Mental Health or Substance Use Disorder Out-of-Network Benefits

In accordance with 42 CFR § 438.910(d)(3), the Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more

stringently than, the processes, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

8.1.N Out-of-State Services

The Contractor is not responsible for services obtained outside the Commonwealth except under the following circumstances:

- a. Necessary emergency or post-stabilization services,
- b. Family planning where it is a general practice for members in a particular locality to use medical resources in another State,
- c. The required services are medically necessary and not available in-network and within the Commonwealth.
- d. While the MCO is honoring a transition of care plan authorized by the Contractor, another MCO, or the Department until services can be safely and effectively transitioned to a provider in the MCO's network within the Commonwealth.
- e. Further, direct and indirect payments to out-of-country individuals and/or entities are prohibited pursuant to Section 6505 of the Affordable Care Act and State Medicaid Director Letter (SMD# 10-026).

8.1.O Patient Utilization Management & Safety (PUMS) Program for Members

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

a. PUMS Program for ARTS

The Contractor shall develop an ARTS specific PUMS program in accordance with the requirements outlined below.

b. Placement into a PUMS Program

Members may be placed into a PUMS program for a period of twelve (12) months when **any** of the following triggering events occur:

1. The Contractor's utilization review of the member's past twelve (12) months of medical and/or billing histories indicates the member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications found in the ARTS Technical Manual.
2. At the end of the twelve (12) month period, the member must be re-evaluated by the Contractor to determine if the member continues to display behaviors or patterns that indicate the member should remain in the PUMS Program.
3. The Contractor is encouraged to utilize the Prescription Monitoring Program (PMP), described in Section 8.7 of this Contract, when evaluating PUMS members.

4. Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

c. PUMS Program Details

Once a member meets the requirements for PUMS placement, the Contractor may limit a member to a single pharmacy, primary care provider (PCP), controlled substances prescriber, hospital (for non-emergency hospital services only) and/ or, on a case-by-case basis, other qualified provider types as determined by the Contractor and the circumstances of the member. The Contractor shall limit a member to providers and pharmacies that are credentialed in their network. The Contractor shall submit the PUMS report using specifications as outlined in the ARTS Technical Manual.

If the member changes from another health plan to the Contractor's health plan while the member is enrolled in a PUMS, the Contractor must re-evaluate the member for the PUMS program within thirty (30) days to ensure the member meets the minimum criteria above for continued placement.

d. PUMS Placement Criteria

- **(PUMS1) Opioid Use Disorder (OUD) Case Management:** the Contractor may review any members receiving OUD and provide case management.
 - Members with a history of opioid overdose(s) in the past three (3) years; ED visits, inpatient hospitalizations, or inpatient rehabilitation stays related to OUD in the past three (3) years; pregnant women with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate;
 - Clinical expertise and judgment shall be used to identify and manage any members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").
- **(PUMS2) High Average Daily Dose:** \geq ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,
- **(PUMS3) Opioids and Benzodiazepines concurrent use** – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order),
- **(PUMS4) Doctor and/or Pharmacy Shopping:** \geq three (3) prescribers OR \geq three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,
- **(PUMS5) Use of a Controlled Substance with a History of Dependence, Abuse, or Poisoning/Overdose:** any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Misuse or Dependence in the past three hundred and sixty-five (365) days,
- **(PUMS6) History of Substance Use, Abuse or Dependence or Poisoning/Overdose:** any Member with a diagnosis of substance use, substance misuse, or substance dependence on any new claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

e. Temporary Change to PUMS Status

At the discretion of DMAS or its Contractor, members identified as eligible for the PUMS program may be required to use one pharmacy of their choice. If they are referred to an ARTS Residential Treatment Facility, and need to continue medication

management via a single pharmacy, the Residential provider shall contact the MCO to request the pharmacy be updated to one that the Residential provider utilizes, so that the member may continue the current medical regimen. Provider may contact the health plans and the Contractor to update the member's preferred pharmacy while member is in the residential treatment program.

Upon discharge from the Residential Treatment Facility, the provider shall notify the member's MCO of the discharge so that the member's pharmacy provider may be updated based on the member's choice and proximity to their place of discharge. This task shall be included in the discharge planning process.

f. PUMS Member Rights Notifications and Requirements

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

- A brief explanation of the PUMS program;
- A statement that the Member was selected for placement into the program;
- An explanation that the decision is appealable;
- A statement that the Contractor shall provide appeals rights to members placed in the PUMS Program, information regarding how the member may submit an appeal request to the Contractor, the member's right to directly request a State Fair Hearing after first exhausting the Contractor's appeals process, and information regarding how the member qualified for the PUMS based on the minimum criteria;
- A statement clearly outlining the provisions for emergency after hours prescriptions if the member's selected pharmacy does not have 24-hour access; and,
- A statement indicating the opportunity and mechanisms by which the member may choose a pharmacy, primary care provider, controlled substance provider, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types. The language must clearly state that if the member does not select the relevant providers within fifteen (15) calendar days of enrollment into the PUMS program, the Contractor may select one for the member.

g. PUMS Reporting Requirements

DMAS will collect reliable and valid data from the Contractor to enable reporting of the ARTS specific metrics to the Centers for Medicare and Medicaid Services (CMS). ARTS metrics are listed in the ARTS Technical Manual. The Department has authority to add and remove ARTS specific metrics. The Contractor shall also be able to report these measures, as specified in the ARTS Technical Manual.

Annually, upon revision (if any) and upon request, the Contractor shall submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as substance use treatment services, etc.).

8.1.P Electronic Visit Verification (EVV) System

DMAS shall require agency-directed providers that bill for personal care services to use an EVV system that will electronically verify and collect data that meets the requirements consistent with

the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). At a minimum, the EVV shall capture in real-time the following data elements for agency-directed personal care and respite services:

1. Type of service performed
2. The member receiving the service
3. Date of service
4. Time the service begins and ends
5. The location of service delivery at the beginning and the end of the service
6. Employee providing the service

The Contractor must ensure that the provider's EVV systems shall:

1. Securely transmit all EVV raw data elements to the Contractor.
2. Limit authority to modify changes and modifications to service entries. In the event the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the attendant's hours. For agency-directed providers, this may be a supervisor or the agency owner or designee who has authority to make independent verifications.
3. Support real time access to Members (if Member authentication is used) and providers.
4. Be compliant with the requirements of the ADA (as amended, 42 USC § 12101 et seq.) and HIPAA (P.L. 104-191).
5. Retain EVV data for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved. Policies regarding retention of records shall apply even if the provider discontinues operation.

Effective January 1, 2021, attendants with a live-in status are exempt from EVV requirements. The Contractor's F/EA shall have a process approved by DMAS and systems edits in place to identify attendants with a live-in status and reside at the same address as the Medicaid member receiving care. The Contractor's F/EA shall verify and collect proof of residence documentation for all attendants with a live-in status.

The Contractor's claim processing system shall have edits in place that prevent claims for services that are not electronically verified and documented using an EVV system.

The Contractor shall submit EVV encounter data to the Department in a format as defined by the Department. For technical assistance on submission of EVV encounters refer to the Encounter Processing System (EPS) Medicaid Enterprise Encounter (MES) Companion guide (<https://eps.dmas.virginia.gov/epsportal/#/guides>) For 837 Professional Health Care and Transportation Encounter Transactions.

8.1.Q Court-Ordered Services

The Contractor shall cover all court-ordered medical services covered under this contract. In the absence of a provider contract, out-of-network payments will be made in accordance with the

Medicaid fee schedule.

8.1.R Second Opinions

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

8.1.S Mental Health Parity

Alignment with State Plan

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

Annual and Lifetime Dollar Limits

Pursuant to 42 CFR §438.905(b), if the Contractor does not include an aggregate lifetime or annual dollar limit on any M/S benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder (MH/SUD) benefits.

Non-Quantitative Treatment Limits (NQTs)

In accordance with 42 CFR §438.910(d), the Contractor may not impose NQTs for MH/SUD benefits in any classification (inpatient, outpatient, emergency care or prescription drugs) unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQT to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for M/S benefits in the classification. See 42 CFR §438.910(d)(2) for an illustrative list of NQTs.

Application Across Classifications

In accordance with 42 CFR §438.910(b)(2), if an enrollee of the Contractor is provided MH/SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), the MH/SUD benefits must be provided to the member in every classification in which M/S benefits are provided. This does not preclude the Contractor from limiting coverage for M/S and MH/SUD services on the basis of medical necessity.

Access to Out-Of-Network Providers

In accordance with 42 CFR 438.910(b)(2), if an enrollee of the Contractor is provided behavioral health benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), the behavioral health benefits must be provided to the member in every classification in which medical/surgical benefits are provided.

Financial Requirements and Quantitative Treatment Limitations

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

Mental Health Parity Reporting

As requested, the Contractor is required to provide documentation and reporting necessary to establish and demonstrate compliance with MHPAEA (42 CFR § 438, subpart K) regarding the provision of MH/SUD benefits. Specific reporting requirements will be described in the Managed Care Technical Manual.

The Contractor shall utilize the following DMAS' definitions for purposes of mental health parity reporting and compliance assurance activities:

- a. MH/SUD Services: services for the conditions listed in ICD-10-CM, Chapter 5 “Mental, Behavioral, and Neurodevelopmental Disorders” with the exception of:
 - The conditions listed in subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09).
 - The conditions listed in subchapter 8, “Intellectual disabilities” (F70 to F79).
 - The conditions listed in subchapter 9, “Pervasive and specific developmental disorders” (F80 to F89).
- b. M/S Services: services for the conditions listed in ICD-10-CM Chapters 1–4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6–20.
- c. Benefit Classifications:
 - Inpatient services: all covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a >24-hour admission to a facility.
 - Outpatient: all covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable) order/certification for a >24-hour admission, and does not meet the definition of Emergency Care (EM). This includes observation bed services for up to 23-hours.
 - Emergency Care: all covered services or items (including medications) provided in an emergency department setting or to stabilize an emergency/crisis, when provided in a setting other than in an IP setting.
 - Prescription Drugs: covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

8.1.T At-Risk Populations

a. Health Equity

The Contractor shall consider the importance of health equity and disparities among populations in developing its various programs to provide services to Medallion 4.0 members. The Contractor must submit an annual report to the Department outlining its

efforts to address health disparities for the Medallion 4.0 population. The Contractor may refer to the Virginia Department of Health’s Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

b. Protection of Children and Aged or Incapacitated Adults

Suspected or Known Child Abuse or Neglect - Immediately upon learning of any suspected or known abuse of a child, the Contractor shall report it to either (1) the local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred or to (2) the Virginia Department of Social Services’ toll-free child abuse and neglect hotline:

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

Suspected or Known Abuse of Aged or Incapacitated Adults – In accordance with Section 63.2-1606 of the Code of Virginia, immediately upon learning of any suspected or known abuse of aged or incapacitated adults, the Contractor shall report it to (1) the local adult protective services office or (2) the Virginia Department of Social Services’ toll-free Adult Protective Services hotline at: (888) 832-3858.

8.2 COVERED SERVICES

The Contractor shall provide, arrange for, purchase, or otherwise make available the full scope of services, with the exception of the carved-out services defined in Section 8.5 and other exceptions noted herein to which persons are entitled under the State Plan for Medical Assistance (State Plan) and State Children’s Health Insurance Plan, as amended, and as further defined by written Department policies (including, but not limited to, agreements, statements, provider manuals, Medicaid memorandums/bulletins, instructions, or memoranda of understanding), and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Brief descriptions of covered services are provided herein.

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

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

1. The Contractor shall provide services for adult members and members under the age of twenty-one (21) at minimum to the same extent that services are furnished under fee-for-service Virginia Medicaid;
2. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member;

3. The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose;
4. The Contractor shall ensure that coverage decisions for individuals with ongoing or chronic conditions are authorized in a manner that fully supports the member's ongoing need for such services and supports and considers the member's functional limitations by providing services and supports to promote independence and enhance the member's ability to live in the community;
5. The Contractor shall ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20;
6. The Contractor shall ensure that services deemed medically necessary are authorized in a manner that supports:
 - f. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder, health impairments and/or disability,
 - g. Ability for a member to achieve age-appropriate growth and development,
 - h. Ability for a member to attain, maintain, or regain functional capacity in the case of EPSDT, correct, maintain or ameliorate a condition. Coverage decisions that depend upon service authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the requirements described in this Contract.

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

8.2.A Addiction and Recovery Treatment Services (ARTS)

The Contractor shall work with the Department to improve ARTS delivery systems for individuals with a substance use disorder (SUD). The Department's system goals for the ARTS delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with SUD.

The Contractor's ARTS criteria shall be consistent with the American Society for Addiction Medicine (ASAM), as well as the Department's criteria for medical necessity determination for the ARTS benefit as defined in 12 VAC 30-130-5000 et al.

The Contractor shall implement all ARTS requirements and improvements as directed by the Department. The Contractor shall work with the Department to ensure that the Contractor's ARTS system of care is able to meet its members' needs.

8.2.B ARTS System of Care

The Contractor's ARTS system of care shall include recognized best practices in the Addiction Disease Management field, including a robust array of services and treatment methods to address the immediate and long-term physical, mental, and SUD care needs of the individual. The

Contractor's system of care shall align with the Department's ARTS policies and include recognized best practices in the Addiction Disease Management field such as the Centers for Disease Control Opioid Prescribing Guidelines.

The Contractor shall provide coverage for services at the most appropriate levels of care based on the Department's criteria defined in 12VAC30-130-5000 et al and the ARTS Provider Manual, which includes inpatient detoxification services provided in an acute care hospital settings licensed by the Virginia Department of Health (VDH); residential treatment services provided in a facility licensed by DBHDS; and SUD outpatient services by licensed or credentialed staff through the Department of Health Professions (DHP). DMAS received approval from CMS to waive the prohibition of coverage for adults age twenty-one to sixty-four (21-64) in an institution for mental disease (IMD), as defined in 42 CFR § 435.1010. As directed by DMAS, the Contractor shall provide coverage in IMD settings as appropriate based on the ARTS requirements for adults who are twenty-one (21) through sixty-four (64) years of age.

a. Appropriate Standards of Care

The Contractor shall use the DMAS defined medical necessity criteria for coverage of ARTS. In order to receive ARTS services, the member must be enrolled in the Medallion 4.0 program and must meet the following medical necessity criteria:

1. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under twenty-one (21));
2. Must meet the severity and intensity of treatment requirements for each level of care defined by the Department for ARTS services. Medical necessity for all levels of care is based on the individual's assessed biopsychosocial severity and is defined by the extent and severity of the individual's problems as defined by a licensed clinician based on the individuals documented severity of need in the multidimensional assessment ; and,
3. If applicable, must meet the ARTS adolescent treatment criteria. For individuals under the age of twenty-one (21) who do not meet the ARTS medical necessity criteria upon initial review, a second individualized review will be administered to ensure the individual's treatment needs are assessed and medically necessary services are coordinated to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-130-5020 and in Section 8.2.AA of this contract. The Contractor shall use the ARTS criteria to review and coordinate service needs when determining medical necessity for ARTS services in accordance with 12VAC30-130-5000 to 5150. The Contractor's ARTS Care Coordinator, or a licensed physician or Medical Director employed by the Contractor, will perform an independent assessment of requests for all ARTS intensive outpatient, partial hospitalization , residential treatment services and inpatient services using member information transmitted by providers via

the ARTS Service Authorization Review Form with attached clinical documentation available.

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

b. Strong Network Development Plan

The Contractor's ARTS network shall ensure Member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care.

c. ARTS Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals including: addiction credentialed physicians; buprenorphine waived practitioners licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain; licensed, registered and certified credentialed addiction treatment professionals; and certified peer recovery specialists as defined in 12VAC30-130-5020. In situations where a certified addiction physician is not available, the Contractor shall recognize physicians who are not addiction credentialed but have some specialty training or experience in treating addiction or experience in addiction medicine or addiction psychiatry. The Contractor shall credential providers for ARTS services using the ARTS Credentialing Forms and ARTS Staff Roster available:

<http://www.dmas.virginia.gov/#/artscredentialing>.

The Contractor shall credential the Preferred Office Based Opioid Treatment (OBOT) providers approved by the Department using the criteria as set forth by the Department in 12 VAC 30-130-5060. Approval will be based on DMAS' Office of the Chief Medical Officer's review of the ARTS OBOT Attestation Application available online at: <http://www.dmas.virginia.gov/#/artscredentialing>. The Contractor shall provide the Department a report on a monthly basis of the Preferred OBOT credentialed organizations in the Contractor's network as defined in the ARTS Technical Manual.

d. ARTS Benefit Management

The Contractor shall provide coverage for ARTS benefits within the amount, duration, and scope of coverage requirements described in the Medallion 4.0 Coverage Chart of this Contract, in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA), 42 CFR § 438.3(e)(1)(ii), and as defined in 12 VAC 30-130-5100.

To the greatest extent possible, the Contractor will aim to maintain compliance with the Centers of Medicare and Medicaid Services length of stay limits, e.g., thirty (30) day statewide average length of stay for residential services. Should length of stay limits be exceeded, the Contractor shall provide evidence to the Department that such limits were exceeded due to the lack of provider availability (e.g., provider shortage area) in a lower level of Care as defined in this Contract.

The Contractor shall allow for the billing methods by level of care as defined by the Department and detailed in the table below:

Level of Care	Billing Method
SBIRT	CMS-1500
Outpatient	CMS-1500
Intensive Inpatient	CMS-1500 or UB
Partial Hospitalization	CMS-1500 or UB
Residential	CMS-1500
Residential	UB
Inpatient	UB
Opioid Treatment Program	CMS-1500
Preferred Office-Based Opioid Treatment	CMS-1500
Substance Use Case Management	CMS-1500
Peer Recovery Support Services	CMS-1500

The Contractor shall not require service authorizations for Screening, Brief Intervention and Referral to Treatment (SBIRT), Outpatient Services, or services provided by a Contractor credentialed OTP or Preferred OBOT organization. The following ARTS Services will require a service authorization to qualify for reimbursement:

- Intensive Outpatient;
- Partial Hospitalization;
- Residential services;
- Inpatient hospital services; and,
- Peer Recovery Support Services.

Authorizations may be approved retroactively based on established provider enrollment contractual requirements after a provider has engaged a member in treatment to promote immediate entry into withdrawal management processes and addiction treatment.

The Contractor shall respond to the provider’s service authorization submission via the ARTS Service Authorization Review Form with the results of the Contractor’s independent assessment following NCQA requirements for urgent preservice and concurrent decisions, within seventy two (72) hours of the request for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1, 2.5).

The Contractor must respond to the provider’s service authorization submission via the ARTS Service Authorization Review Form within seventy two (72) hours of the request for placement in Residential Treatment (ASAM levels 3.3, 3.5, and 3.7) and Inpatient Hospitals (ASAM Level 4.0).

The preferred method of notification of service authorization approvals, denials and extension request is to provide written confirmations (via fax or mail) to the providers.

In accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, the contractor shall cover medication-assisted treatment (MAT), including FDA approved drugs, counseling services, and behavioral therapy.

c. ARTS Clinical Care Coordination

The Contractor shall employ an ARTS Care Coordinator who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner, licensed marriage and family therapist, licensed substance abuse treatment practitioner; or registered nurse with clinical experience in treatment of substance use disorder.

The ARTS Care Coordinator shall perform an independent assessment of requests for all ARTS residential treatment services and inpatient services. The ARTS Care Coordinator shall also provide clinical care coordination as defined in this Contract.

The Contractor shall require all ARTS Intensive Outpatient Program, Partial Hospitalization Programs, and Residential Treatment Providers ensure that Medicaid members with an Opioid Use Disorder admitted to any of these programs have access to evidence-based and FDA-approved medication-assisted treatment, including buprenorphine, methadone, or naltrexone. The Contractor shall be responsible for ensuring that ARTS IOP, PHP, and RTS providers are assessing and referring members for MAT in these settings.

The Contractor, consistent with Federal and State confidentiality requirements, shall implement structured care coordination plans for achieving seamless transitions of care. These plans will address overall care coordination for ARTS, transitions between all Levels of Care, transitions between ARTS service providers, transitions between delivery systems (i.e., moving from fee-for-service to managed care), collaboration between behavioral health and physical health systems, and collaboration between the health plans and the Behavioral Health Services Administrator (BHSA). The Contractor shall emphasize care coordination for any member with SUD transitioning from emergency departments or inpatient stays. The Contractor shall provide members access to clinical staff twenty-four (24) hours a day, seven (7) days a week through a toll-free telephone number.

The Contractor shall use data from multiple sources (including utilization data, health risk assessments, state agency aid categories, demographic information, and Health Department epidemiology reports) to identify members with complex health needs, including members who need help navigating the health system to receive appropriate delivery of care and services. When clinically indicated, the Contractor may assign each member to a care coordinator to provide care coordination support throughout the course of treatment, ensuring that all relevant information is shared with the treating providers through care transitions.

The Contractor shall provide ongoing education to providers regarding the requirement to engage in discharge planning for all members, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care. The Contractor shall conduct chart reviews to ensure compliance and identify opportunities to improve quality of care. The Contractor shall facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.

The Contractor shall refer to and collaborate with the BHSA for mental health services not specifically related to substance use disorders and not covered by the Contractor. The BHSA shall communicate via medical records and other appropriate means to enable the Contractor to adequately track member progress.

The Contractor shall develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

In order to minimize barriers to care, the Contractor shall ensure that its network includes behavioral health professionals performing addiction and recovery treatment service assessments via telehealth (where available). Services provided via telehealth shall be consistent with State regulations. ARTS Care Coordinators will be knowledgeable about the telehealth delivery system in Virginia and will refer members in rural and other hard to access areas to these systems in order to receive an assessment. It is expected that there will be some members who will not be able to access this evaluation through a telehealth solution or an office visit due to transportation, psychosocial, or health issues, thus the Contractor shall contract with a subset of evaluators to provide in home evaluations in order to accommodate the needs of these members.

f. Integration of Physical Health and Addiction and Recovery Treatment Services

The Contractor shall implement viable strategies for coordinating physical health, including primary care, behavioral health, and pharmacy services. This includes clinically indicated infectious disease testing for members with SUD at initiation of and as indicated during treatment. The Contractor shall also ensure coverage of Hepatitis C treatment and HIV treatment and prevention including pre-exposure prophylaxis and that these treatments are not being withheld due to a member's substance use, regardless of SUD treatment engagement. For women of childbearing age, the Contractor shall promote contraception management with addiction treatment including long acting reversible contraception (LARC).

g. Collaboration with DMAS, DBHDS, and Interested Stakeholders

The Contractor shall work collaboratively with DMAS, as well as with DBHDS, DHP, VDH, OCS and local CSA Coordinators, DSS, providers, DMAS contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support successful transition of the Residential Treatment Services,

Independent Assessment, Coordination and Certification Teams and Treatment Foster Care Case Management services and to ensure that the Contractor's RTS benefit is fully operational upon notification from the Department, and through separately issued guidance on the planned transition of RTS into managed care, the date of which is to be determined.

h. Community Integration

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

Peer recovery support services are made available to Medallion 4.0 members receiving ARTS services at all levels of care. Peer recovery support resources will be an integral component of community integration.

i. Services for Adolescents and Youth with SUD

The Contractor shall ensure timely access to the full scope of coverage for members younger than the age of 21. For members under the age of 21 who do not meet the medical necessity criteria upon initial assessment, a second individualized review by a licensed physician shall be conducted to determine if the member needs medically necessary treatment under the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit described in the Social Security Act § 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions, including SUD, discovered by the screening.

The Contractor shall ensure that providers working with children under age 12 have the experience in addiction treatment with children and adolescents.

j. ARTS Reimbursement

The Contractor must reimburse practitioners for all ARTS specific services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule.

k. 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 point-of-sale denial edits consistent with 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”. The Contractor shall have in place authorization procedures to override any of the denials when the prescriber provides compelling clinical documentation and medical necessity for the override.

8.2.C Behavioral Health & Substance Abuse Treatment Services (BHS)

The Contractor shall provide coverage for Medicaid covered inpatient, outpatient, and community-based behavioral health treatment services to its Medallion 4.0 members within the amount, duration, and scope described in this contract and the attached *Medallion 4.0 Summary of Covered Services Chart*. The Contractor’s medical necessity criteria shall be consistent with Federal, State, and the Department’s guidelines. At all times, the Contractor’s coverage rules and authorization practices shall comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

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

In accordance with Item YYY, Chapter 552, of the 2021 Reconvened Special Session I, the Department is developing and implementing a new suite of behavioral health services including new service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates. Assertive Community Treatment (ACT), Mental Health Intensive Outpatient (MH-IOP), and Mental Health Partial Hospitalization Program (MH-PHP) go into effect July 1, 2021 and all relevant changes are reflected in this contract. Functional Family Therapy, Multi-Systemic Therapy and Crisis services (Mobile Crisis Intervention, Community Stabilization, 23 hour temporary observation and residential crisis stabilization unit services) will go into effect December 1, 2021. The services rolling out December 1, 2021 are

not reflected in this contract but revisions will be made prior to the December 1, 2021 effective date.

a. Covered Behavioral Health Services

For behavioral health services, including MHS, a clinical interpretation and clinical judgement from a mental health professional is required for service authorization approvals or denials. The Contractor may employ UM reviewers of behavioral health services and MHS who are licensed health care professionals in a state other than Virginia, however those individuals must be licensed in a state in the United States, the license must be in good standing, and he/she must report to a mental health professional who is licensed in Virginia.

b. Inpatient Behavioral Health Services

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

The Contractor may authorize admission to a freestanding psychiatric hospital as an in lieu of service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements.

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

The Contractor is not required to cover services rendered in freestanding psychiatric hospitals. 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.

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

c. Outpatient Behavioral Health and Substance Use Treatment Services (Traditional Individual, Family, and Group Therapies)

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

d. Temporary Detention Order (TDO) and Emergency Custody Orders (ECO)

A Temporary Detention Order (TDO) is an order issued by a magistrate for a person who (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to

himself or others as evidenced by recent behavior, causing, attempting, or threatening harm, and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs; (ii) is in need of hospitalization or treatment; and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment. The Contractor shall provide coverage for TDOs and ECOs pursuant to 42 CFR § 441.150 and the Code of Virginia, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691. The Contractor shall follow all Department program policies and MCO guidance Memos issued by the Department on TDO processes. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the member is under TDO for Mental Health Services. The duration of temporary detention shall be in accordance with §16.1-335 et seq. of the Code of Virginia for individuals under age eighteen (18) and §37.2-800 et. seq. for adults age eighteen (18) and over. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in state-run psychiatric hospitals.

Coverage for services for Members admitted to a freestanding psychiatric facility under a TDO shall be handled as follows:

- If the Member is under age twenty-one (21) or over age sixty-four (64), and goes into private freestanding IMD or a State freestanding IMD for a TDO, the Contractor is responsible for the TDO. If the Member remains admitted to the IMD after the TDO expires, the Contractor is responsible for the psychiatric stay. Following expiration of the TDO, the Contractor can require that the Member transfer to a network facility.
- For Members age twenty-one (21) through sixty-four (64), where the Member goes into private freestanding IMD or a State freestanding IMD for a TDO, providers should submit the TDO claim to the state TDO program. The Member will remain enrolled with the Contractor beyond the TDO timeframe. The Contractor will manage the Member's treatment needs beyond the TDO timeframe and can require that the Member transfer to a network facility.

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

- For Individuals under age eighteen (18) (Minors) – Pursuant to §16.1-340.1.G of the *Code of Virginia*, the duration of temporary detention shall be sufficient to allow for completion of the examination required by § [16.1-342](#), preparation of the preadmission screening report required by § [16.1-340.4](#), and initiation of mental health treatment to stabilize the minor's psychiatric condition to avoid involuntary commitment where possible, but shall not exceed ninety six (96) hours prior to a hearing. If the ninety six (96)-hour period herein specified

terminates on a Saturday, Sunday, or legal holiday, the minor may be detained, as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. The minor may be released, pursuant to § [16.1-340.3](#), before the ninety six (96)-hour period herein specified has run.

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

8.2.D Behavioral Therapy for Children Under Twenty-One (21) Years

The Contractor shall provide coverage for Behavioral Therapy for FAMIS and Medicaid eligible children under twenty-one (21) years of age. Behavioral Therapy for children may be provided to individuals with developmental delays such as autism and intellectual disabilities. Children must exhibit intensive behavioral challenges to be authorized for services. Behavioral Therapy services are available to individuals under twenty-one (21) years of age, who meet the medical necessity criteria described in the MHS Behavioral Therapy Supplement. 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.

8.2.E Mental Health Services (MHS) [Formerly Known As Community Mental Health Rehabilitation Services (CMHRS)]

The Contractor shall provide coverage for the subset of behavioral health services now known as Mental Health Services (MHS). MHS are listed in the attached *Medallion 4.0 Covered Services Chart*.

The Contractor shall work with the Department to implement the MHS benefit and improve care coordination between MHS and other healthcare providers to improve integrated care based delivery systems for individuals with mental health disorders.

The Contractor's MHS criteria shall be consistent with the Department's criteria for the MHS benefit as defined in 12 VAC 30-50-130, 12VAC30-50-226, 12VAC30-60-5, 12VAC30-60-61 and 12VAC30-60-143 and 12VAC30-130-2000. Prior to submitting a request for MHS, providers are required to perform a Comprehensive Needs Assessment as defined in the MHS

(formerly CMHRS) Manual. Behavioral therapy services shall be consistent with the Department's criteria as defined in the Behavioral Therapy Manual Supplement. All MHS Services will require a service authorization or registration to qualify for reimbursement.

The Contractor shall implement all MHS requirements, provider training goals and targeted programmatic improvements as directed by the Department. The Contractor shall work with the Department and the MHS Transition Implementation Workgroup to ensure that the Contractor's MHS system of care is able to meet its members' needs. Discretion with utilization management requirements is allowed by the Contractor subject to prior approval.

a. MHS Standards of Care

The Contractor shall use the DMAS defined medical necessity criteria for coverage of MHS. In order to receive MHS services, the member must be enrolled in the Medallion 4.0 program and must meet the service specific medical necessity criteria as defined in the MHS Provider Manual and the Behavioral Therapy Manual Supplement. The Contractor shall review the requests on an individual basis and determine that the length of treatment and service limits are based on the individual's most current clinical presentation.

b. MHS Network Development Plan

The Contractor's MHS network shall ensure sufficient member access to high quality service providers with demonstrated ability to provide evidence based treatment services that consist of person centered, culturally competent and trauma informed care using a network of high quality, credentialed, and knowledgeable providers in each level of care within the access of care and quality of care standards as defined by the Department.

c. MHS Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-60-143 and 12VAC30-60-61. The Contractor shall verify that registration requirements for peers and qualified mental health professionals are met as directed by the Department of Health Professions and in accordance with all applicable regulations.

8.2.F Residential Treatment Services and Treatment Foster Care Case Management

Treatment Foster Care Management and Residential Treatment services consisting of Psychiatric Residential Treatment Facility Services (PRTF) Therapeutic Group Home Services (TGH) for the Department's Medallion 4.0 program individuals shall be administered through the Department's BHSA.

1. Any person or child admitted to a Psychiatric Residential Treatment Facility will be temporarily excluded from the Medallion 4.0 program until they are discharged.
2. Any person or child admitted to a Therapeutic Group Home will not be excluded from the Program; however, the TGH per diem service is carved out of this contract and will be administered through Magellan of Virginia. Any professional medical services rendered to individuals in the TGH will be administered by the Medallion 4.0 MCOs.

The Contractor shall work closely with the Department's BHSa to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. The Contractor shall work collaboratively with the Department's BHSa to ensure coordination of medical, ARTS, and mental health services for its members and shall provide coverage for transportation and pharmacy services necessary for the provision of, and as related to, these carved out services.

8.2.G Comprehensive System of Care

The Contractor shall develop a comprehensive system of care for the provision of medically necessary services to children ages 13-18 years in the Medallion 4.0 program. The Contractor must ensure that in the provision of services to this population any strategies and innovations implemented align with and advance the following goals:

- An increase in oral health and vision health;
- An increase in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT);
- Preventing and/or reducing obesity, asthma, or other chronic conditions;
- Focuses on teens and adolescent health, including trauma-informed care, ACES and resilience;
- Focuses on children and youth with special health care needs (CYSHCN);
- Providing transition planning to help teens and young adults prepare for changes following their 18th birthday.

8.2.H Clinic Services

The Contractor shall cover clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to outpatients by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients, as set forth in 12 VAC 30-50-180. With the exception of certified nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.

8.2.I Clinical Trials as EPSDT

Clinical trials are considered on a case by case basis 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.

8.2.J Colorectal Cancer Screening

The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

8.2.K Dental and Related Services

Members are provided routine and preventive dental services as a carved out benefit from managed care provided by a dental benefits administrator (DBA). The Contractor shall refer members needing dental care to the Department's DBA. The Contractor shall not cover any dental service for any member, inclusive of routine and preventive dental services previously offered as a part of an enhanced benefit, with the exception of emergency services described below. The Contractor shall assist the Department as requested in the transition and coordination to the adult dental benefit.

The Contractor shall coordinate with the DBA to improve member utilization and to share information on dental services that must be included in both the Contractor's handbook and website. The Contractor is responsible for transportation and any medication related to covered dental services. In addition, the Contractor shall be responsible for working closely with the DBA to coordinate medically necessary procedures for adults and children, including but not limited to, the following:

- CPT codes billed for dental services performed as a result of external trauma from a dental accident that results in damage to the hard or soft tissue of the oral cavity;
- Preparation of the mouth for radiation therapy; maxillary or mandibular frenectomy when not related to a dental procedure; orthognathic surgery to attain functional capacity; and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.
- In accordance with § 38.2-3418.12 of the Code of Virginia, anesthesia and hospitalization services when deemed medically necessary to effectively and safely provide dental care.

Coordination with Dental Benefits Administrator (DBA)

The Contractor shall designate a liaison (by name, phone number, and email address) and a back-up to work collaboratively with the Department's DBA and to assure that the required authorizations are handled timely and in accordance with the provisions as described below:

a. Dental Screenings (Under EPSDT)

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

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

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

b. Dental Varnish (Under EPSDT)

Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a CMS 1500 form shall be covered. The contractor must report utilization to the Department on an annual basis.

c. Hospitalization and Anesthesia Related Services

In accordance with § 38.2-3418.12 of the Code of Virginia, the Contractor must cover anesthesia and hospitalization for medically necessary dental services. The Contractor shall work with the Department's DBA to coordinate coverage for these services as follows:

1. Coverage is required for children under the age of five (5), persons who are severely disabled, and persons who have a medical condition that require admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.
2. The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA. The Contractor shall respond in writing via facsimile (262) 834-3575 to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request. The Contractor shall provide a comprehensive list of routine and escalation contacts. This list should be updated as changes occur. The Contractor shall adhere to all turnaround times.

If the Contractor disagrees with the DBA's decision for medical necessity, the Contractor may appeal within two (2) business days of notification by the DBA of the authorization. The appeal must be made directly with the Department's Dental Benefit Manager. The Department's decision shall be final and shall not be subject to further appeal by the Contractor. The Department's decision, however, does not override any decisions made as part of the Member's State Fair Hearing Process.

8.2.L Durable Medical Equipment (DME)

All medically necessary medical supplies and equipment shall be covered as set forth in 12 VAC 30-50-165. For a complete listing of Medicaid covered medical supplies and equipment refer to the Durable Medical Equipment (DME) and Supplies Appendix B of the Medicaid DME Provider Manual, as amended. The Contractor shall provide a secondary review for children for denied services in accordance with EPSDT review requirements.

Any specialized DME authorized by the Contractor will be reimbursed by the Contractor, even if the member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the member is retroactively dis-enrolled for any reason by the Department and the effective date of the retroactively disenrollment precedes the date the equipment was authorized by the Contractor. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following:

- Customized wheelchairs and required components;
- Customized prone standers and
- Customized positioning devices.

The Contractor shall cover supplies and equipment necessary to administer enteral nutrition as outlined in Section 8.2.Z of this contract. Coverage of enteral nutrition (EN) that does not include a legend drug shall be limited to when the nutritional supplement is the sole source form of nutrition. Coverage of EN shall not include the provision of routine infant formula. The

Contractor is not responsible for covering WIC-specialized infant supplemental nutrition. The Contractor shall refer members who are potentially eligible for WIC to the Virginia Department of Health (VDH) who shall bill The Department for services provided.

a. Durable Medical Equipment and Supplies Reimbursement Rate

The Contractor must not pay less than ninety (90) percent of the Fee-For-Service Medicaid fee schedule rate for all DME services. If no rate is available, the Contractor must utilize the reimbursement methodology in 12VAC30-80-30.A(6) to determine a Fee-For-Service benchmark rate. When the Contractor and the DME provider enter into a mutually agreed upon VBP or APM (including, for example, PMPM) arrangement, the VBP or APM payment must not fall below ninety (90) percent of the Fee-For-Service rate per item.

8.2.M Early Intervention (EI) Services

The Contractor shall cover Early Intervention (EI) services as outlined in this Contract and related state and federal laws and regulations, as well as the DBHDS Part C manual and the Department’s EI program manual. EI services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d), and are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have: 1) a 25% developmental delay in one or more areas of development, 2) atypical development, or 3) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

In accordance with federal and state law, children may be eligible to receive EI services from birth to age three. 20 U.S.C. §§ 1431, 1432; Virginia Code § 2.2-5300; 12VAC35-225-70; 12VAC30-50-131. EI services are not medically indicated for children aged three and above. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EI services for children who are enrolled in a contracted MCO are covered by the health plan within the Department’s coverage criteria and guidelines described in 12 VAC 30-50-131. By law, Part C funds are to be used as “payer of last resort” for direct services to children and families when no other source of payment is available. 20 U.S.C. § 1440; 12VAC35-225-210.

In Virginia, the EI services program is called the “Infant and Toddler Connection of Virginia” and is managed by the Department of Behavioral Health and Developmental Services (DBHDS). DBHDS contracts with forty (40) local lead agencies (LLAs) to facilitate implementation of local EI services statewide and also is responsible for certification of EI providers and service coordinators/case managers. Providers (or the agency) must be enrolled with DMAS as an Early Intervention Provider. 12VAC30-50-131.

All EI service providers participating in the Virginia Medicaid Medical Assistance Services Program and MCOs must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of Early Intervention services, as well as both of the Early Intervention Practice Manuals (DMAS and DBHDS Part C). The Department shall provide a roster of EI providers currently certified by DBHDS.

EI shall be recommended by the child's primary care provider or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition (12VAC30-50-131). When a developmental delay has been identified by the provider for children under age 3, the Contractor shall ensure appropriate referrals are made to the Infant and Toddler Connection and documented in the member's records. The Contractor shall work with the Department to refer members for further diagnosis and treatment or follow-up of all conditions uncovered or suspected.

If the family requests assistance with transportation and scheduling to receive services for Early Intervention, the Contractor is to provide this assistance. The Contractor shall coordinate with EI providers for children who "age-out" (age 3 and above) of the early intervention program and need to continue receiving services. The care coordinator shall ensure that services are transitioned to non-early intervention providers (Physical Therapy, Occupational Therapy, Speech Language Pathology, etc.).

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

A multidisciplinary team (two or more individuals from separate disciplines or professions and one of these must be the LLA EI Service Coordinator), which includes the family/caregiver, must develop the Individualized Family Service Plan (IFSP). The IFSP shall describe the developmental service needs and the amount, duration, and scope of EI services determined necessary by the IFSP team. Medical necessity for EI services shall be defined by the IFSP that is approved by a physician, physician's assistant, or nurse practitioner. The Contractor shall not require any additional services authorizations for EI services indicated in the IFSP.

The Contractor shall work collaboratively with the LLA EI Service Coordinator to: (1) ensure the member receives the necessary EI services timely and in accordance with Federal and State regulations and guidelines, (2) to coordinate other services needed by the member, and (3) to transition the member to appropriate services. The Contractor shall ensure that there are designated EI leads on their care coordination teams who are knowledgeable about EI services and related federal and state laws. EI leads shall have demonstrated working knowledge in the operations of EI services and act as a point of contact for stakeholders and providers serving EI members.

The Contractor shall not require any additional service authorization beyond what is indicated in the IFSP for EI services, as defined by EI codes, nor deny the EI services authorized in the IFSP, unless the child does not meet EI criteria or the billing provider is not a certified EI provider. The LLA EI Service Coordinator shall send to the Contractor the following sections of the IFSP:

Section I – Child and Family Information

Section V – Services Needed To Achieve EI Outcomes

Section VI – Other Services

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

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

The following codes/services are excluded from this requirement and should pay with or without the IFSP at the full EI rate.

Code	Description
T2022	<ul style="list-style-type: none"> • Service coordination
T1023	<ul style="list-style-type: none"> • Initial Assessment for Service Planning • Development of initial IFSP • Annual IFSP
T1023 U1	
T1024	<ul style="list-style-type: none"> • Team Treatment activities (more than one professional providing services during same session for an individual child/family • IFSP Review Meetings (must be in person) • Assessments that are done <u>after</u> the initial Assessment for Service Planning • Providers may use T1024 and the T1024 U1 on the same day, same child, same date of service and potentially the same NPI number
T1024 U1	

EI services shall be performed by EI certified providers in the child’s natural environment, to the maximum extent possible and shall meet the requirements of the DMAS Early Intervention Services Provider Manual and all relevant state regulations, including 12 VAC 30-50-131. Natural environments can be the child’s home or a community based setting in which children without disabilities participate. EI 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.

Early intervention reimbursement is defined by ten (10) distinct codes, inclusive of appropriate modifiers. These codes can only be billed for EI enrolled children (as indicated by the EI indicator on the 834-eligibility file) by providers who are certified by DBHDS and enrolled with DMAS/MCOs as an EI provider. EI codes require no authorization from the Contractor.

The Contractor shall reimburse EI services no less than the EI Medicaid fee schedule in place at the time of services. The Contractor also shall use the full EI rate when paying secondary claims for EI services submitted by EI providers for EI enrolled children.

The Contractor shall not require an EOB for an EI child that has a decline to bill form on file.

For children enrolled in early intervention who have 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) EI evaluation/assessment [T1023 and T1023 U1];
 - b) Development or review of an Individual Family Service Plan (IFSP) [T1024 and T1024 U1]; and,
 - c) EI targeted case management/service coordination [T2022]
- 2) Developmental services [T1027 and T1027 U1]; and,
- 3) Any covered early intervention services where the family has declined to bill to their private health/medical insurance.

8.2.N Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

“Early Periodic Screening, Diagnostic and Treatment” or “EPSDT” is a Federal law (42 CFR § 441.50 et seq.) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements. EPSDT services include periodic screenings; and vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care services listed in Section 1905(a) of the Act be provided to an EPSDT member when the service is needed to correct or ameliorate a medical condition. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse.

For more information on EPSDT visit:

<https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>. Coverage may be available under EPSDT even if services are not available under the State’s Medicaid Plan to the rest of the Medicaid population. Each April, the Department reports to CMS EPSDT screening information results.

EPSDT may provide additional benefits for children outside the basic Medicaid benefit package where it is determined that the otherwise excluded service/benefit for a child is a medically necessary service that will correct, improve, or is needed to maintain (ameliorate) the child’s medical condition.

a. Medical Necessity (Under EPSDT)

In addition to the traditional review for medical necessity, Medicaid children who request services that do not meet the plan’s general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered.

The Contractor’s secondary review process for medical necessity must consider the EPSDT’s correct or ameliorate criteria. The Department must approve the Contractor’s

second review process for EPSDT prior to implementation or when requested. Denial for services to children cannot be given until this secondary review has been completed. The Contractor shall establish a process approved in advance by the Department which allows providers to contact case managers to explore alternative services, therapies, and resources for members when necessary. See Section 8.2.K “Clinical Trials as EPSDT” for additional information. No service provided to a child under EPSDT can be denied as “non-covered”, “out-of-network” and/or “experimental” unless the approved secondary review applying EPSDT criteria has been completed and determined that it is not medically necessary.

Any such denial (non-covered, out-of-network, and/or experimental) shall also state that EPSDT criteria was reviewed and the reason the requested service does not fit the criteria. The Contractor can deny a service specifically noted as a carved-out service under Section 8.5 of this Contract. Additionally, the Contractor must inform members that although a service is carved out and therefore not covered under the member’s managed care health plan, it may be available through the Department under the Medicaid State Plan, and provide the appropriate contact information for the member to inquire with the Department. The Contractor shall also ensure that care coordination is provided and referrals are made to other clinically appropriate services.

b. Screenings (Under EPSDT)

EPSDT Screenings include comprehensive, periodic health assessments, or screenings, from birth through age twenty (20), at intervals as specified in the EPSDT medical periodicity schedule established by the American Academy of Pediatrics (AAP) policy statements and clinical guidelines and as required and indicated in the Screenings and Assessments provisions of this Contract. The medical screening shall include:

- a. A comprehensive health and developmental history, including assessments of both physical and mental health development to include reimbursement for developmental screens (CPT 96110) rendered by providers other than the primary care provider.
- b. A comprehensive unclothed physical examination, including:
 - i. Vision and hearing screening;
 - ii. Dental inspection;
 - iii. Nutritional assessment;
 - iv. Height/weight and Body Mass Index (BMI) assessment and
 - v. The Contractor shall require pediatric primary care providers to incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings must be documented in the medical record using a standardized screening tool. The Contractor shall not require any service authorization associated with the appropriate billing of these developmental screening services (e.g., CPT 96110) in accordance with AAP recommendations.

- c. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.
- d. Appropriate laboratory tests. The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.
 - i. Hemoglobin/hematocrit
 - ii. Tuberculin test (for high-risk groups)
 - iii. Blood lead testing including venous and/or capillary specimen (finger stick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater than five (5) µg/dL obtained by capillary specimen (finger stick) must be confirmed using a venous blood sample.

The Virginia “Reportable Disease” regulations require the directors of laboratories to report all “detectable” blood lead levels to the local Health Department within three (3) days. “Lead, reportable levels” means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10). The providers are to report children’s blood lead levels that are greater than or equal to 5 µg/dL using the EP-1 form.

<http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf>

c. Health Education/Anticipatory Guidance

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

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

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

d. Additional Services Under EPSDT

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

The Contractor shall inform members about EPSDT services.

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

1. The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider.
2. Documentation of a comprehensive screening shall, at a minimum, contain a description of the components described herein.
3. The Contractor shall assure that a participating child is periodically screened and treated in conformity with the periodicity schedule. To comply with this requirement, the Contractor shall design and employ policies and methods to assure that children receive prescreening and treatment when due. If the family requests assistance with transportation and scheduling to receive services, the Contractor is to provide this assistance.
4. The Contractor shall incorporate EPSDT requirements such as lead testing and developmental screenings in its quality assurance activities. The Contractor must implement interventions/strategies to meet the following criteria:
 - i. Childhood Immunization rates must meet requirements pursuant to Section 8.
 - ii. Well-child rates in all age groups must meet requirements pursuant to Section 8.
 - iii. Lead testing rates must meet requirements pursuant to Section 8.
 - iv. Increase percentage of lead testing of one to five (1-5) year olds for prior contract year.
 - v. The Contractor will follow a long-term improvement plan not to exceed five (5) years to increase EPSDT levels.
5. When a developmental delay has been identified by the provider, the Contractor shall ensure appropriate referrals are made and documented in the member's records.
6. Case management services for infants up to age two (2) are required as set forth in 12 VAC 30-50-280 through 410, to include:
7. Case management services for all newborns/infants admitted to the NICU (Nursery Level 3/NICU) for neonatal intensive care.

EPSDT requires that all medically necessary services for children needed to correct, ameliorate, or maintain health status shall be covered by the Contractor. EPSDT services for members under age twenty-one (21) also apply to the Medicaid Expansion population described above in section 2.2.F.

8.2.O Emergency Services

The Contractor shall cover emergency and post stabilization services without service authorization. The Contractor shall cover emergency services after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that

a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions or
- Serious dysfunction of any bodily organ or part.

The Contractor shall cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a member's choice of provider to emergency services. In accordance with 42 CFR § 438.114, the Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week through the Contractor's network.

The Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Additionally the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the Contractor of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. Title 42 CFR § 438.114 further requires that a member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the condition. The Contractor is also prohibited from denying payment for treatment obtained when a representative of the Contractor instructs the member to seek emergency services. Additionally, in accordance with 42 CFR §438.114, the Contractor is required to cover post-stabilization care services administered to maintain, improve, or resolve the member's stabilized condition without preauthorization, when the Contractor's representative and the treating physician could not reach agreement and the Contractor's physician was not available for consultation.

When the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was ultimately non-emergent in nature, the Contractor may not retroactively deny a claim for an emergency screening examination.

In accordance with Section 1867 of the Social Security Act, hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in an un-stabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements.

In the absence of an agreement or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered.

When emergency services are provided to a member of the Contractor, the organization's liability for payment is determined as follows:

a. Presence of a Clinical Emergency

If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor must pay for both the services involved in the screening examination and the services required to stabilize the patient.

b. Post-Stabilization Care

The Contractor shall pay for all post-stabilization care that the treating emergency physician views as medically necessary provided subsequent to the stabilization of an emergency medical condition even after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within a reasonable medical likelihood that no material deterioration of the patient's condition is likely to result from or occur after discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the Contractor concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own physicians with appropriate privileges to consult with the on-scene attending physician and potentially assume taking care of the patient, including stabilizing, treating, admitting, or discharging the patient.

Coverage and payment for post-stabilization care services must be in accordance with provisions set forth in 42 CFR § 422.113(c), as described below.

- a. Coverage - The Contractor shall cover post-stabilization care services that are:
 - a. Pre-approved by a plan provider or the MCO;
 - b. Not pre-approved by a plan provider or the MCO, but administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services;
 - c. Not pre-approved by a plan provider or the MCO, but administered to maintain, improve, or resolve the member's stabilized condition if:
 - i. The MCO does not respond to a request for pre-approval within one (1) hour;
 - ii. The MCO cannot be contacted; or
 - iii. The MCO and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the member until a plan physician is reached or until one of the criteria listed below is met.
- b. Payment - In accordance with 42 CFR § 422.113 (c), the Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- i. A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- ii. A plan physician assumes responsibility for the member's care through transfer;
- iii. The Contractor and the treating physician reach an agreement concerning the member's care; or,
- iv. The member is discharged from the facility

c. Absence of a Clinical Emergency

If the medical screening examination leads to a determination by the examining physician that an actual emergency medical condition does not exist, the Contractor shall pay for all services involved in the screening examination if the presenting symptoms (including pain) were of sufficient severity to have warranted emergency attention under the "prudent layperson" standard, as defined herein. If a member believes that a claim for emergency services has been inappropriately denied by the Contractor, the member may seek recourse through the MCO or State appeal process.

d. Emergency Department Utilization Program

The Department shall allow for the pending, reviewing and the reducing of fees for avoidable emergency room claims for codes 99282, 99283 and 99284, both physician and facility. The Department shall utilize the avoidable emergency room diagnosis code list currently used for MCO clinical efficiency rate adjustments. If the emergency room claim is identified as a preventable emergency room diagnosis, the Department shall direct the Contractor to default to the payment amount for code 99281, commensurate with the acuity of the visit.

e. Medicaid Hospital Readmission Policy

Hospital readmissions shall include cases when members are readmitted to a hospital for the same or a similar diagnosis within thirty (30) days of discharge, excluding planned readmissions, obstetrical readmissions, admissions to critical access hospitals, or in any case where the member was originally discharged against medical advice. If the member is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at fifty (50) percent of the normal rate, except that a readmission within five (5) days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three (3) digits.

f. Virginia Emergency Department Care Coordination Program

As required by state law for Medicaid health plans, the Contractor shall participate in the Virginia Emergency Department Care Coordination Program. This program is a statewide technology solution connecting all hospital emergency departments (EDs) in the Commonwealth to enable 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 program facilitates the sharing of and access to: real-time patient visit information; real-time alerts triggered by analytics to identify patient-specific risks; collaboration on coordination plans, care

recommendations, and other clinically beneficial information; treatment and care coordination information such as care plans, hospital admissions, transfers, and discharges with designated primary care physicians and clinical and care management personnel. Participation will require Contractor to sign the ConnectVirginia Exchange Trust Agreement.

The Contractor shall work with DMAS and hospital and physician representatives on any workgroup established by DMAS, VDH, and/or ConnectVirginia to develop shared care coordination models to leverage this technology solution to improve outcomes for high risk and high cost Medallion 4.0 members with high utilization of EDs or other high risk, priority populations.

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

8.2.P Family Planning

The Contractor shall cover all family planning services which include services and supplies for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. Contractor shall provide education on available family planning services. Covered services include family planning services, including drugs, supplies, and devices by network and out-of-network providers provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 CFR § 441.20.

In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 CFR § 431.51(b)(2), as amended, the Contractor may not restrict a member's choice of provider for family planning services, drugs, supplies, or devices. Federal law (42 CFR § 441.20) requires that the Contractor also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. *Code of Virginia* § 54.1-2969 (E), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

As required by section 1902(a)(23)(B) of the Act, the Contractor cannot require the member to obtain a referral prior to choosing a provider for family planning services. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral.

a. Long Acting Reversible Contraception (LARC) Utilization and Reimbursement

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

be required for approval. The member must be allowed to select any qualified family planning provider from in-network or out-of-network without referral. In addition to a member's free choice of family planning provider, members are free to choose the method of family planning as provided in 42 CFR § 441.20.

Immediate Post-Partum Coverage

The Contractor must provide reimbursement for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor shall also reimburse practitioners for the post-partum insertion of the LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.

Outpatient Coverage

The Contractor must provide coverage for all LARC devices, The Contractor shall not impose service authorization requirements or quantity limits on LARCs. The Contractor shall reimburse practitioners for evaluation/management (E/M) visits, where the practitioner and member discuss contraceptive options, in addition to same day LARC insertion or removal procedures. The Contractor must reimburse practitioners for LARC devices and procedures at a rate no less than the Medicaid fee schedule.

8.2.Q Hearing Services (Under EPSDT)

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Periodic auditory assessments appropriate to age, health history, and risk, which include assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. At a minimum, hearing screening shall include observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit.

8.2.R Home Health

The Contractor shall cover home health services, including nursing services and home health aide services, as set forth in 12 VAC 30-50-160. The Contractor is not required to cover the following home health services: medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, and custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services. The Contractor is prohibited from paying for home health care provided by an agency or organization unless said agency or organization

provides the Commonwealth with a surety bond as specified in Section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x).

The Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement. If the member is readmitted for the same condition within 90 days, it is counted as the same admission.

a. Consumer Direction and Contract with the Department's Fiscal/Employer Agent (F/EA)

Eligible Medallion 4.0 members may choose the Consumer-Directed model of service delivery for their personal care in which the member, or someone designated by the member, employs attendants and directs their care. The member will receive financial management support in their role as employer by the Contractor's Fiscal/Employer Agent (F/EA) vendor.

The Contractor shall subcontract with a qualified F/EA to provide financial management services to members who choose Consumer Direction for eligible services. The Contractor shall have policies and procedures (including timeframes), and internal controls for implementing F/EA services that includes defined processes for all required IT and data exchange processes. The Contractor shall sub-contract with a qualified vendor who will operate as a F/EA Fiscal/Employer Agent (F/EA) vendor under Section 3504-1 of the IRS code, including Agent Employment Tax Liability proposed Regulations (REG-137036-08) issued by the IRS on December 12, 2013 and Revenue Procedure 70-6.

A qualified F/EA vendor shall have a separate Federal Employer Identification Number (FEIN) for the sole purposes of filing federal tax forms (IRS Forms 2678, 940, 941, W-2 and W-3) and paying federal taxes (Federal income tax withholding, FICA and FUTA) on behalf of the members (employers) it represents as Agent. The F/EA shall obtain an FEIN for each member or the Employer of Record and maintain copies of the FEIN, IRS FEIN notification, and copy of the filed form SS-4, in the Member's file. A qualified F/EA shall have significant experience in withholding, filing, and paying state income and employment taxes for employers and Personal Care Assistants (employees). The Contractor's F/EA shall have verification methods in place to verify a live in attendant's legal name and physical address. Forms of identification can include but are not limited to driver's license, voter registration card, banking statement, credit card statement, utility bill statement, and cell phone statement.

Financial Management Services, provided by the F/EA for eligible Medallion 4.0 members include:

- Pre-employment services, including enrolling members (employers) and their Personal Care Assistants (employees);
- Criminal, child abuse and neglect, and other State and Federally required background checks;
- Processing employee timesheets;

- Deducting, filing, and paying State and Federal income and employment taxes and other withholdings;
- Paying Personal Care Assistants (employees);
- Providing customer service through a Call Center;
- Providing training on F/EA enrollment and payroll processing procedures to members and Service Facilitators or the Designated Entity responsible for supporting the Medicaid member in managing his or her Personal Care Assistants; and
- Providing an electronic visit verification (EVV) system compliant with the 21st Century Cures Act for personal care services.

The Contractor shall submit for approval to the Department, at implementation, revision, or upon request, the policies and procedures for handling Consumer-Directed services and the F/EA. The Contractor shall have a dedicated project manager for Consumer-Directed services and shall report updates on the status of each deliverable on a weekly basis. Refer to the MCTM for the required format.

The Department reserves the right to conduct a readiness review for implementation of F/EA services.

b. Self-Service Web Portal and Website

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

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

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

- Enrollment status;
- Employer and employee demographics;
- Timesheets;
- Service authorization;
- Service use;
- Paystubs;
- Tax;
- Patient pay (if applicable);
- Garnishments;
- Withholdings; and
- Year-end tax.

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

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

c. Service Initiation/Enrollment System

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

d. Member/Employer Enrollment Packet Requirements

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

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

e. Personal Care Assistant/Employee New Hire Packet Requirements

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

- Introductory letter;

- F/EA services, roles and responsibilities information;
- Customer service contact information and hours of operation;
- Criminal background, child abuse and neglect central registry information and requirements;
- Information on the federal List of Excluded Individuals and Entities (LEIE);
- Required federal employment eligibility, tax, and related forms that the employee must sign and submit with accompanying instructions;
- Required state forms with accompanying instructions;
- Description of payroll periods, timesheet due dates and timelines for processing and payment distribution;
- Direct deposit information and debit card options;
- Notice of Discontinued Employment form;
- Disclose employee's relationship to the employer per IRS Publication 15-Circular E Form;
- Enrollment options when internet access is unavailable; and
- Electronic visit verification information.

f. Background Checks

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

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

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

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

- Criminal, child abuse and neglect, and federal LEIE database background checks for prospective employees;
- Maintaining results in each employee's file and in the employer and/or employee's web portal self-service account;
- Written notification to the employer, upon discovery, when the results of the background check disqualify the employee from employment; and

- A system for blocking the employee in the F/EA payroll system from receiving payment effective the date that adverse findings are received by the F/EA.

g. Electronic Visit Verification

The Contractor's F/EA shall have an EVV system that will electronically verify and collect data and meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). At a minimum, the EVV shall capture in real-time the following data elements for consumer-directed personal care services.

1. Type of service performed
2. Member receiving service
3. Date of service
4. Location of service delivery
5. Employee providing the service
6. Time service begins and ends

The EVV system shall be capable of securely transmitting all raw data elements to the Contractor in the approved format and in accordance with approved transmission schedules. The system shall contain edits and audits to ensure correct and complete formatting of data submitted to the EVV system by members and employee(s). Complete verification and documentation for each visit is required.

The F/EA shall have system edits in place preventing claims for services that are not electronically verified and documented using the EVV system or otherwise inconsistent with an approved Service Authorization.

The F/EA's EVV system shall support real time access to members and employees. The EVV system shall meet the following requirements:

- Collect clock in/clock out time submissions, date of service, member and employee ID numbers, and GPS technology used to verify location and visits using GPS enabled devices;
- Allow for review, approval, and submission of timesheets by the appropriate designee;
- Provide roles-based access controls that allow members and employees to create user roles. The system shall provide real time jurisdictional views for Designated Entities and the Contractor; and
- Have the capability to limit authority to modify changes and modifications to service entries.

h. Contractor Database and Automated Payroll Systems

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

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

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

The Contractor must calculate and make accurate payment to attendants who are authorized to receive time and a half up to eight) hours and effective July 1, 2021, up to sixteen (16) for a single attendant who works more than forty (40) hours per week.

Employees who live in the home of the Member are exempt from overtime payments in accordance with the FLSA. Overtime pay is not permitted for any employee who lives in the home of the Member.

Direct deposit and debit card payroll solutions shall be made available to all attendants.

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

- Medicaid Individual and Employer of Record (EOR)
 - Name;
 - Medicaid ID number;
 - Eligibility status;
 - Birth date;
 - Social Security Number;
 - Demographics and contact data;
 - FIPS codes;
 - FEIN;
 - Individual's relationship to employee(s);
 - Individuals relationship to EOR;
 - Enrollment data;
 - Enrollment status;
 - Enrollment and Tax forms completion status; and
 - Tax filing data.
- Services
 - Procedure codes and names;
 - Waiver types;
 - Patient pay (if applicable);
 - Service Authorization (SA) Number;
 - SA units and date ranges; and
 - SA hours used and balance.

- Employee
 - Name;
 - Employee ID Number;
 - Social Security Number;
 - Demographics;
 - Enrollment Date;
 - Enrollment and Tax Forms Completion Status;
 - Enrollment Status;
 - Background Check Status and Results;
 - Pay Rates (Northern Virginia and rest of State);
 - Billable Rates (Northern Virginia and rest of State);
 - Payroll Schedule;
 - Pay Period;
 - Tax Status;
 - Employment Agreement Signed;
 - Tax Filing, Exemptions, Allowances, and Withholdings;
 - Garnishments and Liens; and
 - Employee Pay Distribution - Bank Account/Debit Card Transit Number.
- Timesheet and Payroll
 - Timesheet Number;
 - Timesheet Authorized Signatures;
 - Dates Worked;
 - Hours Worked;
 - Timesheet Status;
 - Timesheet Pend Reasons;
 - Timesheet Import Type – Web, Manual;
 - Journal Posting Dates;
 - Pay Date;
 - Check/EFT/Debit Card Payments;
 - Payment Authorized/Blocked;
 - Check Number; and
 - Pay Check Amounts.
- Services Facilitator (if applicable)
 - Agency Name;
 - ID Number; and
 - Demographics and Contact Data.

To comply with Chapter 449 (HB 2137), 2021 Acts of Assembly and Item BBBB, Chapter 552, of the 2021 Reconvened Special Session I, Virginia Acts of Assembly, effective July 1, 2021, the Contractor's F/EA shall have a payroll and audit process, claims and billing process, and distribution system that has the capacity to provide sick leave to providers of consumer-directed personal, respite or companion care. The Contractor's F/EA must ensure that, at a minimum, the following requirements are met:

- Attendants who work on average at least twenty (20) hours per week where the average number of hours worked is calculated by using a calendar quarter as the reference period;
- The determination of eligibility for paid sick leave shall be conducted at the end of the calendar quarter and is based on hours worked that have been reimbursed;
- Time worked during the quarter that is reimbursed more than twenty (20) days after the end of the calendar quarter will not be included in the determination of paid sick leave eligibility for the calendar quarter;
- Upon meeting the average of twenty (20) hours per week in any calendar quarter, employees shall accrue sick leave;
- Eligibility for an attendant to accrue sick leave shall be determined on an annual basis at the beginning of every fiscal year;
- Accrue a minimum of one (1) hour of paid sick leave for every thirty (30) hours worked for all employees. Paid sick leave shall be carried over to the year following the year in which it was accrued. Sick leave shall not be counted as time worked;
- An employee shall not accrue or use more than forty (40) hours of paid sick leave in a fiscal year;
- Create a process and system edits that will disallow accrued sick leave balances to be payable upon termination or resignation;
- Paid sick leave shall begin to accrue when the first shift worked is submitted and approved by the employer;
- Hours are accrued on a fiscal year schedule July 1st – June 30th;
- Attendants with a failed criminal background result do not qualify for sick leave payment;
- An employer shall not provide all paid sick leave at the beginning of the year;
- Sick leave balances shall be displayed on the attendant pay stub;
- Sick leave balances shall be available to the EOR;
- The Contractor is not required to collect documentation to justify the paid sick leave has been used for a specific purpose;
- Attendants may use sick leave in fifteen (15) minute increments;
- Sick leave shall not be counted as time worked and shall not be included in the calculation for overtime payments;
- An attendant shall submit sick leave hours used within thirty (30) days. Sick leave hours submitted for payment after thirty (30) days will be denied;
- Sick leave shall be incorporated in the billable rate calculations and deposited into a non-interest bank account;
- The contractor shall provide sick leave accrual and utilization report to DMAS on a quarterly basis. The elements to be added to the monthly scorecard report include:
 - Accrual amount earned during the quarter
 - Accrual amount used during the quarter
 - Accrual amount earned year-to-date
 - Accrual amount used year-to-date;
- Sick leave shall not apply to the Difficulty of Care (DOC) tax exemption. Sick leave is taxable income;

- Employee Sick Leave accruals shall be specific to the Employer (EOR) relationship;
- A F/EA to F/EA process shall be developed for transition attendants.

i. Patient Pay Through the F/EA

Some Medicaid individuals that receive Consumer-Directed services have Patient Pay responsibilities for services received, as determined by local Department of Social Services eligibility workers. Patient Pay is a source of payment that is reported as income on the employee’s W-2 and deducted for the employee’s net (not gross) wages. Should the Contractor choose to withhold patient pay from consumer-directed payments, the Contractor shall develop a policy and procedure describing how the F/EA shall accurately deduct Patient Pay amounts from employee’s paychecks.

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

The Contractor's reimbursement for consumer-directed personal care shall be the same as the Department’s reimbursement. The Contractor shall have two employee pay rates: (1) a higher rate for employees of members residing in Northern Virginia; and, (2) a base rate for employees of members residing elsewhere in the State. Billing rates are reviewed and adjusted in accordance with pay and tax rate changes. Data elements shall be determined by the Department and include unduplicated waiver members service types, employees, timesheet dates, hours worked, net pay billable rates, and amounts billed. Refer to the following for a listing of CD pay rates:

http://www.dmas.virginia.gov/Content_atchs/ltc/EDCD_No%20Units_HCBS%20Waiver%20Web%20rate%20SFY%202017%20updated%2007_29_2016_B.pdf .

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

F/EA Reports and Refunds due to the Contractor	Quarter Ending	Contractor Report & Refund Due
Quarterly Payroll Register	Mar 31	May 20
Quarterly Payroll Tax Reconciliation Summary	Jun 30	Aug 20
IRS Form 941	Sep 30	Nov 20
VA-5	Dec 31	Feb 20
VEC-FC-21/20		

Monthly Bank Statements for the Quarter	Mar 31	May 20
Monthly Bank Reconciliations for the Quarter	Jun 30	Aug 20
Quarterly Check Register	Sep 30	Nov 20
Monthly Cleared Checks Reports for the Quarter	Dec 31	Feb 20
Listing of Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue Date		
Employer Tax Filing Penalties & Interest Incurred Report & refund		
Amounts due to (from) Contractor's Payroll Tax Reconciliation Report	Mar 31	May 20
Refund due to Contractor for Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue	Jun 30	Aug 20
Report and refund to Contractor or proof of credit to the CD-Services Payroll Payment Account for bank	Sep 30	Nov 20
penalties and interest incurred	Dec 31	Feb 20
Copy of the Annual FUTA Tax Return with proof of receipt of payment from the IRS.	Annual	Feb 20
Refund, to Contractor, for employer portion of annual, over collected FICA immediately following F/EA's refund, for overpaid taxes, from the IRS	Annual	April

k. Tax Processes, Reconciliation, and Refunds

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

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

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

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

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

- Identifying employees due FICA refunds, determining their current mailing address and refunding FICA to applicable employees who did not earn the required annual gross wage amount for which employer and employee FICA is required to be calculated, withheld, and deposited for employees, per IRS requirements and maintaining relevant documentation;
- Preparing, filing, and distributing IRS form W-2, *Wage and Tax Statement*, for employees per *IRS Instructions for Agents* for electronic filing when processing 250 or more IRS form W-2's by January 31st of each year and maintaining relevant documentation;
- Preparing, filing, and distributing IRS form W-3, *Transmittal of Wage and Tax Statements*, in the aggregate for all members per *IRS Instructions for Agents* and maintaining relevant documentation;

- Preparing, filing, and distributing IRS form VA-6, *Employer's Annual or Final Summary of Virginia Income Tax Withheld Return*, and form W-2, state copy, and maintaining relevant documentation;
- Complying with all applicable state and federal laws and requirements for transferring employer and employee records and information to another F/EA Vendor when applicable;
- The F/EA shall provide the Contractor with a copy of the Annual FUTA tax returns, with proof of receipt of payment from the IRS;
- The F/EA shall provide the Contractor with an electronic *VEC-FC-21/20* copy of the employers *Quarterly Tax Report*, including proof of funds received, by the Virginia Employment Commission;
- The F/EA shall provide the Contractor with an electronic copy of form *941-Employer's Quarterly Federal Tax Return*, including proof of funds received by the Internal Revenue Service and any amended returns;
- The F/EA shall provide the Contractor with an electronic copy of form *VA-5 Employer's Return of Virginia Income Tax Withheld*, with proof of funds received by the Virginia Department of Taxation;
- The F/EA shall provide to the Contractor, a report of all penalties and interest incurred on federal and state employer tax filings during the quarter that are not shown on the forms submitted. The report shall include an explanation of each charge and its disposition; and
- The F/EA shall provide to the Contractor, a Quarterly report of uncashed or cancelled (voided) checks beyond a period of 180 calendar days from the issuance date including the amount refunded.

l. Customer Service Call Center

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

m. Satisfaction Survey

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

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

n. Employment and Earnings Verification

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

o. Training, Education and Outreach

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

- Prepare written communication, participate in stakeholder meetings, training sessions and provide web-based outreach and training materials, as approved by the MCO, for users of the system;
- Provide initial, refresher, and ongoing system training at least annually to Medicaid individuals, employees, and Services Facilitators (as applicable); and
- Provide a detailed plan for initial and ongoing training, including a training manual and web-based training models. The Vendor F/EA must address how questions will be received and answered upon completion of implementation and ongoing support initiatives.

p. Disaster Recovery

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

q. Quality Assurance Plan

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

- 10% per quarter sampling of each key operations area;
- Performance analysis as compared to each performance standard;
- Outcome measurement tools;
- F/EA Vendor annual performance review results; and
- F/EA staffing requirements that mirror industry standards.

The Contractor shall, at any time a deficiency in the F/EA's performance is identified, request a corrective action plan to address non-compliance. The Contractor shall notify DMAS of F/EA non-compliance on a monthly basis, outlining the approach to resolving the issues.

8.2.S Hospital Services

a. Inpatient Hospital

The Contractor shall cover inpatient hospital stays in general acute care and rehabilitation hospitals for all members. The Contractor's pre-authorization process for inpatient hospital services must be congruent with guidelines detailed in this Contract.

b. Outpatient Hospital

The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative, or palliative in nature that are furnished to outpatients, except in the case of certified nurse-midwife services that are furnished under the direction of a physician, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110.

Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to twenty-three (23) hours. A patient stay of twenty-four (24) hours or more shall require inpatient pre-certification and admission.

c. Inpatient Rehabilitation Hospitals

The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System, as set forth in 12 VAC 30-50-200 and 12 VAC 30-50-225, and 12 VAC 30-70-10 through 12 VAC 30-70-90, excluding 12 VAC 30-70-50.

d. Inpatient Behavioral Health Hospitalization Services (Traditional Inpatient BHS)

The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service/benefit to members in accordance with the Contractor's overall mental health protocols, policies, and network requirements.

e. General Obstetrical Hospital

The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and follow-up visits as set forth in 12 VAC 30-50-220.

8.2.T Immunizations/Vaccinations

The Contractor shall ensure that providers render immunizations in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the EPSDT screening. The Contractor also shall ensure that members are not inappropriately referred to other providers for

immunizations. The Contractor shall, as set forth elsewhere in this Contract, work with its network providers to adhere to the ACIP recommendations.

The Contractor is responsible for educating providers about reimbursement of immunizations, educating members about immunization services, and coordinating information regarding member immunization. The Contractor shall encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children Program (VVFC), administered by the Virginia Department of Health. The Contractor also shall include enrollment instructions and a “Vaccines for Children” application (or, if electronic, a hyperlink to the application) in its provider network enrollment and re-enrollment packages.

The capitation rate paid to the Contractor includes the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The Contractor shall not allow primary care providers to routinely refer Medicaid members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, the Contractor and its network of providers shall participate in the statewide immunization registry database. Further, the Contractor is required to submit its immunization data to the Virginia Immunization Registry on a monthly basis. Coordination of Benefits is not applicable for VVFC claims submitted by VVFC providers. Payments for such claims are to be made by the Contractor.

The Contractor is responsible for educating providers, parents and guardians of members about immunization services, and coordinating information regarding member immunizations.

a. Flu Vaccinations

The Contractor shall be required to cover adult flu vaccinations in accordance with the Affordable Care Act (ACA) as a required preventative service.

8.2.U Infant Care

The Contractor shall develop a comprehensive Infant Care program for the provision of services to infants ages 0-3 years in the Medallion 4.0 program. The Contractor must ensure that any strategies and innovations implemented in the provision of services align with and advances the following goals:

- Increase in infant immunizations;
- Increase in well visits and required EPSDT screenings;
- Implement safe sleep initiatives, including participating in DMAS pilot initiatives related to sleep boxes to include physician visits, home visiting, education, and evaluation;
- Provide early intervention services;
- Provide services for substance-exposed infants (SEI) and infants with Neonatal Abstinence Syndrome;
- Reduction in infant death;
- Early detection, screening and intervention;
- Infant and early childhood mental health, including trauma-informed care, ACES and resilience.

a. Substance Exposed Infants (SEIs) and Neonatal Abstinence Syndrome (NAS)

Infants

As a result of the opioid crisis, Virginia is seeing an increase of infants born exposed to substances, herein known as Substance Exposed Infants (SEIs). To best support SEIs/NAS infants, the Contractor shall create specialized care coordination services to address the medical and psychosocial needs of the infant and the infant's mother along with creating a plan of safe care for the SEI/NAS infant. These services shall be done with the objective of ensuring that the SEI/NAS infant is receiving care in conjunction with the substance use recovery care coordination provided for his or her mother.

The Contractor shall provide case management services to each family parenting an identified SEI/NAS infant. SEIs/NAS infants shall be identified through both their own health status and their biological mother's risk factors for drug use including their prenatal substance use history. These case management services shall include parental psychosocial education on the potential developmental needs of SEIs/NAS infants, trauma-informed services for both the parents of SEIs/NAS infants and the SEI/NAS infant, as developmentally appropriate, a plan of safe care developed for the SEI/NAS infant with a licensed behavioral health professional and the SEI's/NAS infant's care giver and substance use treatment care coordination services for the biological parents of SEIs, as applicable. Adoptive parents parenting an SEI/NAS infant who qualifies for Medicaid through adoption assistance shall also have the option of receiving these case management services, as clinically appropriate and requested.

b. WIC Referrals

Section 1902(a)(11)(C) of the Social Security Act, as amended, requires the State Plan to provide for the coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), administered by the Virginia Department of Health (VDH). The Contractor shall refer potentially eligible women, infants, and children to the WIC Program.

c. Safe Sleep program

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

8.2.V Laboratory and X-Ray Services

The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the healing arts, as set forth in 12 VAC 30-50-120. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may

perform the full range of services for which they are certified.

8.2.W Maternity Care

The Contractor shall develop a comprehensive Maternity Care program for the provision of services to pregnant women in the Medallion 4.0 program. The Contractor must ensure that in the provision of services the Maternity Care program aligns with and advances the following goals:

- Ensure access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant women;
- Ensure an increase in post-partum care including maternal mental health screenings;
- Reduce early elective deliveries;
- Support lower C-Section rates;
- Increase family planning access;
- Increase HEDIS scores related to maternity;
- Implement Addiction and Recovery Treatment Services (ARTS), specifically for pregnant women with substance use disorder;
- Increase screenings for SUD for both high risk and non high risk mothers (Monthly Maternal Reports);
- Increase outreach and education, including the use of social media, to pregnant women; and,
- Collaborate with the Department on initiatives targeted to pregnant women.

When the Department determines a pregnant woman's enrollment into the Contractor's plan or when the Contractor identifies a pregnant or postpartum woman, the Contractor shall:

- Cover pregnancy-related and postpartum services as may be appropriate based on aid category or eligibility, as set forth in 12 VAC 30-50-290;
- Cover services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290; and
- Cover prenatal and infant programs as outlined in this contract.

8.2.X Prenatal Care Requirements

The Contractor shall have written policies and procedures that outline how the Contractor will provide access to prenatal services for all pregnant women, including identifying and tracking high risk members. At a minimum, the policies and procedures must outline how the following requirements will be met:

- Within ten (10) days of identification, the Contractor shall send information to pregnant women to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services;
- The Contractor shall cover all obstetric and gynecological services as stated in Section 8.2.DD;
- The Contractor shall ensure that the travel time and distance standards stated in Section 4.6 are met;
- The Contractor shall ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant members as follows:

- First trimester - within seven (7) calendar days of request;
- Second trimester - within seven (7) calendar days of request;
- Third trimester - within three (3) business days of request.
- Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists;
- The Contractor shall implement activities to promote and incent healthy pregnancies. These activities may include: member incentives for adhering to timely and adequate prenatal services, text messages, health promotion and educational materials (e.g., reducing preterm birth, breast feeding, applying for WIC, safe sleep practices, and family planning), etc.;
- The Contractor shall ensure that every pregnant member is advised of the value of HIV testing as set forth in 12 VAC 30-50-510 and shall request that each pregnant member consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Pregnant members shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record;
- The Contractor shall ensure preauthorization requirements do not apply to basic prenatal care as stated in Section 8.1.D;
- The Contractor shall cover the services of certified nurse-midwives as stated in Section 8;
- The Contractor shall disseminate information about the WIC Program to potentially eligible women, infants, and children.

a. Promotion and Incentives

The Contractor shall promote and incent access and adherence to timely and adequate prenatal services as may be appropriate based on aid category or eligibility.

b. Depression Screenings and Referrals

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

c. Ancillary Services

a. Certified Nurse-Midwife

The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260.

b. Smoking Cessation Services

The Contractor shall ensure tobacco cessation services, education, outreach and pharmacotherapy are covered for all pregnant individuals (12VAC30-50-60).

c. Day and Residential Treatment for Substance Abuse

Day and residential treatment for substance use for pregnant and postpartum women shall be covered as outlined in the ARTS requirements.

d. Expanded Prenatal Care Services

The following services will be provided when medically necessary and within the amount, duration, and scope of the provisions described in 12 VAC 30-50-510:

- Nutritional assessment, counseling, and follow-up, as well as blood glucose meters.
- Addiction and recovery treatment services.
- Patient education in areas such as labor and delivery, Lamaze, planned parenthood, smoking cessation, substance abuse, and child rearing.
- Household maintenance services for pregnant women, primarily in third trimester, who need bed rest.

d. High Risk Pregnancy Requirements

The Contractor shall have written policies and procedures that outline how the Contractor differentiates pregnant women according to risk status. The methods applied to assess the risk of a pregnant member shall be evidence-based and developed in accordance with guidance set forth by organizations such as the American Congress of Obstetricians and Gynecologists (ACOG). At a minimum, the process must consider:

- The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.;
- Previous pregnancy complications and adverse birth outcomes;
- History of or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use);
- History of, or a current positive screen for, depression, anxiety and/or other behavioral health concerns;
- The member's personal safety (e.g., housing situation, violence).

The Contractor shall have methods in place to monitor high-risk maternity programs and track members who are deemed by the Contractor as being "high-risk." The Contractor shall also continue to monitor, as deemed appropriate, the risk status of pregnant members not originally considered "high-risk" for potential enrollment in the Contractor's high-risk maternity programs. The Contractor shall report monthly to the Department information outlined on the Managed Care Technical Manual on the status of both their high-risk maternity programs and services rendered for all other pregnant and postpartum women.

c. Doula Services

Beginning October 1, 2021, the Contractor must provide Doula services as a covered service to address many of the drivers of poor maternal and child health outcomes. Doulas are individuals based in the community who offer a broad set of nonclinical pregnancy-related services centered on continuous support to pregnant women throughout pregnancy and in the postpartum period. Emotional, physical, and informational support provided by Doulas include childbirth education, lactation support, and referrals for health or social services. Like other community health workers, Doulas provide culturally congruent support to pregnant and postpartum women through their

grounding within the unique cultures, languages, and value systems of the populations they serve.

The Contractor shall submit to the Department no later than August 1, 2021, and upon revision thereafter, for review and approval specific policies and plans regarding the reimbursement, recruitment and training of Doulas.

Doula services will be delivered by providers with training as outlined by the Department and certified by the Virginia Department of Health. Upon implementation of the state Doula certification and registration process as established by the Virginia Department of Health (VDH), a Doula must meet the qualifications and education requirements established by VDH through the state Doula certification and registration process in order to be enrolled as a Doula under the Virginia Medicaid program. Doulas must provide documentation to the Contractor demonstrating completion of requirements as outlined in the Virginia curriculum requirements for state-certified Doulas, as may be amended. Prior to implementation of the state Doula certification and registration process, a Doula must meet the qualifications described in draft curriculum requirements (see "[Virginia Curriculum Requirements for the State-Certified Doula](#)").

A standard case will be composed of nine touchpoints: eight prenatal/postpartum visits and attendance at delivery. Minimum requirements for reimbursement for delivery are built in to promote delivery of the full package of services, continuity of care, and timely care. Service flexibilities emphasize individualized, culturally sensitive, and appropriate care for a given case while recognizing that not all services can be delivered in all cases. To ensure that Doulas and their services are integrated into the broader spectrum of maternal and child health available to Medicaid Members, postpartum-focused incentive payments will be made based on successful referrals for the mother and/or newborn by Doulas to other providers of complementary maternal and pediatric care.

See Attachment 1 – *Covered Services Chart* of this contract for list of covered Doula services.

Additional requirements

- Doulas will provide and directly bill Virginia Medicaid and the Contractor for services as long as those services were provided at the “recommendation” of a physician or other licensed provider acting within their scope of practice.
- Doula services will not require a service authorization.
- Doula services can only be provided in the community, in clinicians offices (if a Doula is accompanying the Member to a clinician visit) or in the hospital.
- All claims for Doula services must include diagnosis Z32.2 (encounter for childbirth instruction)
- Claims for Doula services will only be accepted up to 365 days from the date of service
- Subsequent pre-natal service visits:

- Must be conducted at least one day after Doula's initial pre-natal service visit, and no later than the date of delivery
- Up to three (3) subsequent prenatal visits can be billed
- Attendance at delivery (vaginal); Attendance at delivery (cesarean)
- Reimbursement for attendance at delivery is a flat rate for both vaginal and cesarean deliveries. No additional reimbursement will be made for non-singleton births.
- Date of service on the claim should be the date of delivery
- Postpartum service visit
 - Must be conducted no earlier than the date of delivery, and no later than 180 days after date of delivery
 - Up to four (4) postpartum visits can be billed
- Incentive payment
 - Doula must provide a postpartum service visit within 6 weeks of delivery
 - Maternal postpartum visit: An obstetric clinician follow-up visit must occur within 6 weeks of delivery
 - Newborn postpartum visit: A pediatric clinician visit must occur within 6 weeks of delivery
- The visit limit (8 prenatal/postpartum visits; 1 attendance at delivery) applies to a Doula-Member pair. In the event that a Member receives care from more than one Doula, one Doula's visits to the Member does not count towards the visit limit for any other Doula
- Multiple visits are not allowed in the same day except when:
- A prenatal Doula visit occurs early in the day, and an attendance at delivery Doula visit later in the day
- an attendance at delivery Doula visit occurs early in the day, and a postpartum Doula visit later in the day

The Contractor shall ensure Doulas are paid no less than the current Medicaid FFS rate. If the Contractor and provider mutually agree to an Alternative Payment Method (for example, PMPM or bundled payment) or Value Based Reimbursement method, the reimbursement must not go below the FFS rate. See the Departments fee schedule for specific Doula rates.

f. Special Needs of Pregnant Women

Within three (3) days of a member being identified as high-risk, the Contractor should make its best effort to contact the member and/or the member's physicians to identify and assess the specialized needs of the member (medical, psychosocial, nutritional, etc.). At a minimum, the Contractor shall provide the following services to members identified as having high risk pregnancies:

Case Management Services

Case management services, including assessing and planning of services; referring members to appropriate services and resources for evaluation and follow-up on identified

issues and coordinating services with other agencies and providers; and, monitoring ongoing progress and ensuring services are delivered;

Service Plans

Service plans that include individualized descriptions of what services and resources are needed and how to access those services and resources to assist the high-risk pregnant woman in meeting her identified needs and;

“Fourth” Trimester (60 Days post-partum)

The Contractor shall promote and incent access to and adherence to timely and adequate postpartum services within sixty (60) calendar days of delivery, as may be appropriate based on aid category or eligibility. Strategies may include scheduling postpartum visits before discharge, telephone reminders, member incentives, etc.

The Contractor shall have written policies and procedures that outline how the Contractor will provide access to postpartum services. At a minimum, the policies and procedures must outline how the following requirements will be met:

- **Early Discharge Follow-up Visit:**
The Contractor shall cover at least one (1) early discharge follow-up visit in cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of delivery as indicated by the most recent “Guidelines for Perinatal Care” developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers and newborns or the newborn alone, if the mother has not been discharged, who meet the Department’s criteria for early discharge, as set forth in 12 VAC 30-50-220.
- **Lactation Consultation and Breast Pumps:**
The Contractor shall cover lactation consultation and breast pumps.
- **Substance Use Intervention:**
The Contractor shall develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use. These structures shall focus on planning strategies to facilitate a recovery environment that addresses improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.
- **Family Planning Services:**
The Contractor shall cover all family planning services as stated in Section 8.2.R.
- **Transition Planning:**
The contractor shall assist pregnant members who are two months post-partum and who may qualify for another Medicaid aid category with assistance in transitioning to that aid category. The contractor shall develop a transition plan to assist members to assure that their newborn child is enrolled in Medicaid, if eligible, and submit it to DMAS. Refer to the MCTM for report specifications.
- **Well Visits:**
The Contractor shall work to ensure that the member is aware of standards for well visits and ensures utilization in accordance with section 4.7.A.c of this contract. The Contractor shall include in care coordination efforts for postpartum

women, efforts to connect them with on going wellness and preventive appointments as clinically appropriate.

- **Safe Sleep Practices:**

Through its Safe Sleep program, the contractor shall educate parents and caregivers regarding the steps they can take to prevent infant sleep-related death and to emphasize safe sleep practices.

- **Plans of Safe Care:**

The Contractor shall ensure that care coordination staff include a plan of safe care for children who are both living with a member receiving a positive screen for substance use disorder and/or safety planning for the member's potential child.

g. Maternity Quality

See Sections 9.3 and 9.5 for measures the Department uses when determining quality of the Maternity Program.

h. Maternity Reporting

Maternity Policies and Procedures

The Contractor shall submit its maternity program policies and procedures and a plan to support positive birth outcomes to the Department in accordance with the requirements outlined in the MCTM. This report shall also include accomplishments, challenges, and partnerships during the previous contract year as well as copies of educational, training, and informational materials that the Contractor provided to OBGYNs.

Maternity Program Summary Report

The Contractor shall submit reporting related to maternity services, including measures demonstrating services for both its high-risk and non high-risk prenatal and postpartum members to the Department in accordance with the requirements outlined in the MCTM.

8.2.Y Nursing Facilities (Screening)

The Contractor is not required to cover nursing facility care. However, the Contractor shall make a good faith effort to refer all members in need of nursing facility care to be prescreened prior to admission. This screening must be done regardless of the member's anticipated length of stay in the nursing facility setting.

Once a member is screened, authorized, and enters a nursing facility, the nursing facility submits a Patient Intensity Rating Survey (PIRS) form to Department's Fiscal Agent. Once a nursing facility admission is entered into the system, any open managed care enrollment is closed on the day prior to the nursing facility admission date. The Contractor must cover all medically necessary services until the member is dis-enrolled from the MCO.

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

8.2.Z Nutritional Supplements and Supplies

Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for members under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Sole source means that the member is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that the nutritional supplements are medically indicated for the treatment of the member's condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Specialized formula for children and enteral nutrition/medical foods for members under twenty-one (21) are carved out of this Contract. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition.

8.2.AA Obstetric and Gynecologic Services

The Contractor shall cover routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered members. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists. The Contractor shall reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule. If the female member's designated primary care physician is not a women's health specialist, the Contractor is required to provide the member with direct access to a women's health specialist within the provider network for covered routine and preventive women's care services.

Note that a pregnant minor is deemed an adult for the purpose of consenting for herself and her child to both survival and medical treatment relating to the delivery as well as treatment for her child pursuant to the Code of Virginia § 54.1-2969 (E), as amended.

The Contractor shall permit any female member 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 prior 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.

a. Sterilizations

The Contractor shall not perform sterilization for a member under age twenty-one (21). The Contractor shall comply with the requirements set forth in 42 CFR § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in *Code of Virginia*, § 54.1-2974. Pursuant to 42 CFR § 441.258, the Contractor shall ensure that the consent form (DMAS-3004) is obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the member being informed, the member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor shall comply with State and

Federal (42 CFR Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

b. Hysterectomies

The Contractor may not impose a thirty (30) day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor shall inform the patient that the hysterectomy will result in sterility and must have the patient acknowledge her understanding. Patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Contractor shall comply with State and Federal (42 CFR Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

c. Mammograms and Mastectomies

The Contractor shall cover screening mammograms for female members ages forty and over, consistent with the guidelines published by the American Cancer Society, and for FAMIS members as medically appropriate. The Contractor must meet all requirements set forth in 12 VAC 30-50-220.

- a. The Contractor shall provide coverage for at least a forty-eight (48) hour hospital stay following a radical or modified radical mastectomy and not less than twenty-four (24) hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) (1) through §32.1-325 (A)(25) of the Code of Virginia .
- b. The Contractor shall cover reconstructive breast surgery in accordance with 12 VAC 30-50-140.
- c. The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

8.2.BB Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Language Pathology & Audiology Services)

The Contractor shall cover all physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and audiology services at least equal in amount, duration, and scope as described in 12 VAC 30-50-160, 12 VAC 30-50-200, and 12 VAC30-130-40. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define “acute conditions” as conditions that are expected to be of brief duration (less than twelve (12) months) in which progress toward goals is likely to occur frequently. “Non-acute conditions” are defined as conditions that are of long duration (greater than twelve (12) months) in which progress toward established goals is likely to occur slowly. The Contractor shall cover medically necessary PT, OT, and SLP therapies, including for both

acute and non-acute conditions, regardless of whether or not the child is receiving PT, OT, and SLP therapies through the school's Local Education-Based Services or through Early Intervention.

The Contractor shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs), as set forth in 12 VAC 30-50-225.

8.2.CC Organ Transplants

The Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-10-280, 12 VAC 30-50-540, VAC 30-50-550, VAC 30-50-560 and 12 VAC 30-50-580 within at least equal amount, duration, and scope as Medicaid fee-for-service.

Transplant services for kidneys, corneas, hearts, lungs, livers (from living or cadaver donors), and bone marrow/stem cell shall be covered as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. The Contractor shall cover necessary procurement/donor related services. Transplant services shall be covered for children (under 21 years of age) per EPSDT guidelines.

The Contractor must use Department service authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department. The Contractor is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by the Department must be honored by the Contractor, as with all authorizations, until such time that the Department can dis-enroll the member from the Contractor, if applicable, if the transplant is scheduled concurrent with the member's enrollment with the Contractor. Any medically necessary transplants that are not experimental or investigational are covered for children under twenty-one (21) years of age, when preauthorized

Any medically necessary transplants that are not experimental or investigational are covered for children under twenty-one (21) years of age, when preauthorized.

a. Stem Cell Transplants (SCT)

SCTs shall be made available for both children and adults with a diagnosis of either Aplastic Anemia, Heritable Bone Marrow Syndrome, Paroxysmal Nocturnal Hemoglobinuria, Beta Thalassemia major or Sickle Cell Disease when a member meets medical necessity criteria.

8.2.DD Physician Services and Screenings

The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses as set forth in 12 VAC 30-50-140. Cosmetic services are not covered unless performed for medically necessary physiological reasons. The Contractor is only required to cover routine physicals when the services are provided under the Early and Periodic

Screening, Diagnosis, and Treatment (EPSDT) benefit. The Contractor is strongly encouraged to cover routine physicals for members not covered through EPSDT.

8.2.EE Podiatric Services

The Contractor shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture, as set forth in 12 VAC 30-50-150.

8.2.FF Private Duty Nursing (PDN)

The Contractor is not required to cover PDN services for adults. The Contractor shall cover medically necessary private duty nursing services for children under age 21 consistent with the Department's EPSDT criteria, and as outlined below.

a. Private Duty Nursing (PDN) (Under EPSDT)

The Contractor shall cover medically necessary PDN services for children under age twenty-one (21), in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement, and as required in accordance with EPSDT regulations described in 42 CFR §§ 441.50, 440.80, and the Social Security Act §§ 1905(a) and 1905(r) I. The contractor is not required to cover PDN services in the school setting, when authorized by the child's Individualized Education Program (IEP) and provided as part of Local Education Agency-Based Services (see 8.5.A(a) Carved Out Services.) Medically necessary PDN services, which are not included in the IEP but are requested to be rendered in the school setting will be paid for by the Contractor, in accordance with the Department's established criteria and guidelines for EPSDT PDN.

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

b. Medical Necessity for PDN Services

The Contractor shall use the Department's criteria, as described in the DMAS EPSDT Manual, and as required in accordance with EPSDT regulations described in 42 CFR §§ 441.50, 440.80, and the Social Security Act §§ 1905(a) and 1905(r) 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. 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.

8.2.GG Prostate-Specific Antigen

The Contractor shall cover Prostate-Specific Antigen (PSA) testing and digital rectal examinations for the purpose of screening for prostate cancer as set forth in 12 VAC 30-50-220.

8.2.HH Prosthetic/Orthotic

The Contractor shall cover medically necessary prosthetic and orthotic services and devices at least equal in amount duration and scope as described in 12 VAC 30-50-210 and 12 VAC 30-60-120. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for members under twenty-one (21) years of age. The Contractor shall cover medically necessary prosthetics and orthotics for a member regardless of the member's age when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.

8.2.II Telemedicine and Telehealth Services

Telemedicine is a service delivery model that uses real time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (see temporary exception for audio only telecommunications in this section) to link the Member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) means the use of digital technologies to collect medical and other forms of health data from patients in one location and electronic transmission of that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data; treatment adherence monitoring; and interactive video conferencing with or without digital image upload.

The Contractor must provide coverage for telemedicine and telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor must provide telemedicine and telehealth services regardless of the originating site and regardless of whether the patient is accompanied by a health care provider at the time such services are provided.

The Contractor cannot require providers to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

The Contractor must allow the prescribing of controlled substances via telemedicine and requires such scripts to comply with the requirements of § 54.1-3303 and all applicable federal law.

The Contractor also must encourage the use of telemedicine and telehealth to promote community living and improve access to health services.

DMAS Medicaid Manuals and Memos on telemedicine specify the types of providers that may provide Medicaid-covered telemedicine and telehealth services. The Contractor may propose additional provider types for the Department to approve for use.

The decision to participate in a telemedicine or telehealth encounter will be at the discretion of the Member and/or their authorized representative(s), for which informed consent must be provided, and all telemedicine and telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department's program requirements. Covered services include the following:

1. Synchronous audio visual telemedicine
2. Store and Forward Applications: The Contractor must reimburse for teleretinal screening for diabetic retinopathy. The Contractor is required to provide coverage for teleretinal screening for diabetic retinopathy that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor cannot be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. The Contractor may also reimburse for additional Store and Forward Applications, including but not limited to, tele-dermatology and tele-radiology.
3. Remote patient monitoring (RPM) for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months. The Contractor is required to provide coverage for RPM for conditions (i)- (v) that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program.
4. Audio only services
5. Provider-to-provider consultations
6. Virtual check-ins with patients

DMAS will publish additional guidance for coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins and specific CPT Codes in upcoming Medicaid Memoranda and Provider Manuals and regulations. The Contractor will be required to provide coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins that is no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Medicaid fee-for-service program.

8.2.JJ Therapy Services

The Contractor shall cover the costs of renal dialysis, chemotherapy and radiation therapy, intravenous and inhalation therapy.

8.2.KK Tobacco Cessation Services

The Contractor shall cover tobacco cessation services, education, and pharmacotherapy for all members.

a. Tobacco Cessation Services (Under EPSDT)

The 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 twenty-one (21). (State Medicaid Director Letter, June 24, 2011 – page 4).

8.2.LL Transportation Services

The Contractor shall cover emergency, urgent, and non-emergency medical transportation (NEMT) to ensure that members have necessary access to and from providers of covered medical services, per 42 CFR § 440.170(a) and 12 VAC 30-50-530 in a manner that seeks to ensure the member's health, safety, and welfare.

Transportation to and from medical, behavioral health (including ARTS and MHS), dental, and all services covered under the contract shall be the responsibility of the Contractor. The Contractor shall provide the NEMT transportation benefit to all carved out services.

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

At times, covered Medicaid services may include transportation services to and from out-of-state medical facilities for treatment that is not available in Virginia and is approved in advance by the Contractor. The Contractor shall honor authorizations (as outlined in this Contract) in place for out-of-state treatment, including transportation services. The Contractor shall maintain an adequate transportation network to cover all approved transportation requests. The Contractor is encouraged to enter into contracts with taxis and commercial carriers as well as public agencies, non-profit and for-profit private agencies, and public carriers.

On an annual basis, the Contractor shall submit to the Department a report of their transportation services as outlined in the Managed Care Technical Manual. Additionally, during initial Contract

implementation, at revision, or upon request by the Department, the Contractor shall provide its policies and procedures for review and approval, including requirements for how far in advance individuals need to call to schedule and receive routine, non-emergency, urgent, and/or emergency transportation services.

Along with representatives from DMAS and other MCOs, the Contractor shall participate in both a transportation workgroup and a Transportation Collaborative to collaboratively review and assess transportation issues, guidelines, metrics, and other facets of transportation services guiding strategy and outcomes.

a. Establish and Maintain Automated Transportation Information System

The contractor shall ensure that the broker or internal transportation services provides and maintains a fully automated integrated Transportation Information Management System (TIMS) sufficient to meet the needs of the NEMT program in the Commonwealth. TIMS shall be provided to transportation providers, members, and end users at no cost for access, applications, software, technology, interface and contractor's proposed devices. The broker or internal transportation services shall ensure the TIMS interface of proprietary or broker software with a transportation provider's software shall be at no charge to providers. TIMS system at a minimum shall consist of the following:

1. Optimized Automated Scheduling
2. Member Management
3. Import, Export, Collect Data and Files
4. Transportation Network Management and Support
5. Member Data Elements

b. Transportation NPI

All transportation providers shall have an individual National Provider Identifier (NPI). The recommended process for transportation providers to obtain this number is as follows: See paragraph D of the NPI application (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.pdf>); follow the link in paragraph D to the "Health Care Provider Taxonomy" (<http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/>); find the category that fits the service provided in order for NPPES to issue the NPI. Examples of transportation NPIs are: Non-emergency Medical Transport (VAN) - 343900000X; Private Vehicle - 347C00000X; Secured Medical Transport (VAN) - 343800000X; Taxi - 344600000X; Transportation Broker - 347E00000X.

c. Transportation Expenses

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

1. The cost of transportation for the member by ambulance, taxicab, common carrier, or other appropriate means;
2. The cost of meals and lodging en route to and from medical care, and while receiving medical care;
3. The cost of an attendant to accompany the member, if medically necessary; and,

4. Tcost of the attendant’s transportation, meals, lodging, and salary if the attendant is not in the member’s family.

d. Administrative Costs

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

e. Transportation Provider Network

The Contractor shall recruit, credential, maintain, and negotiate reimbursement to ensure an adequate network of qualified NEMT providers to furnish high-quality transportation services that are safe, reliable, and on-time. Capacity shall include sedans, vans, mini-buses, wheelchair vans, stretcher vans, ambulances (non-emergency ambulance services as defined in 42 CFR § 414.605 – Definitions that include BLS, ALS, PI, SCT), alternate transportation (e.g., fixed-route public transportation, volunteer drivers, vouchers, and gas reimbursement), and taxicabs. The use of metered taxis shall be limited to safety net/last resort, unless specifically authorized by DMAS.

The Contractor shall make use of innovative alternate transportation including, but not limited to, fixed route public transportation, trained volunteer drivers and providing gas reimbursement or vouchers.

The Contractor should be aware of Coordinated Human Services Transportation programs in Virginia. Since the beginning of the federal United We Ride initiative, the Virginia Department of Rail and Public Transportation (DRPT) has provided resources to regional and local human services agencies to develop plans for close coordination of their transportation programs with public transit systems, both urban and rural. Most of the coordination plans cover a multi-county Planning District. The service areas of Virginia’s Community Services Boards (CSBs) and Area Agencies on Aging (AAAs) usually follow the Planning District boundaries as well. A number of these coordination plans are now in operation and others will follow. Contractors may want to contact DRPT (info@drpt.virginia.gov) to determine the roles these agencies may play in the development of the NEMT provider network.

The Contractor may authorize out-of-state NEMT services to enrolled DMAS providers located in cities and counties on or near the Virginia state border (District of Columbia, Kentucky, Maryland, North Carolina, Tennessee, and West Virginia).

The Contractor, broker or internal transportation services shall ensure that for all NEMT providers:

1. All vehicles are titled and licensed by the Virginia Department of Motor Vehicles to operate in Virginia and shall have the proper operating authority or meet DMVs exception criteria for state and local license “Exempt Operations” section titled Exempt Passenger Carrier Operations:
https://www.dmv.virginia.gov/commercial/#mcs/programs/intrastate/exempt_op.asp.
2. Vehicles garaged in adjacent localities in adjoining states must meet State inspection and safety requirements.
3. Those transportation providers with “taxi” license plates are in compliance with state and local ordinances for taxis and are currently licensed by the local taxi authority, if one exists, in the jurisdictions in which they operate.
4. Transportation Network Companies shall meet driver and vehicle requirements outlined in this addendum and as required by DMV.
5. The correct and current USDOT Number as an Interstate Carrier from the Federal Motor Carrier Safety Administration (FMCSA) if the provider is assigned trips that cross the Virginia border.
6. NEMT providers provide copies of required permits and licenses from the counties and cities in which they operate to the Contractor.
7. Have contracted providers, drivers, and vehicles that can access military installations to transport members.

The Contractor, broker, or internal transportation services shall ensure transportation to covered services is available 24 hours per day, 7 days a week, 365 days per year, including evenings, weekends, and holidays. Furthermore, the Contractor shall ensure that members can access transportation services without language barriers.

The Contractor, broker, or internal transportation services shall:

1. Ensure that it has a sufficient number of vehicles and drivers available to meet the timeliness requirements for access to care standards as described in Section 4.6, Access to Care, of this Contract.
2. Partner with NEMT providers to support their success.
3. Document its provider relations strategy, which shall include procedures and personnel dedicated to the efforts described in this section.
4. Conduct monthly written performance reviews with providers taking into consideration quality of service, on time performance, company safety (accidents/incidents) as well as other NEMT contract requirements. Have a corrective action plan for under-performing providers, and a means to track and report to the Contractor and DMAS on actions and results.
5. Assure provider compliance with all model contract requirements. Requirement compliance remains the responsibility of the Contractor, broker, or internal transportation services.
6. Enroll bordering out-of-state ambulance companies as needed for facility to facility transfers that occur within the bordering state boundaries. Virginia ambulance companies are not permitted to transport members unless pick up or drop off addresses are located in Virginia. Virginia ambulance providers are not allowed to transfer members within the boundaries of other states.

7. Ensure that any NEMT providers accepting out-of-state trips have authority including, but not limited to US DOT Regulations, and applicable federal, state and local licensing requirements.
8. Assure that all contracts entered into comply with all terms and conditions, and of the approved model contract.
9. Process all provider enrollment packets that are complete within 30 calendar days of receipt. Have an applicant tracking system for the enrollment process with real-time access for DMAS upon request.
10. Assure that all documentation required for enrollment is current, within 90 days of application.
11. Assure that any provider approved or denied to provide NEMT services is notified within 15 days of approval/denial. Approved providers shall have a contract negotiated and executed within 30 days of approval notification.
12. Assure that no contracted providers are permitted to deliver NEMT transportation services before driver and vehicle requirements are completed, contracts are executed, and provider is approved by DMAS.
13. Develop a re-evaluation and notification process for renewal of contracts and rate negotiation.
14. Have a system in place to track and exclude suspended or terminated providers or drivers from participating in any VA Medicaid NEMT covered services upon notification by DMAS.
15. Report to DMAS upon request subsequent suspensions or terminations of providers and drivers for various safety or erroneous acts.

The Contractor, broker, or internal transportation services shall have contingency plans for unexpected peak transportation demands and plans for back-up drivers, (e.g. TNCs), for instances when a vehicle is late or is otherwise unavailable for service. Upon request the Contractor, broker, or internal transportation services shall describe its capacity (including providers of bariatric transport and equipment available) to transport bariatric patients throughout the Commonwealth of Virginia. The provider must meet the requirements and guidelines established for bariatric transport by the Virginia Department of Health, Office of Emergency Medical Services.

The Contractor or Contractor's "Broker" must have a "Broker" license from DMV and be registered with the State Corporation Commission of Virginia (SCC).

f. Adequacy of Network for the NEMT Program

The Contractor shall ensure that its NEMT brokers or internal transportation services have a sufficient number of vehicles available to meet the on time performance requirements. If the Contractor or DMAS identifies insufficient transportation resources in an area, the Contractor shall notify the broker or internal transportation services, and the broker or internal transportation services shall have ten (10) business days after the date of such notice to recruit sufficient NEMT providers to meet the needs of the members in the identified area. If the broker or internal transportation services identifies an area with insufficient transportation resources, the broker or internal transportation services shall immediately notify the Contractor, and shall have ten (10) business days to

recruit sufficient NEMT providers to meet the needs of the members in the identified areas.

g. Ambulance Transports To and From Bordering States

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

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

h. Alternate Transportation

Alternate transportation includes fixed-route public transportation, volunteer drivers, vouchers and gas and/or mileage reimbursement.

i. Option to Leverage Transportation Network Companies (TNCs)

The Contractor may contract with TNC providers. If the Contractor elects to utilize a TNC for its members, the Contractor shall provide written notice to the Department through the submission of a TNC Project Plan which shall be reviewed and approved by the Department. The Contractor shall adhere to the TNC requirements below. See the Managed Care Technical Manual for the TNC Report and the TNC Project Plan specifications. The Department reserves the right to adjust, add, or remove limitations as well as to rescind the use of TNCs, if necessary, at any time during this or future contracts.

TNCs may be used as a provider if the member meets the criteria to ride with a TNC. Members requesting that they not ride with a TNC should not be permitted to utilize a TNC.

In order to maintain the viability of the NEMT network, the Contractor shall comply with the following TNC requirements:

1. Ensure the TNC has additional liability insurance to cover accidents and incidents not covered by the TNC driver's insurance;
2. Obtain a Virginia State TNC Certificate of Fitness from the Virginia State DMV;
3. Waive the signature requirement for TNC trips that will be acknowledged by electronic means (See NEMT Signature Waived);
4. Ensure Transportation Brokers are paying for trips directly and not reimbursing members for TNC transportation;
5. Ensure TNC software meets HIPAA, MCO, and the Department's System Security requirements.

The Contractor shall notify the Department in writing which TNC(s) and type the Contractor will be using, if any, for its members. The Contractor shall also assure the Department that the TNC(s) has been notified of and understands the limitations set forth below.

j. Transportation Network Company (TNC) Types

Type 1 TNCs consist of drivers and vehicles that meet the State of Virginia DMV TNC driver and vehicle requirements (i.e., Lyft, Uber). The following member requirements must be met in order to utilize a Type 1 TNC:

1. The member must have a cell phone that is able to receive information texted from the TNC.
2. The member must be able to interpret and understand information texted from the TNC.
3. The member must be able to redirect the driver if the TNC is at the wrong address.
4. All members enrolled in a CL, BI, FIS (IDD) and CCC Plus (EDCD) Waiver shall be excluded unless the member is approved by the parent or guardian as well as their case manager/Care Coordinator, and if applicable, Group Home Manager.
5. No minor children seventeen (17) years of age and younger shall ride alone.
6. No members requiring hand-to-hand or door-to-door assistance should utilize a TNC.
7. No members who need assistance from the TNC driver (i.e., wheelchair, walker, etc. should use a TNC.

Type 2 TNCs consist of drivers and vehicles that meet or exceed State of Virginia DMV TNC requirements and the Department's NEMT MCO driver training and vehicle requirements (i.e., UZURV, internal TNC). The scheduling software is able to send the TNC driver special transport instructions to include hand to hand or door to door levels of service as well as all special instructions required to transport the member safely.

k. On Time Arrival

On-time means from fifteen (15) minutes before the scheduled pick-up time until fifteen (15) minutes after the scheduled pick-up time of an A-leg. If the vehicle arrives within this thirty-minute span of time, the vehicle is on-time for the pick-up.

No more than one percent (1%) of all trips shall be late or missed per day. The Contractor shall ensure that the broker reports the percent of all trips late or missed per day on a weekly and monthly basis.

Subsequent trip legs must be at the scheduled return time or within 45 minutes of a “will call” to the ride assist for a return trip.

l. Travel Time on Board

For multi-passenger trips, every effort shall be made by the Contractor, broker, or internal transportation services and the NEMT providers to ensure members do not remain in the vehicle for more than 45 minutes plus direct travel time for transport of the member. No member shall have a travel time on board of more than one hour fifteen minutes unless the trip is a long distance trip.

m. Choice of Provider

Members do not have freedom to choose transportation by a particular NEMT provider. However, the Contractor shall strive to maintain existing relationships between NEMT providers and members and shall try to accommodate a member’s request for a specific provider in the Contractor’s network, especially for the transportation of members with disabilities.

n. Back-Up Services

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

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

o. Urgent Trip Recovery

Occasionally, the Contractor may not be able to identify a provider in its network for a member’s trip (e.g., a late night hospital discharge). In these instances, the trips still must be provided.

p. Gas Reimbursement

Gas reimbursement can be used for transportation to covered services that can be provided safely by a spouse, by the parent or guardian of a minor child, or by the member. The driver must have a valid operator's license and there must be an available registered vehicle at the home. The vehicle must be in operable condition and available for use at the time of the appointment

q. Volunteer Driver

A volunteer driver is an individual who transports members in a personal vehicle that meets the driver, insurance, vehicle inspection and other safety requirements of a contracted driver, and who accepts occasional trips (e.g., long-distance trips or recovery trips) from the Contractor in exchange for gas and/or mileage reimbursement.

r. Transportation Needs of Member

The Contractor is expected to provide services by assigning and scheduling trips on a per-trip or recurring basis with the most appropriate cost-effective non-emergency medical transportation (NEMT) provider, consistent with the transportation needs of the member. Consideration must be made regarding:

1. Level of Assistance – member assistance requested or when necessitated by the member's mobility status or personal condition. This includes door-to-door and hand-to-hand assistance. Curb to Curb is the default level of assistance.
2. Members with Disabilities – Members with a physical, sensory, intellectual, developmental, or cognitive disability. Members with disabilities may require door-to-door or hand-to-hand transportation assistance

s. Determining Level of Assistance Needs

Transportation services shall be scheduled and provided for members based upon the member's level of assistance need, i.e., whether the member requires hand-to-hand, door-to-door, or curb-to-curb service. The Contractor shall ensure that members receive the appropriate level of assistance.

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

1. Hand-to-Hand Transportation – Transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported hand-to-hand.
2. Door-to-Door Service – Transportation provided to passengers who need assistance to safely move between the door of the vehicle and the door of the passenger's pick-up point or destination. The driver exits the vehicle and assists the passenger from the door of the pick-up point (e.g., residence), escorts the passenger to the door of the vehicle and assists the passenger in entering the vehicle. The driver shall assist the member throughout the trip and to the door of the destination. It does not include the lifting of any member. Drivers, except for ambulance or stretcher van personnel, should not enter a residence.

3. Curb-to-Curb Service – The default level of assistance. Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The assistance provided by the driver includes opening and closing the vehicle doors, helping the passenger enter or exit the vehicle, folding and storing the member’s wheelchair or other mobility device as necessary, or securing the wheelchair or other wheeled mobility device in the vehicle. It does not include the lifting of any member. Drivers are to remain at or near their vehicles and are not to enter any buildings.

t. Availability of Services

The Contractor shall ensure that covered transportation services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

u. NEMT Driver Outreach, Training, and Education

The Contractor, broker, or internal transportation services shall ensure that all NEMT drivers (contracted, non-contracted, in-network, out-of-network, volunteers) including any taxi company or independent (i.e., Uber, Lyft, UZURV) drivers providing NEMT services receive or have received initial orientation training and ongoing refresher training. The Contractor, broker, or internal transportation services shall ensure drivers who perform transports for Medallion 4.0 enrolled members, members with dementia or cognitive impairments, members who require hand-to-hand or door-to-door level of assistance complete appropriate training prior to performing any trips for those levels of assistance.

The Contractor, broker, or internal transportation services shall:

1. Develop a NEMT driver’s manual that documents the Contractor, broker, or internal transportation services’ operating procedures. The manual shall be provided to all transportation providers with whom the Contractor, broker, or internal transportation services has entered into provider agreements with, as well as their drivers. The manual shall be reviewed in a mandatory orientation program to be provided by the Contractor, broker, or internal transportation services to all contracted transportation drivers.
2. Provide initial and refresher training as needed. The Contractor, broker, or internal transportation services shall schedule and arrange all training sessions, and all costs of the training sessions shall be borne by the broker or internal transportation services. Certification of completed refresher training is required every 3 years.
3. Assure that all drivers complete orientation training prior to transporting members under this contract. Upon satisfactory completion of training, drivers shall be certified. This certification must be renewed via completed refresher training every three years.
4. Require that all taxi company drivers complete PASS training prior to performing any trips.
5. Create an ongoing program for NEMT refresher training.
6. Accept third party training that meets all requirements including PASS certifications from other sources.

7. All training curricula and materials must be reviewed and updated annually to incorporate changes in requirements, regulations and/or procedures.
8. Store, maintain and update a database of all training participants.
9. Ensure NEMT Broker(s) or internal transportation staff undergo staff training to include TNC utilization, call center, reservations, ride assist/customer service, and operational staff as well as training on the exceptions list for each type of TNC utilized in the NEMT program.
10. Develop an orientation program for all NEMT drivers. The initial orientation plan for providers and a training plan for drivers shall be required. At a minimum, the orientation program shall include:
 11. An overview of the transportation program and the division of responsibilities between Contractor and NEMT drivers;
 12. Vehicle requirements;
 13. Procedures for handling and reporting accidents, moving violations, and vehicle breakdowns;
 14. Driver qualifications;
 15. Driver conduct;
 16. Proper use of attendants;
 17. Scheduling procedures, including criteria for determining the most appropriate mode of transportation for the member;
 18. Procedures for handling requests for urgent trips;
 19. Criteria for trip assignments;
 20. Dispatching and delivery of services;
 21. Procedures for obtaining reimbursement for authorized trips;
 22. Driver customer service standards and requirements during pickup, transport, and delivery;
 23. Record keeping and documentation requirements for scheduling, dispatching and driver personnel, including completion of required logs for reimbursement:
 - Procedures for handling complaints from members, facilities, or other service providers;
 - Procedures for submitting claims to the Contractor for reimbursement;
 - Procedures for reporting suspected fraud and abuse;
 - A written policy that includes all of the above items.
 - Initial orientation or ongoing refresher Driver training shall also encompass the following areas:
 - Customer service;
 - Passenger Assistance Safety;
 - Sensitivity training (PASS) (The Contractor, broker, or internal transportation services shall issue an NEMT Program ID Badge to every driver who completes PASS certification);
 - Basic first aid;
 - Safety and precautions needed for members with dementia, cognitive impairments, and special needs populations;
 - Behavioral health and substance abuse issues;
 - Title VI requirements (Civil Rights Act of 1964);

- Applicable HIPAA privacy requirements;
- ADA requirements (Americans with Disabilities Act of 1990);
- Wheelchair securement/safety and proper use of wheelchair lifts, if applicable, before transporting members under this Contract;
- Seat belt usage and child restraints;
- Emergency evacuation;
- Daily vehicle inspection;
- Defensive driving (such as a commercial driver improvement clinic certified by the Department of Motor Vehicles or the National Safety Council);
- Risk management;
- Communications;
- Infection control;
- Annual road tests

v. NEMT Provider (Owner and Manager) Outreach, Training, Education

All persons providing transportation services to the Virginia NEMT Program must undergo required training prior to transporting members.

The Transportation Provider Communication Strategy must facilitate a smooth operation and participation for both new and established providers in the NEMT program. The frequency of regular communications must meet the needs of both providers and the program, and must effectively communicate changes to policies and procedures.

The Contractor, broker, or internal transportation services shall assure that all initial and refresher trainings for Owners/Managers shall include the following:

- An overview of the transportation program and the division of responsibilities between Contractor and NEMT drivers;
- Vehicle requirements;
- Vehicle maintenance;
- Procedures for reporting accidents, moving violations, and vehicle breakdowns;
- Driver qualifications;
- Driver conduct;
- Proper use of attendants;
- Scheduling procedures;
- Procedures for providing urgent trips;
- Criteria for trip assignments;
- Dispatching and delivery of services;
- Procedures for submitting claims to the Contractor for reimbursement;
- Procedures for obtaining reimbursement for authorized trips;
- Payment schedule;
- Customer service standards and requirements for drivers during pickup, transport, and delivery;

- Record keeping and documentation requirements for scheduling, dispatching and driver personnel, including completion of required logs for reimbursement;
- Procedures for handling complaints from members, facilities, or other service providers;
- Procedures for reporting suspected fraud and abuse;
- A written policy that includes all of the above items.

w. Attendants

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

x. Transferable Driver and Attendant Requirements

The following shall be transferable between Virginia NEMT transportation brokers or internal NEMT transportation program services.

1. Passenger Assistance Safety and Sensitivity training (PASS) or equivalent;
2. Basic first aid training;
3. Defensive driving training;
4. HIPAA training;
5. Wheelchair securement training (if applicable);
6. State of Virginia Criminal background check or National Data Base Criminal Background check report;
7. Drug screen (if applicable);
8. DMV Driving record or National Data Base Driving Record Report
9. Virginia OEMS credentialing or licensing of EMTs meets all ambulance NEMT driver requirements as long as the license has not expired.

y. Honoring OEMS Licenses of Ambulance Companies

When the Department updates or enrolls ambulance companies, it requires a copy of ambulance company OEMS licenses. The OEMS license ensures the ambulance company employees and vehicles meet or exceed State of Virginia OEMS requirements to conduct business as a licensed ambulance company.

The Contractor’s NEMT program is required to honor the OEMS license of the ambulance company as the only requirement for provider enrollment. By honoring the EMS license as enrollment, this prevents duplicate work on behalf of the ambulance company and NEMT MCO programs.

The Department's NEMT OEMS requirement can be found at <http://dmas.virginia.gov/#/nemtservices>.

z. Transportation Services for Minor

An escort or personal assistant is a parent, caretaker, relative or friend who is authorized by the Contractor to accompany a member or group of members who have special needs or who are minor children (defined as under age 18). No charge shall be made for escorts or personal assistants.

The Contractor shall authorize transportation services for children under the age of 18. The Contractor shall have guidelines that include transporting children by themselves to after school Medicaid programs with an attendant or escort. If an escort cannot be found, then the Contractor will work with the member/designated representative to identify and secure an attendant to ensure timeliness and reduce behavioral problems while in route.

aa. Driver, Attendant, and Vehicle Requirements

At a minimum, the Contractor shall verify that all vehicles and drivers meet the requirements for training, licensing, vehicle inspection, registration, and insurance coverage as defined by the Department's Fee-For-Service NEMT program at <http://www.dmas.virginia.gov/#/nemtservices>. The Contractor shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits. These requirements shall be included in all agreements with NEMT providers. With prior approval from the Department, the Contractor may establish additional driver and attendant requirements.

The Contractor shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

The Contractor shall conduct all driver and attendant credentialing reviews prior to implementation and at least annually thereafter. All the records of these reviews shall be maintained by the Contractor. The Contractor shall assure compliance with driver requirements.

The Contractor and its transportation broker must abide by Department of Motor Vehicle (DMV) rules in the *Code of Virginia* with respect to non-emergency transportation requirements. The *Code of Virginia* exempts certain providers such as non-profits (e.g., AAAs, CSBs) from Intrastate Operating Authority and from requiring "For Hire" plates. The list of exempt provider types can be found in the "Intrastate Operating Authority - Exempt Operations" section titled Exempt Passenger Carrier Operations and found in: https://www.dmv.virginia.gov/commercial/#mcs/programs/intrastate/exempt_op.asp. The exemption links for the Code of VA for vehicles that qualify for government license plates, who are exempt from needing "For Hire" tags are available at the following Links:

bb. Passenger Safety Requirements

The Contractor, NEMT providers, drivers, and attendants shall ensure compliance with the following passenger safety requirements:

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

cc. Transportation of Provider/Driver Trip Logs

The Contractor shall require that transportation providers maintain trip logs. The Contractor shall provide training, support and periodic refresher training to ensure compliance. The Department, as part of monitoring this Contract, will audit the log for compliance and completeness. At a minimum, the following information shall be contained in the trip log:

1. Date of service;
2. Driver's name;
3. Driver's signature (written or digital);
4. Attendant's full name (if applicable);
5. Member's name;
6. Member's or attendant's signature (if applicable);
7. Vehicle Identification Number (VIN) or other identifying number on file with the Contractor;
8. Mode of transportation authorized;
9. A unique transportation provider number, assigned by Contractor. For providers of ambulance service, the Department's ambulance provider number shall be utilized;
10. Actual start time (from base station) (in military time);
11. Each authorized Member transported with the actual pick-up time (in military time);
12. Trip indicator (i.e. Trip completed, Member no-show, etc.);
13. Each actual drop off time (military time) for authorized member;
14. Actual number of wheel chairs, attendants, and children, per trip;
15. Actual return time (to base station) in military time;

16. Authorized stamp or signature of the transportation provider; and,
17. Other pertinent information regarding completion of the trips.

The Contractor shall:

1. Ensure that all information trip logs are complete and accurate.
2. Ensure that trip logs approved by the Department shall be maintained and available in an easily retrievable electronic format for no less than 5 years.
3. Provide training, support and regular monthly monitoring for trip log compliance to all transportation providers.

dd.NEMT Signature Requirement Waived

The NEMT requirement for member signatures on trip logs or trip manifests is waived for NEMT providers who have software, scheduling systems, apps, or a device that does not capture member signatures (i.e. Jaunt, Community Service Boards (CSB), and Transportation Network Company (TNC)) or for NEMT providers who have fully automated routing software capable of tracking vehicles with Global Positioning Systems (GPS) and that are able to capture trip arrival and trip completion times that have been acknowledged by the driver. The Contractor's broker shall ensure providers in these categories are subject to validation audit, utilizing a statistically significant random sample, to ensure members were transported. The Department may request the list of providers who are waived and subject to the validation audit. The Contractor shall submit to the Department for review and approval prior to implementation, upon revision, or upon request, its audit policies and procedures that reflect how the Contractor will validate members were transported by providers who are waived from the signature requirement.

8.2.MM Vision Services

The Contractor shall cover vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all members, shall be allowed at least once every two (2) years. The Contractor shall cover eyeglasses and contact lenses prescribed by a physician skilled in diseases of the eye or by an optometrist for members up to age twenty-one (21), as medically necessary and as set forth in 12 VAC 30-50-210.

Annually, the Contractor shall submit a plan that details its efforts to increase utilization of vision services for children to the Department. The Contractor shall gradually increase screening and eye examinations rates for all children between the ages of three to eighteen (3-18) using the American Academy of Pediatrics' recommendations for Preventive Pediatric Health Care.

a. Vision Services (Under EPSDT)

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.

8.2.NN Well Baby and Well Child Care

The 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, and ensure provision of services meets EPSDT and HEDIS scheduling,

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;
- The Contractor shall allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at risk guidelines;
- Hearing Services All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist;
- Periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective). At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.

8.2.OO Lead Investigations

The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the member's local health department to see if a member qualifies for a risk assessment. More information is available at: <http://www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for-publichealth/elevated-blood-lead-levels-in-children>.

Payments for environmental investigations shall be limited to no more than two visits per residence.

8.2.PP Affordable Care Act Minimum Essential Benefits for Expansion Population

Medicaid Expansion populations shall receive the same amount, duration and scope of services as other Medallion 4.0 members, in addition to the following four (4) federally-required essential health benefits, recommended by the United States Preventive Services Task Force (USPSTF).

- Annual adult wellness exams;
- Smoking cessation;
- Nutritional counseling for individuals with obesity or chronic medical diseases;
- Recommended adult vaccines or immunizations.

The USPSTF recommended preventive and wellness services and chronic disease management shall be covered in addition to the benefits listed in Summary of Covered Medallion 4.0 (Medicaid and FAMIS) Services – Part 5 – Extended Benefits for Expansion Population.

Covered “preventive” services and items only include evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the USPSTF. The USPSTF definitions of “A” or “B” ratings are listed below.

1. USPSTF Grade A – The USPSTF recommends the service. There is a high certainty that the net benefit is substantial. The USPSTF’s suggestion is to offer or provide this service.
2. USPSTF Grade B – The USPSTF recommends the service. There is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. The USPSTF’s suggestion is to offer or provide this service.

For best practice guidelines and up-to-date resources visit the USPSTF website at <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>.

8.3 PROHIBITED AND NON-COVERED SERVICES

Medicaid non-covered services are those services not covered by the Department and, therefore, not included in the covered services as defined in the Virginia State Plan or State regulations, except if ordered as a result of an EPSDT screen or high-risk pregnancy screen. The following services are non-covered services. The Department reserves the right to amend this list as deemed necessary:

- **Chiropractors:**
Services rendered by chiropractors, as set forth in 12 VAC 30-50-150.
- **Christian Science Nurses:**
Services of Christian Science nurses, as set forth in 12 VAC 30-50-300(B).
- **Experimental/Investigational Procedures:**
In accordance with 12 VAC 30-50-140, any procedure that is experimental or investigational, as defined by the Department, are not covered under the State Plan. Experimental or investigational procedures, including clinical trials, must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.
- **Erectile Dysfunction Drugs:**
Coverage of drugs for the treatment of erectile dysfunction.
- **Incarcerated Members:**
Services provided to inmates/incarcerated members enrolled with the Contractor. Individuals on house arrest are not considered incarcerated. The Contractor shall report to the Department any members it identifies as incarcerated, within forty-eight (48) hours of knowledge (see MCTM).

8.3.A Abortions

Under the terms of this Contract, the Contractor shall not cover services for elective abortion. This includes any related services performed at the immediate time of the abortion. The Contractor shall cover 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, which 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.

The Contractor shall submit to the Department annually, and upon request, a report detailing any claims for abortion services and related codes. The specific codes, services, and format for the submission will be communicated by the Department in the Managed Care Technical Manual.

8.3.B Assisted Suicide Funding Restriction Act of 1997- Prohibited Service

Under the terms of this Contract and the Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.), the Contractor shall not cover services related to assisted suicide, euthanasia, or mercy killings, or any action that may secure, fund, cause, compel, or assert/advocate a legal right to such services.

8.4 ENHANCED SERVICES & STATE PLAN SUBSTITUTED SERVICES

Enhanced services are those services offered by the Contractor to members in excess of covered services. During this time the Contractor may provide additional services but none of these services can be discontinued or decreased. Pursuant to 42 CFR §438.3(c)(1)(ii), no increased reimbursement will be made for additional services provided by the Contractor under this Contract. The Contractor must inform the Department at least ninety (90) calendar days prior to implementing any new enhanced services and prior to implementing revisions to, or removing any existing enhanced services. The Contractor must report the enhanced services it offers at start up, upon revision or upon request. Enhanced services for step-down care or adult psychiatric care provided in a free-standing psychiatric hospital may not be used to substitute for state plan covered services.

Enhanced services offered by the Contractor are listed in the Department's Managed Care Program comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services should be made only at open enrollment. However, the Contractor may revise enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts. The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to members during the contract year for rate setting purposes.

The contractor shall provide to DMAS any additional enhanced services provided to the Medicaid expansion population and shall provide such services for at least one year from the effective date of the contract. Additionally, the contractor shall submit to DMAS ninety (90) days prior to the start of the contract a list of the enhanced services that will be provided to Medicaid expansion members for inclusion in the DMAS comparison chart.

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

8.4.A State Plan Substituted (In Lieu of) Services

The Contractor may provide alternative services or services in settings that are not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services that are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). Such services shall comply with Federal requirements described in 42 CFR §438.3(e)(2). The Contractor shall not require a member to use a state plan substituted service “in lieu of” arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

a. Treatment in an Institution for Mental Diseases

In accordance with 42 CFR § 438.6(e), for individuals aged 21 through 64 the Contractor may provide coverage for a Member receiving inpatient treatment in an Institution for Mental Diseases, as defined in 42 CFR § 435.1010, only if specific conditions are met. Pursuant to 42 CFR §438.3 (e)(2), a MCO may cover services or settings that are “in lieu of” services or settings covered under the State plan as long as the provision of this service meets the four conditions for “in lieu of” services. These conditions are stated in §438.3(e)(2) as:

- a) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
- b) The member is not required by the MCO to use the alternative service or setting;
- c) The approved in lieu of services are authorized and identified in the MCO contract, and will be offered to members at the option of the MCO; and
- d) The utilization and actual cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

If these four conditions are met, MCOs shall provide coverage in an IMD setting “in lieu of” providing services in an inpatient psychiatric unit of an acute care hospital. The length of stay shall be limited to no more than fifteen (15) calendar days in any calendar month.

For individuals aged twenty-one (21) through sixty-four (64), the Department will make a monthly capitation payment to the Contractor for coverage of a member receiving inpatient treatment in an Institution for Mental Diseases only within the following guidelines:

1. The Member elects such services in an IMD as an alternative to otherwise covered settings for such services;

2. The facility providing services is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services;
3. The length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly capitation payment;
4. The provision of inpatient psychiatric or substance use disorder treatment in an IMD meets the requirements for in lieu of services as described above and in 42 CFR§438.3(e)(2).

The Contractor shall refund the full capitation payment paid by the Department for any treatment provided to the Contractor's member in an IMD where the length of stay in the IMD exceeds fifteen (15) days during the period of the monthly capitation payment. The fifteen (15) calendar day limit does not apply to IMD treatment for substance use disorders.

8.5 CARVED-OUT SERVICES AND EXCLUSION CRITERIA

8.5.A Carved-Out Services

The following list of services referred to as carved-out services identifies services that may be covered under the Medicaid or CHIP State Plan, but are carved out of managed care and handled by DMAS directly, on a fee-for-service basis:

a. Local Education Agency-Based Services

State plan approved health care services authorized by a child's individualized education program (IEP) plan and delivered via the Local Education Agency's Special Education and Related Services are carved out of this Contract and are reimbursed directly by the Department.

The following services provided on school grounds may be covered by the Contractor:

- Services that are not authorized by the child's IEP, and not delivered as part of the school's Special Education and Related Services.
- Services performed by an in-network clinic, FQHC, RHC, or medical facility housed on school grounds and providing covered medical and/or behavioral health services;
- Well-child screenings and/or immunizations performed by a registered nurse or nurse practitioner employed by the school system in Department-identified provider shortage areas.
- Early Intervention services as defined in this contract, with the exception of services performed within a private school or day care setting.

The MCO cannot directly reimburse a nurse practitioner for services rendered if not operating within the licensing requirements defined in 18 VAC 90-30-10 et seq.

The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies as authorized by their IEP and as part of Special Education and Related Services.

b. Targeted Case Management Services

Targeted case management services provided individuals with intellectual disability; individuals with intellectual disability and related conditions participating in home- and community-based care waivers; the elderly; and members of Auxiliary Grants as provided in 12 VAC 30-50-420 through –470.

c. Dental Services

Dental Services as set forth in 12 VAC 30-50-190 and those included in the adult dental benefit implemented July 2021, as authorized by HB5005 Budget Item 482.20 #5c supporting the implementation of a comprehensive Medicaid adult dental benefit.

d. Private duty nursing (PDN)

Private duty nursing services for adults (over age 19 for FAMIS, age 21 and older for Medicaid) or when provided for a child as part of LEA-based school health services included in the child’s Individualized Education Plan (IEP).

8.5.B Service Exclusion Criteria

Members who receive any of the following services shall meet the criteria for exclusion from the Medallion 4.0 Program. Once the Contractor determines that a member is receiving these services, and notifies the Department, the Department will begin the process to exclude the member. Until the Department has excluded the member, the Contractor is responsible for covering services for that member. However, in no event is the Contractor responsible for provision of the following services once the member is excluded:

a. Home and Community-Based Services

Members who are participants in the Home and Community Based Services Waiver are excluded as set forth in 12 VAC 30-50-450, 12 VAC 30-120-70 through 30-120-249.

b. Plan First

Services for members in the Plan First, Family Planning Program.

c. Inpatient Mental Health in State Psychiatric Hospital

Inpatient mental health services rendered in a State psychiatric hospital, as set forth in 12 VAC 30-50-230 through 12 VAC 30-50-250.

d. Hospice Services (Medicaid Members Only)

Hospice services defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in 42 CFR, Part 418 and as set forth in 12 VAC 30-50-270.

e. Nursing Facility Care

Nursing facility care, as set forth in 12 VAC 30-50-130.

8.5.C Nonpayment

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items for services furnished in an emergency room of a hospital) that is:

- Furnished under the health plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVII, or XX or under this title pursuant to sections 1128, 1128 A, 1156, or 1842(j)(2) of the Act;

- Furnished at the medical directions or on the prescription of a physician, during the period when such physician is excluded under participation under title V, XVII, or XX or under this title pursuant to sections 1128, 1128 A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
- The Contractor is prohibited from paying for an item or service furnished by an individual or entity that the Contractor is investigating (or has been informed that the Department is investigating) relating to the Department’s determination that a credible allegation of fraud exists, unless the Department determines there is good cause, in accordance with federal law, not to suspend such payments.
- With respect to the amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

8.6 ASSESSMENTS & ADDITIONAL REQUIREMENTS FOR MEMBERS WITH SPECIAL HEALTH CARE NEEDS

8.6.A Medically Complex Determination

A Medically Complex Determination shall be completed for the Medicaid expansion population described above in Section 2.2.E. The Medically Complex Determination consists of three elements, two of which are the responsibility of the Contractor – the MCO Member Health Screening and Data Surveillance/Identification.

1. The Contractor conducts the MCO Member Health Screening.
 - a. If the Contractor is unable to contact a Member to administer the MMHS, or if the Member refuses to participate in the MMHS in its entirety, the Contractor shall notate this on the MMHS and the Member shall be covered under the Medallion 4.0 program at the beginning of the following month.
2. The Contractor conducts Data Surveillance / Identification.
3. The Department conducts Data Surveillance / Validation or Identification.

a. Standard Application Attestation

The standard Medicaid application requires Medicaid applicants to indicate whether they attest to being “medically complex” or “not medically complex.” A member who attests to being medically complex is presumed to be medically complex, and likewise, a member who attests to being non-medically complex is presumed to not be medically complex. An applicant who is presumed to not be medically complex will be enrolled in the Medallion 4.0 program and a member who is presumed to be medically complex will be enrolled in the CCC Plus program. An individual will not be switched between the Medallion 4.0 and CCC Plus programs unless the presumption created by the individual’s attestation of medical complexity is rebutted by the results part 1 of a MCO Member Health Screening.

b. MCO Member Health Screening

The MCO Member Health Screening (MMHS) consists of questions that provide insight on the population, identify opportunities for supports, and support clinical pathways to improved outcomes. The MMHS may be used to determine if a Health Risk Assessment (HRA) is needed for the expansion population or to triage the completion timeframes for

HRAs. The Department will provide the Contractor with notice before implementing any such changes. The MMHS will not replace the HRA or any other assessments required under this Contract. The MMHS is included in this Contract as Attachment IX.

Part 1 of the MMHS contains questions that determine if a member is medically complex. Part 2 of the MMHS contains questions regarding social determinants of health, and will not be used in the medical complexity determination.

For all members of the Medicaid expansion population who will be covered under Medallion 4.0, the Contractor shall administer both parts of the MMHS within 90 days of the member's enrollment with the Contractor, unless the Contractor is unable to screen the member after three (3) good faith attempts.

The MMHS shall be submitted to the Department within no more than five (5) business days of the date on which the screening was completed, upon the third instance of the inability to contact the Member, or the date on which the Member refused to participate. While the MMHS is required to be completed within 90 days in order to affect enrollment changes the MMHS must be submitted prior to the end of the Member's initial four (4) months. Refer to the MMHS technical manual for details.

If a member is enrolled in Medallion 4.0 and part 1 of a MCO Member Health Screening indicates that the member is medically complex, the member will be dis-enrolled from Medallion 4.0 and enrolled with the same MCO in CCC Plus. If a member is enrolled in CCC Plus and part 1 of a MCO Member Health Screening indicates that the member is not medically complex, the member will be dis-enrolled from CCC Plus and enrolled with the same MCO in Medallion 4.0. The rules for members switching MCOs in Section 6.3 above will apply.

If, upon completion of the MMHS, the Contractor determines that the individual is medically complex, a re-screening of medically complex classification is not required unless there are changes to the individual's medically complex classification or stated by or on behalf of the individual or through the Contractor's analysis of the Member-specific health data.

Global MMHS Tool

The MMHS tool, including parts 1 and 2 can be found in Attachment IX. At a minimum, the Contractor shall ask the member or his representative(s) all of the questions in both parts when administering the MMHS. If additional questions are necessary to determine a member's medical complexity or a member's social determinants of health, the Contractor may be required to ask additional questions as appropriate. The MMHS shall be conducted telephonically unless the members health condition(s) or place of residence requires face-to-face contact or where claims on service authorizations identify complexity and precede a plan's ability to complete the MMHS. The Department shall give the Contractor one hundred twenty (120) days' notice before making changes to the MMHS unless changes are mandated by law.

MMHS Requirements

1. The Contractor shall make accommodations available at no charge to the member that address the needs of members with communication impairments (e.g., hearing and vision limitations) and members with limited English proficiency, in a culturally and developmentally appropriate manner and shall consider a member's physical and cognitive abilities and level of literacy in the screening process.
2. The Department reserves the right to require future revised screenings.
3. The Department reserves the right to conduct reviews, including reviews based on claim data or chart reviews to validate that members are correctly classified as medically complex or not medically complex based on the medically complex criteria. The Department also reserves the right to determine the member's medically complex status, including an over-ride of the Contractor's determination.
4. The Contractor shall document efforts made to contact and conduct the MMHS for members the Contractor has difficulty locating. The Contractor shall notate on the MMHS the number of attempts and date(s) of attempts made to contact the member.
5. When conducted face-to-face, the Contractor shall conduct the MMHS in a location that meets the needs of the member.
6. The Contractor's staff administering the MMHS shall have the demonstrated ability to communicate with members who have complex medical needs and may have communication barriers.
7. As necessary, relevant and comprehensive data sources (including the member, providers, family/caregivers, etc.) shall be used by the Contractor in the administration of the MMHS.
8. The Contractor shall report specific data elements from the MMHS in a format and frequency as specified by DMAS in the MCTM. The Contractor shall describe how it involves members, authorized representatives, family members and caregivers in the MMHS process, including the Contractor's efforts to obtain documentation, including signatures, to signify that members, authorized representatives, and family members and caregivers understand and consent to the MMHS process. The contractor shall also provide description of the Contractor's methods used in completing the MMHS for the different populations.

Reporting Requirements

The Contractor shall submit its MMHS policies and procedures to the Department for approval prior to implementation, upon revision, or upon request. Refer to the MCTM for further reporting details. The Contractor's MMHS policies and procedures shall describe all of the following required elements:

1. 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 MCO Member Health Screenings are conducted for each member (e.g., conducted by phone interview, face-to-face, written form completed by member, etc.).
2. When the MMHS is conducted (i.e., how far in advance of effective date).
3. How the results of the MMHS are used to confirm the appropriate medical complexity determination.
4. The personnel who review, analyze, and stratify medically complex needs.

5. If the contractor cannot screen the member after three (3) good faith efforts, the contractor shall report to DMAS the identifying information on the members that could not be screened.

c. Contractor Data Surveillance/Identification

Upon completion of Part 1 of the MMHS, the Contractor shall send the screening information via batch file to the Medicaid system. When the MMHS criteria is met, the individual receives a medically complex indicator (X). The Indicator “X” is reflected on the Contractor’s 834 file, which includes the Contractor ID that completed the screening. Where criteria is pending, the individual receives an indicator “XP.”

Upon completion of Part 2 of the MCO Member Health Screening, the Contractor shall send the screening information via batch file to the Medicaid system. The screening information is shared on the medical transition file when members transition between health plans. The screening information may be used to support member risk stratification, identify members who require program supports, or may be used for HRA triage purposes.

The Contractor shall conduct ongoing Data Surveillance/Identification of their members to determine if there has been a change in a member’s medically complex status. If a change has been identified, or if the Contractor’s Medical Director deems the member to be medically complex, the Contractor must complete the MMHS and submit the results to the Department. The Contractor may use surveillance to identify claims that support appropriate enrollment in the Medallion 4.0 or CCC Plus programs. Upon validation by the Department, the member shall be transferred from CCC Plus to Medallion 4.0 or vice versa. (See Section 5.2.2.4).

d. DMAS Data Surveillance/Validation or Identification

The Department shall carry out statistical sampling and other data analysis techniques to audit the Contractor to ensure that Medicaid expansion members are (1) appropriately eligible for expansion claiming and (2) being placed in the appropriate managed care program as a result of the appropriate utilization of the medically complex screening processes and other processes.

The Department shall use available data sources including claims/encounters and member responses to the MMHS to validate that members are in the correct delivery system (Medallion 4.0 or CCC Plus). This may include identification of emerging or existing risk, confirmation of reported physical or behavioral health conditions reported by the member or the Contractor, and other delivery system monitoring and assessments.

The Department reserves the right to conduct desk or on-site audits of the Contractors completed MMHS’ and related systems, policies and process.

Identification of issues or potential inappropriate delivery system assignment may result in additional screening events or in the disenrollment in one program delivery system and enrollment in an alternate program or delivery system. This may include members

moving from Medallion 4.0 or from CCC Plus to Medallion 4.0. These actions shall occur in consultation with the member's assigned Contractor.

The Contractor shall advocate for and support enhanced fraud prevention efforts.

8.6.B Health Risk Assessment Development

The Contractor shall work with the Department to develop a standard Health Risk Assessment tool that all managed care plans will use. This assessment will assist case managers in identifying member physical and behavioral health status and risk factors along with their social, economic and housing needs. The HRA will be used to create a plan of service that will encompass member goals for their health outcomes, strengths and community resources. The goal of both the HRA and service plan shall be to develop member centered care strategies and ultimately aid in the improvement of member health outcomes and overall social and economic independence. The Contractor shall annually submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as housing referrals, etc.).

Populations Requiring Assessments

In accordance with 42 CFR § 438.208, the Contractor must take all reasonable steps to assure that the following newly eligible/enrolled populations receive an assessment:

- Children and Youth with Special Health Care Needs (CYSHCN), including Early Intervention, Substance exposed infants (including infants with Neonatal Abstinence Syndrome),
- Members in Foster Care and adoption assistance as described in Section 2.2.D are excluded. Members in Foster Care and adoption assistance will be evaluated on a sixty (60) day timeframe.

Please note that Assessment provisions specific to high-risk pregnant women, with different requirements and thresholds, are found in the Maternity Care section of this Contract. The treatment or service plans must be reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee.

8.6.C Assessment Timeframes

The Contractor shall take steps to assure that newly eligible/enrolled members requiring assessment as defined in 8.6.B, are assessed within sixty (60) calendar days of initial enrollment.

A monthly report of new members, noting who received a successful assessment must be submitted to the Department as specified in the Managed Care Technical Manual. A successful assessment is considered a contact with the member, by the health plan, which results in a fully completed health assessment that meets the requirements of this Section. A fully completed assessment must assess health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs and have all applicable questions completely answered.

8.6.D Assessment Thresholds and Completeness

The chart below illustrates the Department’s thresholds for completion of an assessment for all members referenced in Section 8.6.B.

Timeframe, beginning on day member meets criteria of Section 8.6.B	% of Required Members who must receive Completed Assessments during the Timeframe
60 days	50%
90 days	100%
After 90 days	Exception Report listing unassessed members and a reason the member did not receive an assessment.

The Contractor must submit reports documenting assessed members for the sixty (60) and ninety (90) day timeframes listed above. The Exception Report due after day ninety (90) should include only those remaining unassessed members. Details and specs of those reports are available in the MCTM.

8.6.E Annual Assessment Plan for Members

The Contractor must develop and maintain a program to address and improve the care and access of services among members requiring assessments. The Department will audit compliance with this requirement and will request copies of monitoring activities, utilization outcomes, and completed assessments.

The Contractor shall submit an annual plan to the Department for approval by September 30th of each year outlining its assessment plan for the contract year. The plan must be developed in accordance with any applicable state quality assurance and utilization review standards. The submission must include its assessment tool, and include all populations referenced in Section 8.6.B. In addition to requesting specific member assessment information, the Department may request a random sampling of completed member assessments to assure the Contractor’s compliance with this requirement.

The Contractor must develop and maintain a system of assessment procedures for identifying members with special health care needs (children and adults), including people with disabilities, or chronic or complex medical and behavioral health conditions, and Children and Youth with Special Health Care Needs. The assessment procedures must be consistent with the requirements of this contract. The Contractor should include in its plan how it will educate and inform members who are not complying with the EPSDT periodicity and immunization section..

The Contractor shall make every reasonable effort to comply with the Health Plan Assessments requirements detailed in this Contract. The Contractor shall meet the reporting requirements for assessments as detailed in the Managed Care Technical Manual. [42 CFR § 438.208(c)(3)-(4)]

8.6.F Assessments for Children and Youth with Special Health Care Needs

The Contractor shall assess the quality of care of CYSHCN in the following areas:

- **Program Development** – Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.

- **Enrollment Procedures** – Identify and collect data on children and youth with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs. The Children with Chronic Conditions Satisfaction Survey described in Section 9 (CAHPS – Child Supplemental Questions) is sufficient in meeting this Satisfaction survey requirement.
- **Provider Networks** – Assure the availability of providers who are experienced in serving children and youth with special needs and provide a “medical home” that is accessible, comprehensive, coordinated, and compassionate.
- **Care Coordination** – Provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.
- **Access to Specialists** – The Contractor shall have a mechanism in place for members determined to have ongoing special conditions that require a course of treatment or regular care monitoring that allows the member direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member’s condition and identified needs.

a. Assurance of Expertise for Child Abuse and Neglect and Domestic Violence

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

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

b. Case Management for Children and Youth with Special Health Care Needs

The Contractor is responsible for establishing policy and procedures which facilitate provider contact with medical management staff to explore alternative resources and services for members with special health care needs. Case managers serving children and youth with special health care needs and children requiring special assistance shall assist these members in scheduling appointments, providing referrals to appropriate medical providers, offering assistance in identifying resources, other appropriate treatment options, referrals to resources, and shall make contact with the member or his family on a regular basis. The Contractor shall assess and provide if necessary, members’ needs for special transportation requirements, which may include but not be limited to: ambulance, stretcher van, curb to curb, door to door, or hand to hand services. “Hand to hand” service

includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported “hand-to-hand.”

8.7 PHARMACY MANAGEMENT

The Contractor shall be responsible for covering all legend and non-legend Food and Drug Administration (FDA) approved drugs for members, as set forth in 12 VAC 30-50-210 and 42 CFR §438.3(s)(1), and in compliance with § 38.2-4312.1 of the Code of Virginia. Legend 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 must allow access to all medically necessary non-formulary or non-preferred drugs, other than those excluded from coverage (see Pharmacy Exclusions below). The Contractor may subject non-formulary or non-preferred drugs to service authorization consistent with the requirements of the Contract.

The Contractor must maintain its own individual pharmacy program, separate from other managed care organizations, inclusive of individual drug pricing policy and processes. The Contractor is prohibited from creating pools to leverage negotiations on drug pricing.

8.7.A Legend and Non-Legend Drug Coverage: Common Core Formulary Adjustment

The Contractor is required to maintain a formulary to meet the unique needs of the members they serve; at a minimum, the Contractor’s formulary must include all preferred drugs on the DMAS Preferred Drug List (PDL), also known as the Common Core Formulary (CCF). The DMAS PDL is available at <https://www.virginiamedicaidpharmacyservices.com>.

a. Formulary

The DMAS PDL/CCF is not an all-inclusive list of drugs for Medicaid members. The Contractor must develop a comprehensive formulary that includes drug classes not included on the CCF. The plans are responsible for 100% accuracy for all PDL coding changes based on drug files provided by DMAS. The \$5,000 penalty will be deducted from the capitation rate in the next quarter for each coding error.

The Contractor’s formulary must be developed and reviewed at least semi-annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit their formulary to DMAS biannually, no later than January 15 and July 15 after review by its P&T Committee and inform DMAS of changes to their formulary. The Contractor must receive the Department’s approval for all formulary and pharmacy related policy changes including service authorizations and quantity limits. The Contractor shall submit changes for review and approval via email at least forty-five (45) calendar days prior to the effective date of the change. The Department will respond within fifteen (15) calendar days.

The Contractor must have an updated link to their formulary available on their website.

By October 1 of the contract year, the Contractor must post a copy of their January 1 formulary to enable members to make informed choices during open enrollment related to their medication coverage. The formulary can continue to be updated as needed over time, and accordingly should be labeled that it is subject to change.

8.7.B Formulary Closed Classes (DMAS Defined)

The Department will define closed classes on the CCF. The Contractor shall not add or remove drugs including alternative dosage forms to drug classes on the CCF. The Contractor shall not solicit additional rebates or discounts for drugs in closed classes.

The Department requires a 95% compliance rate to the closed classes of the Department PDL. The only exception will be for grandfathered authorizations up to thirty (30) days when a member transitions from another plan. MCO will be penalized \$25,000 per quarter for failure to comply. The \$25,000 penalty will be deducted from the capitation rate in the next quarter.

8.7.C Formulary Non-Closed Classes

The Contractor may add drugs to their formulary in CCF “open” drug classes. For open drug classes on the CCF, the Contractor retains the ability to negotiate rebates or discounts. All drug rebates and discounts must be reported to DMAS as defined in this contract.

8.7.D Program Preferred Drug Access Requirements

The “preferred drugs” included on the DMAS PDL and the Common Core Formulary may still be subject to edits, including, but not limited to, service authorization requirements for clinical appropriateness as determined by the DMAS P&T Committee. The Contractor shall assure that access to all “preferred drugs” from the DMAS PDL is no more restrictive than the DMAS PDL and the DMAS Supplemental PDL requirements applicable to the “preferred drug” and that no additional service authorization criteria or clinical edits are applied. In addition, the Contractor must comply with the CMS requirement that health plans may not use a standard for determining medical necessity for a “preferred drug” that is more restrictive than is used in the state plan.

8.7.E Contractor Responsibility to Deploy Changes to DMAS PDL

If DMAS makes any changes to the PDL, the Contractor shall have sixty (60) calendar days after notification of the changes to the PDL to comply with the DMAS changes.

8.7.F Pharmacy Co-Pays

The Contractor may not impose co-payments on any medications.

8.7.G Pharmacy Exclusions

The Contractor must exclude coverage for the following:

- Drugs used for anorexia or weight gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are;
- used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;

- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs and
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

8.7.H Medication Therapy Management (MTM)

The Contractor shall implement a MTM program within the first ninety (90) days of operation. The MTM program shall include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists. The Contractor's MTM program must meet or exceed the requirements described in CFR 423.153(d)(1) and is applicable to all eligible members.

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.

8.7.I Pharmacy and Therapeutics (P&T) Committee

The Contractor shall have a P&T Committee that will ensure safe, appropriate, and cost effective use of pharmaceuticals for the Virginia Medicaid enrollees of this Contract.

The P&T Committee shall serve in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of this Contract and the appropriate use of medications.

The Contractor's P&T Committee shall meet at least semi-annually.

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. The Contractor shall require all individuals participating in the P&T Committee to complete a financial disclosure form annually which is reviewable by the Department upon request.

8.7.J Drug Utilization Review (DUR) Programs

In following with 42 CFR§ 438.3(4)(5), the Contractor shall develop and maintain a DUR program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR 456, subpart K including prospective DUR, retrospective DUR, educational program, and the DUR Board.

The Contractor's DUR program shall comply with requirements in the federal Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Public Law 115-271).

The Contractor is not required to have a separate DUR Board. The Contractor may utilize its P&T Committee or comparable committee to fulfill the DUR requirements defined at 42 C.R.F. 456, Subpart K and 1927 (g) of the Social Security Act. If the Contractor does not maintain a separate DUR Board; the Contractor must define, for the Department's review and approval, how it will fulfill the DUR requirements under the Contract.

The Contractor's DUR Board will meet at least semi-annually. The DUR Board must include a voting representative from the Department. DMAS must receive meeting notification and associated meeting materials at least 7 business days prior to the meeting. The Contractor must provide the Department with the minutes from each DUR Board meeting within thirty (30) calendar days of the date of the meeting.

The Contractor must submit to the Department a copy of its CMS DUR Annual report, a detailed description of its DUR program activities as described in 42 CFR 456.712, at least forty-five (45) days prior to the due date established by CMS. The Department will share with the Contractor all reporting requirements including the web link for the submission of the DUR Report to CMS.

The Contractor shall require all individuals participating on the DUR Board to complete a financial disclosure form annually which is reviewable by the Department upon request.

8.7.K Drug Rebates

Any outpatient drugs dispensed to members covered by the Contractor (including where the Contractor paid as the primary and/or secondary payer under this Contract) shall be subject to the same rebate requirements as the State is subject to under Section 1927 and the State shall invoice such rebates from pharmaceutical manufacturers.

The Contractor shall report on a quarterly basis (within 45 days of the end of the quarter) all rebates invoiced and rebates collected on drugs or devices dispensed to any Medicaid Member from pharmaceutical manufacturers, distributors or any other source since the plan's participation in the Medallion 4.0 program. Refer to the Managed Care Technical Manual for the format and requirements.

Any impact to the collection of manufacturer rebates allowed under federal law that is the result of delayed encounter claim submission to the Department or the omission of required claim-level data elements will be assessed as a contract penalty at the full amount of lost manufacturer rebates.

Drug utilization encounter data must include all drugs 1) dispensed at point-of-sale (POS), 2) administered in a provider's office or 3) other outpatient settings including outpatient hospitals. Pursuant to Section 2501(c)(1)(C)(III) of the Social Security Act, the Department requires encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS drug code. Unless otherwise specified by the Department in supporting documentation, the quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier (F2, ML, GR or UN) is also

required. Each HCPCS drug code must be submitted with a valid NDC and NDC units on the corresponding claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a separate claim line. For the purpose of this contract the term “administer” is defined to include the terms “provide” and “dispense.” Drug utilization data for MCO reporting must be reported based upon the date dispensed (date of service) within the quarter, as opposed to the claim paid date. As set forth in 42 CFR §438.3(s)(2), the Contractor must report drug utilization encounter data that is necessary for the Department to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period.

As set forth in 42 CFR §438.3(s)(3), the Contractor must develop a process and procedure to identify drugs administered under Section 340B of the Public Health Service Act as codified at 42 USC § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate program. Failure to identify aforementioned 340B drugs on submissions to the Department or its rebate vendor shall be treated as a compliance violation. The Contractor shall identify encounter claims administered under Section 340B in a manner, mutually agreed upon between the Department and the Contractor, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing. If a Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the Contractor shall ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This shall include the use of a unique BIN/PCN combination to distinguish Medicaid managed care claims from commercial or other lines of business. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered as part of the DMAS pharmacy benefit.

The Contractor (and/or its Pharmacy Benefits Manager) must make available two (2) pharmacy representatives (one primary and one secondary) to work directly with the Department and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

8.7.L Prescription Monitoring Program (PMP)

The Department of Health Professions established, maintains, and administers an electronic system to monitor the dispensing of Schedule II, III, and IV controlled substance prescription drugs pursuant to § 54.1-2520 and § 54.1-3400 et. seq. of the Code of Virginia, known as the Prescription Monitoring Program (PMP).

Under § 54.1-2523 of the Code of Virginia, the Contractor may obtain information from the PMP about specific members in order to determine eligibility and to manage the care of the specific member participating in the PUMS or a similar program (refer to the Patient Utilization Management & Safety (PUMS) Program section of this Contract for more information.) Information may only be obtained by a current employee of the Contractor who is also a physician or pharmacist licensed in the Commonwealth.

The Contractor shall give notice to members that information may be requested from the Prescription Monitoring Program by a licensed physician, pharmacist, or designated and

authorized Department of Health Professions licensed professional employed by the Contractor. The Contractor must notify its members of the possibility that the member's information may be accessed using the PMP, such as via the Member Handbook, postcard mailings, PUMS letters, etc. Note that all data related to the PMP are exempt from FOIA requests and considered confidential information.

a. Process for Contractor Access to the PMP

The Contractor shall provide to DMAS, in the format specified by the Department of Health Professions, an actively maintained list of up to eight (8) Commonwealth-licensed pharmacists/physicians employed by the Contractor who will be utilizing the PMP. PMP access login credentials will be provided by the Department of Health Professions and shall not be delegated to or used by other staff. The Contractor, and its employees accessing the PMP, shall only use the PMP in accordance with all applicable State laws, including but not limited to § 54.1-2520, § 54.1-2523, and § 54.1-3400 et. Seq. of the Code of Virginia, and will be required to attest to such usage as a conditional term of access. The Contractor shall notify the Department of Health Professions immediately (within twenty-four (24) hours) when an employee is terminated or of any other situation (such as a transfer of position or change in job responsibilities) arising that would render PMP access by the individual employee as no longer required or appropriate. The Contractor acknowledges that the Department of Health Professions will be able to monitor Contractor use for compliance, outlier activity, and has the authority to sanction any misuse of the PMP without DMAS involvement.

8.7.M Utilization Management for Pharmacy Services

a. Transition of Care

The Contractor shall have in place policies and procedures to ensure the transition of care for Members with established pharmacological treatment regimens. The Contractor shall also ensure that it is able to process pharmacy claims using either the Medicaid ID or the MCO ID number. The MCO will allow a 30 day transitional refill for all prescriptions the member had received from the prior health plan.

b. Service Authorization

The Contractor shall have in place authorization procedures to allow providers to access drugs outside of the formulary, if medically necessary. This includes medications that are not on the Contractor's formulary, and especially in relation to the Attention-Deficit/Hyperactivity Disorder (ADHD) class of medications (e.g., safeguards against having individuals go back through the Contractor's step therapy program when pre-authorizations end).

The Contractor may require service authorization as a condition of coverage or payment for a covered outpatient drug. The Contractor shall follow service authorization procedures pursuant to the Code of Virginia § 38.2-3407.15:2 and comply with the requirements for prior authorization for covered outpatient drugs in accordance with Section 1927(d)(5)(A) of the Social Security Act and 42 CFR §§ 438.3(s)(6), and 438.210(d)(3). The Contractor shall incorporate the requirements into its pharmacy

provider contracts. The Contractor shall not require a pharmacy service authorization as secondary payer as long as the primary payer has made any payment for the cost of the medication.

The Contractor must accept telephonic, facsimile, or electronic submissions of service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug programs' SCRIPT standards for service authorization requests.

Pharmacy services for children must be reviewed in accordance with EPSDT requirements to cover drugs when medically necessary based upon a case-by-case review of the individual child's needs, such as for off-label use.

The Contractor must submit all pharmacy service authorization and step therapy policies, procedures, and any associated criteria to DMAS for review and prior approval.

The Contractor must submit any proposed pharmacy program changes, such as pill-splitting programs, quality limits, etc. to DMAS for review and approval prior to implementation.

c. Day Supply Limitations

The Contractor must limit coverage to a maximum of a thirty four (34) day supply of medication per prescription per member in accordance with the prescriber's orders and subject to the Board of Pharmacy regulations, unless otherwise stated below. The Contractor must cover prescriptions of contraceptives for up to a twelve (12) month supply for beneficiaries in the Medicaid and CHIP programs. The Contractor must cover select maintenance legend and non-legend drugs identified in the "DMAS 90 Day Medication Maintenance List" for a maximum of a ninety (90) day supply per prescription per patient after two thirty four (34) day or shorter duration fills.

8.7.N Response to Service Authorizations and Denial of Services

The Contractor must provide a response by telephone or other telecommunication within 24 hours of a service authorization. If the Contractor denies a request for service authorization, the Contractor must issue a Notice of Action within twenty-four (24) hours of the denial to the prescriber and the member. The Notice of Action must include appeal rights and instructions for submitting an appeal in accordance with the requirements described in the Grievances and Appeals section of this Contract. The Department reserves the right to conduct random reviews to ensure that enrollees are being notified in a timely manner in accordance with 42 CFR §438.228.

8.7.O Emergency Supply

A seventy-two (72) hour emergency supply of a prescribed covered pharmacy service shall be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, feels that the Member's health would be compromised without the benefit of the drug.

8.7.P Notification Requirement

The Contractor must have policies and procedures for general notifications to participating providers and Members of revisions to the formulary and service authorization requirements. Notification for changes to the formulary and service authorization requirements and revisions must be provided to all affected participating providers and Members at least thirty (30) calendar days prior to the effective date of the change.

8.7.Q Pricing Data for Pharmacy Benefit Management Programs

The Contractor shall report the following to the Department for all pharmacy claims:

- The actual amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement;
- Dispensing fees;
- Copayments and;
- The amount charged to the plan sponsor for each claim by its pharmacy benefit manager. Reporting requirements are defined in the State Companion Guides and the Technical Manual.

In the event the Department identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy benefit manager the health plan shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. On a monthly basis, the Department will notify the health plan when this report is required. Health plans are required to provide such reports by the 15th of each month or the next business day. Further reporting requirements are defined in the MCTM.

8.7.R Requirements for Pharmacy Benefit Management Programs

Any agreement between the Contractor and a pharmacy benefits manager shall include provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the Contractor's managed care plan.

8.7.S ARTS Pharmacy Management

The Contractor shall be responsible for covering all legend and non-legend Food and Drug Administration (FDA) approved drugs for members based on the Common Core Formulary 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. Criteria may be located on the DMAS website at: <https://www.virginiamedicaidpharmacyservices.com>. The Contractor is expected to meet all other requirements as set forth in the Pharmacy section of this Contract.

The Contractor or its Pharmacy Benefit Manager, at a minimum, will cover all DMAS Preferred Drug List (PDL) "preferred" non-opioid pharmacologic therapies for pain. The Contractor shall cover naloxone injection and nasal spray without restrictions for all Members. The DMAS PDL can be accessed at <https://www.virginiamedicaidpharmacyservices.com>. The Contractor shall assure that coverage is no more restrictive than the applicable DMAS PDL requirements and that no additional service authorization criteria, quantity limits or clinical edits are applied.

The Contractor shall be responsible for complying with the DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria can be found in the DMAS Provider Memo dated December 1, 2016 titled “Implementation of CDC Guideline for Prescribing Opioids for Chronic Pain – Coverage of Non-Opioid Pain Relievers and Uniform, Streamlined Prior Authorization for New Opioid Prescriptions Effective December 1, 2016”.

The Contractor shall cover buprenorphine containing drugs, naltrexone, and methadone when provided as part of Medication Assisted Treatment (MAT) program which includes psychosocial therapy at rates no less than the Medicaid Fee-for-Service fee schedule in place at the time of service.

The Contractor shall utilize the Department’s approved service authorization criteria and quantity limits for methadone, short-acting opioids, long-acting opioids and buprenorphine containing products when evaluating benefit coverage. DMAS approved service authorization forms can be accessed at <https://www.viriniamedicaidpharmacyservices.com/asp/authorizations.asp>. The Contractor shall not place additional service authorization criteria, quantity limits or other clinical edits on these drugs.

The Contractor shall allow prescriptions for preferred/formulary buprenorphine/naloxone drugs written by providers of organizations that are credentialed by the Contractor as a Preferred Office Based Opioid Treatment (OBOT) as well as in-network buprenorphine waived providers (BWP) to by-pass all service authorization requirements when prescribed in dosages at or below the Board of Medicine recommendation. The Contractor shall not authorize more milligrams per day than exceed the Board of Medicine allowance.

The Contractor shall ensure all orders, prescriptions, or referrals for items, or services for Members originate from appropriately licensed practitioners. The Contractor must credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to Medallion 4.0 members. All claims for payment for ordered or referred drugs, items or services must include the NPI of the ordering or referring physician or other professional. If the NPI is not provided on the claim for payment of the ordering or referring provider is not credentialed by the Contractor, the Contractor may deny the claim, unless otherwise instructed by DMAS. The Contractor must permit claims for the preferred product for treatment of Opioid Use Disorder (OUD) - Suboxone® film - to be approved for all in-network and out-of-network prescribers for up to 90 calendar days. This requirement does not apply to Sublocade™ SQ, which must only be covered by MCO in-network prescribers. The contractor must not require a prior authorization for Sublocade™ SQ. The only prerequisites will be the REMS criteria from the specialty pharmacy. Claims for the mono-buprenorphine product written by Preferred Office-Based Opioid Treatment (OBOT) providers shall process without prior authorization restrictions while other in-network and out-of-network would be limited to a pregnancy diagnosis and/or 9 month prenatal vitamin lookback.

8.8 SOCIAL DETERMINANTS OF HEALTH

The Contractor shall collaborate with the Department to continually develop programs and/or establish partnerships to address social factors that affect health outcomes, also called social

determinants of health (SDOH), which contribute significantly to the cost of care and the member's health care experience. The Contractor shall provide care coordination efforts that identify and address member access to employment, food security, housing stability, education, social cohesion or resources that support Member connection to social supports, health and health care, as well as environmental needs identified by the member. These social determinants are encompassed under five key areas: Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment.

On an annual basis, the Contractor shall complete the following reporting requirements: A) the Contractor shall submit its policies and procedures related to the programs and partnerships established to address SDOH;

B) the Contractor shall submit Care Coordination Training Materials for both the Medallion 4.0 non-expansion and Medicaid Expansion Populations;

C) the Contractor shall submit its policies and procedures related to identifying, addressing, and tracking the following three (3) determinants belonging to the SDOH areas described as Economic Stability:

- Employment
- Food security
- Housing stability

The Contractor shall utilize the pdf templates for submission of its policies and procedures and other reporting requirements in the format(s) specified in the MCTM.

The Department has the discretion to expand the SDOH reporting criteria throughout future Contract years, to include specific data for the areas noted above or additional areas as necessary.

The Department encourages the Contractor to focus SDOH programs and partnerships on addressing the following priority populations:

- Transitions of care – Members transitioning from the hospital to the community, from the nursing facility to the community, and from incarceration to the community;
- High Risk populations – Members who are considered high emergency department (ED) utilizers; Children with asthma;
- Substance use / Opioid Use Disorders – Members with SUD and/or OUD especially pregnant mothers with SUD and/or OUD.

8.8.A Nutritional Insufficiency Initiative

As nutritional insufficiency of Medicaid enrollees is a significant concern for the Commonwealth, the Contractor shall work collaboratively 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.

8.9 INNOVATION

The Contractor shall submit an annual plan reflecting its work on innovations in health care delivery that support and promote Medicaid and efficient and effective health care delivery. This plan should be reported by September 30.

9. QUALITY IMPROVEMENT (QI) & POPULATION HEALTH OVERSIGHT

DMAS is responsible for evaluating the quality of care provided to eligible enrollees in the contracted managed care organizations (MCOs). To ensure the care provided meets acceptable standards and Medicaid members are receiving high quality cost effective care, driven by innovation; DMAS follows both state and federal regulations in addition to DMAS' policies. DMAS partners with MCOs to provide high quality integrated physical, and behavioral services that will improve the health and wellbeing of our members. The care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness.

Quality improvement (QI) is a continuous improvement process. QI is a proactive approach to improve members' experience of care, improve member health, and reduce per capita costs of health care.

9.1 QUALITY DEFINITION AND DOMAINS

As defined by Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Guided by this definition, the Contractor shall deliver quality care that enables its Members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

1. Quality of physical health care, including primary and specialty care;
2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;
3. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and Medallion providers and services;
4. Continuity and coordination of care across all care and services settings, and for smooth transitions in care and maximum care continuum; and,
5. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services.

9.2 QUALITY IMPROVEMENT (QI)

The Contractor shall cooperate with the Department's quality improvement requirements to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor shall cooperate with the Department or its designated agent (EQRO) with quality improvement activities in accordance with federal regulations, CMS recommended protocols, and the processes utilized by the Department or its designated agent.

9.3 QUALITY IMPROVEMENT STRUCTURE

9.3.A Quality Assessment and Performance Improvement Program

In compliance with 42 CFR § 438.330, the Contractor shall provide to the Department annually in accordance to the Technical Manual timeline, a written description of its ongoing Quality Assessment and Performance Improvement (QAPI) program.

The contractor shall have a comprehensive QAPI program and must include collection and submission of performance measurement data, including any required by the Department or CMS as specified:

1. The Contractor should clearly define its quality improvement structure.
2. Address all aspects of health care, including specific reference to behavioral health care with respect to monitoring and improvement efforts, and integration with physical health care.
3. Address involvement of a behavioral healthcare clinician(s) with respect to the QI program.
4. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems;
5. Include organization-wide policies and procedures that document processes through which the Contractor ensure clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management;
6. Be fully compliant with and contribute to the Virginia Medicaid Quality Strategy and the annual DMAS Quality Work Plan;
7. Identify and analyze objectives for servicing diverse memberships to include but not limited to analyzing significant health care disparities gaps; and,
8. Have a Quality Improvement Committee that oversee quality functions as outlined in the contract; and.
9. Evaluate the QAPI annually and update as appropriate.

The QAPI shall also include written processes for taking appropriate Remedial/Corrective Action whenever, as determined under the QAPI, inappropriate or substandard services are furnished, or services that should have been furnished were not. These written remedial/corrective action procedures include:

1. Specification of the types of problems requiring remedial/corrective action;
2. Specification of the person(s) or body responsible for making the final determination regarding the quality problems;
3. Specific actions to be taken;
4. Provisions of feedback to appropriate medical or behavioral health providers and staff;
5. The schedule and accountability for implementing corrective actions;
6. The approach to modifying the corrective action if improvements do not occur; and,
7. Procedures for terminating the affiliation with physical or behavioral health providers.

The Contractor shall use the results of the QAPI activities to improve the quality of services and member's health with appropriate input from providers and members.

Contractor shall take appropriate action to address service delivery, including continuity and coordination of care, access to care, utilization of services, health education, and emergency services; patient safety; provider; and other QAPI issues they identified.

The Contractor shall make all information about its QAPI available to providers and members. The Contractor shall include in all its provider contracts, a requirement securing cooperation with the QAPI.

9.4 ANNUAL EVALUATION OF THE QAPI/QI PROGRAM

Pursuant to 42 CFR § 438.330, the comprehensive QAPI must include a mechanism to detect underutilization and overutilization of services; and, to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State Quality Strategy. The Standards for Quality Management and Improvement are from the most recent version of the NCQA's Standards and Guidelines for the Accreditation of Health Plans. The Contractor shall conduct an annual written evaluation of the QI program that includes the following information:

1. The evaluation of the QAPI shall address quality studies and other activities completed; and ongoing QI activities that address quality and safety of clinical care and quality of services;
2. Trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and
3. An analysis and evaluation of the overall effectiveness of the QAPI program to include its progress toward influencing network wide safe clinical practices.

Health Plans new to Virginia Medicaid shall provide their Quality Improvement Plan (QIP) at least sixty (60) days before the first membership file is provided to the MCO. The new MCO shall submit a plan that adheres to NCQA's "Element A, Standards for Quality Improvement Plan Structure." The new health plan must provide the Department with an update to its QIP at least once every twelve months for possible review by both the Department and the EQRO.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's Medallion 4.0 website.

9.5 QUALITY STRATEGY

DMAS developed a Medicaid Comprehensive Quality Strategy in accordance with the Code of Federal Regulations (CFR), at 42 CFR §438.340. DMAS developed the Quality Strategy to continually improve the delivery of quality health care to all Medicaid and Children's Health Insurance Program [CHIP] recipients served by the Virginia Medicaid managed care and fee-for-service (FFS) programs. DMAS' Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

The Contractor's QI program and work plan shall align with the Virginia Medicaid Quality Strategy to include the Medicaid expansion population. The Contractor's QI initiatives shall be

designed to help achieve the goals outlined in the Virginia Medicaid Quality Strategy. The Quality Strategy is available publicly on the DMAS website.

9.6 QUALITY COMMITTEE MEETING REQUIREMENTS

The Contractor shall have a Quality Committee with established parameters for the role, structure, and the function of the committee defined. The Committee shall include a designated senior executive who is responsible for program implementation, the Contractor's Quality Director, Chief Medical Officer and plan providers.

This Committee shall analyze and evaluate the result of the quality activities, recommend policy decisions, ensure that providers are involved in the Quality program, institute needed action, and ensure that appropriate follow-up occurs.

The Quality Committee shall review the approved written Quality Assessment and Performance Program (QAPI) work plan and associated work prior to submission to DMAS.

The QAPI Committee shall be accountable to the Contractor's Governing Body. The Governing Body of the organization is a designated committee of the senior management of the Contractor. Responsibilities of the Governing Body for monitoring, evaluating, and making improvements to care include:

1. Oversight of Quality Program- There is documentation that the Governing Body has approved the overall Quality Program and the annual QAPI work plan.
2. Quality Program Progress Reports-The Governing Body receives written reports at least quarterly from the Quality Committee describing actions taken, progress in meeting quality objectives, and improvements made.
3. Program Modification- Upon receipt of regular written reports from the Quality Program delineating actions taken and improvements made, the Governing Body take action when appropriate and directs that the operational quality program be modified on an ongoing basis to accommodate review findings and issues of concerns within the organization. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality monitoring and improvement.

The QAPI Committee shall meet on a regular basis (no less than quarterly) with specified frequency to oversee quality activities. This frequency is sufficient to demonstrate that the structure/committee is following-up with specified frequency to oversee quality activities. The QAPI Committee shall keep written minutes of all meetings. A copy of the signed and dated written minutes for each meeting shall be available on-file after the completion of the following committee meeting in which the minutes are approved and shall be available for review upon request an during the Operational System Review completed by the EQRO.

9.7 QI STAFFING

The Contractor shall employ and maintain sufficient and qualified staff to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. The Contractor shall report all key staffing changes to the Department as requested in Section 3.7 of this contract. QI staff shall include:

1. Key Contractor and subcontractor staff who can represent all major areas of the Contractor's Medallion line of business;
2. At least one designated physician who shall be a Medical Director or Associate Medical Director; at least one designated behavioral health clinician;
3. A qualified individual dedicated to serve as the QI Director who will be directly accountable to the Contractor's Project Manager or Medical Director/Chief Medical Officer and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Contractor's executive leadership team. This individual shall be responsible for:
 - Overseeing all QI activities related to Members, ensuring compliance with all quality activities, and maintaining accountability for the execution of, and performance in, all such activities;
 - Maintaining an active role in the Contractor's and subcontractor's overall QI structure; and,
 - Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities.

9.8 QUALITY COLLABORATIVE

The Contractor shall actively participate in the Quality Collaborative, including attendance at all meetings by the QI Director and the Contractor's Chief Medical Officer or Medical Director or designee if approved by the Department in advance of the meeting. The Contractor shall also actively participate in all other workgroups that are led by the Department, including any quality management workgroups or activities that are designed to support QI activities and provide a forum for discussing relevant issues.

Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup. The Contractor shall also serve as a liaison to, and maintain regular communication with, the Department or its designated QI representatives.

Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or promptly sharing data relevant to all QI activities. These QI activities may include ongoing health plan quality monitoring, sharing quality data and best practices through the Quality Collaborative, coordinating performance improvement projects, and participating in a quality workgroup for survey planning and Medallion Health Plan Rating System development updates as needed.

These workgroups will be attended by representatives of the Department, the Department's contractors, and other entities, as appropriate. The Contractor will identify qualified representatives, including the QI Director and senior physicians such as medical directors or associate medical directors and clinicians who are actively working on quality activities, to participate in these workgroups.

9.9 HEDIS MEASURES

The Contractor is required to consent to publication via NCQA's Quality Compass of all Medicaid HEDIS measures for the Virginia Medicaid product. The Department will require all measures to be reported based on populations in accordance to the Virginia Medallion 4.0 Managed Care Organization Data Request document provided by the EQRO. In addition, the Contractor shall, at a minimum, consider the following Medicaid HEDIS performance measures

as a priority. The Contractor will assure annual improvement in these Medicaid HEDIS measures until such time that the Contractor is performing at least at the 50th percentile for “HMOs” as reported by Quality Compass. Thereafter, the Contractor is to at least sustain performance at the Medicaid 50th percentile. The Contractor is encouraged to set goals to support the Department’s goal of attaining the seventy-fifth (75th) percentile for each of these measures. All measures must be calculated without rotation per NCQA technical specifications:

- Childhood Immunization Status (Combo 3), each vaccine must be reported separately
- Comprehensive Diabetes Care including: Hemoglobin A1C testing and control, retinal eye exam, and blood pressure control
- Controlling High Blood Pressure
- Postpartum Visits
- Timeliness of Prenatal Care
- Breast Cancer Screening
- Antidepressant Medication Management (Acute Phase and Continuation Phase)
- Follow-Up Care for Children Prescribed ADHD Medication (initiations, continuations and maintenance phases)
- Follow-up after Hospitalization for Mental Illness (seven (7) day follow up only)
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits
- Cervical Cancer Screening
- Medical Assistance with Smoking and Tobacco Use Cessation (different facets include: advising smokers to quit, discussing cessation medication, discussing cessation strategies)
- Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adults’ Access to Preventative/Ambulatory Health Services
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Colorectal Cancer Screening
- Flu Vaccinations for Adults Ages 18-64

In conducting these HEDIS calculations, the Contractor shall use the hybrid methodology unless HEDIS technical specifications only require the use of administrative data only, unless otherwise specified by the Department. Failure to use hybrid methodology may result in corrective action. The scores for the measure which are in effect on January 1 of the applicable contract year must be reported to the Department by July 31 of the same year. (For example, HEDIS technical specifications used for calculating and uploading scores to NCQA in June 2020 must be reported to the Department by July 31, 2020). In order to facilitate the Department’s reporting requirements to the CMS on national measures, the Contractor is required to provide all numerators and denominators for all measures listed above. With respect to the HEDIS measures listed in the contract, the Contractor’s scores may be publicized in a manner that ensures the results are available and understandable to the general public and actual and potential Medicaid members.

9.10 OTHER MEASURES

In addition to HEDIS measures, DMAS has identified clinical quality, access, and utilization measures using nationally recognized measure sets to track and trend MCO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures will be listed in the DMAS Quality Dashboard and are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each MCO's provider network. Additionally, when selecting measures for the specific needs of the populations, DMAS will take into consideration the availability and reliability of the data for Medallion 4.0 Medicaid Managed Care Contract that are used to calculate the measure.

- OHSU: Developmental Screening in The First 3 Years of Life
- Early Elective Deliveries Rate
- CDC: Percent of Live Births <2,500 Grams
- AHRQ: PQI 14: Asthma Admission Rate (2-17)
- AHRQ: PQI 15: Asthma in Younger Adults Admission Rate
- AHRQ: PQI 05: COPD and Asthma in Older Adults Admission Rate

9.11 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®)

The Contractor will perform the Children and the Adult CAHPS annually. The CAHPS Adult Survey and the CAHPS Child Survey reports provided to the Department shall include detailed results for all survey items. Composite scores shall also be reported. The Contractor is required to submit their CAHPS for Children and CAHPS for Adults results to the Agency for Healthcare Research and Quality (AHRQ) for inclusion in the National CAHPS Benchmarking Database if the option is available through AHRQ. Performance on CAHPS surveys may also be publicized as described above. The Contractor is required to identify Spanish speaking members through administrative data and ensure those members who are included in the CAHPS sample receive the Spanish version of the survey rather than the English version.

9.12 EQRO QUALITY ACTIVITIES

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the EQRO, which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for members' medical records in the format and timeframe requested by the EQRO or the Department.

The Contractor shall also submit requested information from the Department or EQRO for Performance Measure Validation, Performance Improvement Projects, Annual Technical Reports, Network Adequacy Reporting, Comprehensive or Modified Operational Systems Reviews, and other EQRO quality reporting requirements as described in this section by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the Contractor to the Department at least one week prior to the requested due date.

9.13 PERFORMANCE IMPROVEMENT PROJECT VALIDATION

The Contractor shall conduct annual performance improvement projects (PIPs) for validation by the EQRO, in accordance with CMS requirements in 42 CFR § 438.330(d). The Department shall

select the topics, and each PIP must include implementation of interventions to achieve improvement in the access to and quality of care.

The Contractor shall perform a least one (1) clinical and one (1) non-clinical PIP in a format specified by DMAS. The Contractor shall ensure that CMS protocols for PIPs are adhered to and that the following are documented for each activity:

1. Rationale for selection as a quality improvement activity;
2. Specific population targeted, including sampling methodology if relevant;
3. Metrics to determine meaningful improvement and baseline measurement;
4. Specific interventions (enrollee and/or provider);
5. Relevant clinical practice guidelines; and
6. Date of re-measurement

The Contractor shall ensure that the topics selected as PIPs reflect the population served by the Contractor in terms of age groups, disease categories, and special risk status.

The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

The Contractor shall use evaluation criteria established by DMAS, determine if one or all PIPs should be continued. Prior to discontinuing a PIP, the Contractor shall identify a new PIP and must receive DMAS's approval to discontinue the previous PIP and perform the new PIP.

The measures for each contract period will be communicated by the Department to the Contractor at a time and in a format as determined by the Department. The due date for PIPs and validation shall be in accordance with the process & methodology of the Department's EQRO agent.

The Contractor must comply with any methodology for PIPs and validation, including but not limited to, rapid cycle improvement models.

9.14 PERFORMANCE MEASURE VALIDATION (PMV)

To meet a CMS EQR mandated activity for validating performance measures, the EQRO will validate a select group of the Contractor's HEDIS or Non HEDIS scores on an annual basis. The measures for each contract period will be communicated by the Department to the Contractor each year at a time and in a format as determined by the Department.

The EQRO will follow the current CMS recommended protocol for validating performance measures, "Validating Performance Measures, A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol."

New Health Plans: The timing of this requirement will be in alignment with the NCQA's most current timeline for Standards and Guidelines for Accreditation of Health Plans. The first performance measure validation will occur the same year as the "First" NCQA evaluation option, which would occur during year three (3) of the health plan delivering care to Virginia Medicaid

members. However, all MCOs that are not accredited and receive a comprehensive onsite review from the EQRO this contract year should expect the EQRO to review the MCOs data validation capabilities during the IS assessment.

9.15 OPERATIONAL SYSTEMS REVIEW (OSR)

Once every three (3) years, the Contractor shall cooperate with and allow the EQRO to perform an onsite review of each of the MCO's operational systems as mandated by CMS through 42 CFR §438.358 (b)(iii).

During the years when the comprehensive OSR is not conducted, the Department may convene a team of internal subject matter experts or contract with the EQRO to perform a "modified-OSR" of the Contractor. The modified-OSR will focus on those elements identified during the most recent OSR as needing improvement and any critical elements of the MCO contract that may need focused attention. The next comprehensive OSR is scheduled for 2021.

For all modified and comprehensive operational system reviews, the Contractor shall adhere to the timelines and tasks set forth by the EQRO or the Department.

9.16 NETWORK ADEQUACY VALIDATION

In accordance with 42 CFR § 438.358(b)(iv), the EQRO will validate network adequacy as it relates to the access requirements set forth in 42 CFR § 438.68 and defined in Section 4 of this contract. The review period will be the preceding 12 months of the contract period.

9.17 COORDINATION OF QI ACTIVITY WITH OTHER MANAGEMENT ACTIVITY AND PUBLICATION OF RESULTS

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels. QI activities shall be coordinated with other performance monitoring activities, including the monitoring of members' grievances and appeals and shall reflect the most current requirements of NCQA.

As required by CMS per 42 CFR § 438.334 to publish a quality rating system (QRS), the Department will publish a consumer decision support tool, comprised of performance measurement data collected from the Contractor. This data will include performance measures identified by CMS and stakeholders and will be published once a year and posted on the Department's Medallion 4.0 website.

The consumer decision support tool will be available by May of each year.

As outlined in 42 CFR § 438.340 the Department will draft and implement a quality strategy for assessing and improving the quality of health care and services furnished by the Contractor. This strategy will be reviewed and updated as needed, but no less than once every three (3) years.

9.18 PERFORMANCE WITHHOLD PROGRAM

The Department introduced the Performance Withhold Program to reinforce VBP principles by setting performance standards and expectations for Contractors in key areas influencing member health and health outcomes. By tying financial incentives to Contractor performance on

designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members. This effort also aligns with the Virginia Medicaid focus areas by including measures pertaining to chronic conditions, prevention, and maternity care.

9.18.A PWP Assessment and Measures

The PWP focuses on measures of Contractor performance in facilitating high quality care for Members under the Medallion 4.0 program. The table below entitled “Current Performance Withhold Program Measures” identified the measures relevant to the PWP. The scoring structure and processes will be made available in the Medallion Technical Manual and on the Department’s website at <https://www.dmas.virginia.gov/#/valuebasedpurchasing>.

The PWP withhold percentage is one percent (1%) of the Contractors’ PMPM capitation rate system payments. Consistent with the methodology developed with the EQRO, the Department will determine the portion of the withhold each Contractor can earn back based on the extent to which the Contractor’s performance compares favorably against benchmarks set for each measure.

Current Performance Withhold Program Measures

#	Measure	Measure Type
1	Adolescent Well-Care Visits	HEDIS
2	Childhood Immunization Status – Combo 3	HEDIS
3	Prenatal and Postpartum Care	HEDIS
4	Comprehensive Diabetes Care	HEDIS
5	Asthma Admission Rate	AHRQ - PDI
6	Follow-up After Emergency Department Visits for Mental Illness	HEDIS

The Department reserves the right to amend the measures included under the PWP composite in future years and may further amend performance thresholds associated with satisfactory performance, the withhold percentage, and other features necessary for implementation of the PWP at its discretion and shall make any such changes to the PWP known to Contractors and the public through adjustments to the Medallion managed care program contract.

9.19 VALUE-BASED PAYMENTS (VBP)

Value Based Payment (VBP) includes a broad set of payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care.

The Contractor shall maintain a VBP strategy that follows the Alternate Payment Model (APM) framework in the White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on models in categories three (3) and four (4).

The Contractor will assure annual improvement in the level of VBP penetration until such time that the contract has a minimum of 25 percent of its relevant spending for medical services governed under VBP arrangements. The Department will take this figure from the Contractors' annual HCP-LAN APM Data Collection Submissions referenced below. The Department may revisit VBP penetration targets, including potential targets for the adoption of more advanced VBP (i.e. HCP-LAN categories 3-4) in future years.

9.19.A Contractor VBP Plan

The Contractor's policies and procedures shall have a VBP Plan for the adoption, evolution, and growth of APMs in its network. Each VBP Plan, as specified in the Medallion Managed Care Technical Manual and below, shall cover the current status of the Contractor's VBP efforts and strategies to enhance or further those efforts over the two subsequent contract years. The Contractor shall update its VBP Plan annually. The Contractor's VBP Plan shall, at a minimum, include:

1. Current State Review:
 - a. A detailed description of all APMs the Contractor is currently using within its Medicaid provider network, by provider type and the HCP-LAN APM framework category/sub-category into which the APM best fits (e.g., 2a, 3b, or 4a); and,
 - b. For the APMs identified above, the percentage of the Contractor's total Medicaid medical expenses expected to be paid under each type of APM model in the current contract year and prior contract year. The numerator and denominator should include all Medicaid related medical spending, including primary and acute, behavioral health, and drug spending.
2. Provider Readiness, Performance Review, and Communication
 - a. Assessment of provider readiness for VBP within the Contractor's provider network;
 - b. Methods and frequency for collection and assessment of quality performance data from providers; and,
 - c. Communication and collaboration approach with providers on reviewing performance and defining strategies for improvement.
3. Strategy and Alignment
 - a. Effectiveness of the Contractor's APM strategies for services and populations under Medallion 4.0, including how the APMs effect Member outcomes, experience, and associated medical spending; and
 - b. Relationship to the Contractor's commercial and/or Medicare Advantage VBP strategy and discussion of how these VBP strategies align with VBP efforts under the Medallion program.

The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals:

- Improved birth outcomes
- Appropriate, efficient utilization of high-cost, high-intensity clinical settings
- Reduce all-cause hospital readmissions

- Reduce hospital admissions for chronic disease complications

The Contractor shall submit a VBP Plan by January 1 of each contract year to achieve both Contractor and Department goals to advance VBP. The Department reserves the right to request revisions to the Contractor's VBP Plan to align with Department priority areas. These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives in which Medicaid is a participant (i.e. multi-payer alignment of incentives across Medicare, Medicaid, and/or commercially insured populations in Virginia).

9.19.B VBP Status Report

The Contractor shall submit a VBP Status Report which includes additional details on its Medicaid VBP initiatives. At a minimum, the Contractor shall include the following information for each VBP initiative as specified in the Medallion 4.0 Reporting Manual and below:

1. VBP Category (and applicable subcategory, using the HCP-LAN model);
2. Short Description (including brief discussion of associated performance measures);
3. Goal(s) and measureable results;
4. Description of targeted providers and number of providers eligible and participating;
5. Description of targeted Members, number of eligible members whose services are covered by VBP initiative, and number of participating members;
6. Total Medicaid payments to providers for services covered under VBP initiative;
7. Total potential payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative; and,
8. Potential overlap with other VBP programs or initiatives.

The VBP Status Report and HCP-LAN Data Collection Submission (see below) shall be due by April 1 of each contract year and the submission shall cover the prior calendar year. The Department will provide a template for Contractors to use in completing this submission.

9.19.C Contractor HCP-LAN APM Data Collection Submission

The Department will use measurement methodologies developed by HCP-LAN to evaluate the adoption, evolution, and growth of VBP arrangements in a Contractor's Medicaid provider network. See <https://hcp-lan.org/apm-refresh-white-paper/>. DMAS will use the measurement methodologies as the framework for VBP. Annually, the Contractor shall complete the Medicaid APM data collection tool for the twelve (12) months of the prior calendar year Contractor submissions should include numerators and denominators that account for all relevant spending for medical services, including primary and acute, behavioral health, and drug spending. The HCP-LAN APM Data Collection Submission and VBP Status Report shall be due on April 1 of each contract year. The Department will provide a template for Contractors to use in completing this submission.

9.20 CLINICAL EFFICIENCIES

In December 2016, the Joint Legislative Audit and Review Commission (JLARC) published a study titled Managing Spending in Virginia's Medicaid Program (<http://jlarc.virginia.gov/medicaid-2016.asp>). Among the study's recommendations, JLARC called for the Department to work with its actuary to identify potential inefficiencies in the Medallion program and adjust capitation rates to account for these efficiencies. The Virginia

General Assembly subsequently enacted, and the Governor signed, budget language to execute this recommendation. To implement this mandate, the Department contracted with its actuary to identify clinical efficiencies (CE) under its managed care programs. The first set of CE analyses focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits, as well as efficient utilization and management of prescription drugs.

9.20.A CE Performance Measurement

To allow for more current and active measurement of the CE areas, the Department developed performance measures for CEs relating to hospital admissions, hospital readmissions, and emergency department visits. These measures allow the Department to run the CE analysis on current data and facilitate transparency in the calculation of each measure. As part of this transparency, the Department will make CE measure technical specifications available for Contractors to deploy for performance monitoring in a manner consistent with the Department. The Department will also provide annual performance reports to each Contractor illustrating the Contractor's performance across these three (3) CE areas.

9.20.B Performance Incentives

The Department's clinical efficiency policy aims to improve incentives for clinical performance and reward Contractors that achieve reductions in medically unnecessary and/or potentially preventable utilization of high acuity settings through the provision of high quality care that improves member health and clinical outcomes.

Both the Medallion and CCC Plus program rates will incorporate a 0.25% withhold specifically devoted to the Contractor's performance on the three (3) CE performance measures pertaining to hospital admissions, hospital readmissions, and emergency department visits. Prior to the start of each SFY, Contractors will receive a customized report from the Department illustrating the performance levels it must achieve on each measure to earn back the CE withhold amount. This report illustrates the Contractor's results on each measure and thresholds for full and partial credit in a given SFY for each of the three (3) CE performance measures. For additional details on the clinical efficiency performance measures, please refer to the Department website at <https://www.dmas.virginia.gov/#/valuebasedpurchasing>.

The Department will evaluate Contractor performance using the SFY (July 1 through June 30) after allowing a six (6) month claims run-out period to ensure data completeness. The Department will evaluate CE measure performance using only encounter data submitted by the Contractor. No other data will be used in assessing the Contractor's performance under these three CE performance measures, so all Contractors should take the necessary steps to ensure their data are accurate and complete prior to the end of the six (6) month claims run-out period following each SFY.

9.20.C Final Determinations

The Department reserves the right to amend, adjust, or otherwise modify any and all provisions, in part or in whole, associated with application of the CE performance measures and associated withhold, including, but not limited to, the adjustment of performance thresholds associated with

CE measures in the event mitigating and/or unforeseen factors make the achievement of such results unreasonable.

The Department will make all final determinations on Contractor CE measure performance, reasonableness determinations, and the corresponding amount of the CE withhold the Contractor earns back based on its CE measure performance. The Department will work with Contractors to address any disagreements in determinations on these points, but in the event the Department and the Contractor are unable to come to agreement, Department decisions are final and not subject to appeal.

10. COMPLIANCE AND REPORTING

10.1 COMPLIANCE MONITORING PROCESS (CMP)

The Department shall be responsible for conducting an ongoing Compliance Monitoring process (CMP). To support this work, the Contractor shall have its own compliance unit and reporting processes. As part of this process, the Department will review the performance of the Contractor in relation to the performance standards outlined in this Contract. The Department may, at its sole discretion, conduct any or all of the following activities as part of the CMP:

1. Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required under the terms of this Contract to submit to the Department or otherwise maintain;
2. Conduct Contractor, network provider, and subcontractor site visits; and,
3. Review Contractor policies and procedures, and other internal documents.

10.1.A Compliance Collaborative

The Contractor must participate in the Department's Compliance Collaborative meetings. The Contractor must ensure that at least one (1) member of the Contractor's Compliance Team will participate in person, as required.

10.1.B Compliance Review Committee (CRC)

The Compliance Review Committee is comprised of subject matter experts within the Department and serves as the Department's formal body to review Compliance Enforcement Action recommendations. The CRC meets monthly to provide a consistent process for reviewing all Compliance Enforcement Actions against MCOs under the Medallion 4.0 program to ensure consistency, fairness, and transparency in issuing compliance enforcement.

10.1.C Compliance Monitoring Process (CMP)

The purpose of the Department's Compliance Monitoring Process (CMP) is to detect and respond to issues of noncompliance and remediate contractual violations when necessary. The CMP uses a tiered points system to achieve the Department's goal of contract compliance. The CMP is comprised of a seven (7) level deficiency identification system described below.

a. CMP Point System

The Contractor incurs points due to issues of non-compliance. These points accumulate over a rolling twelve (12)-month schedule. The Department will carry over all active

points from the previous contract cycle, however, points more than twelve (12) months old expire and will no longer be counted. No points will be assigned for a violation the Contractor is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (i.e., natural disasters, etc.). Examples of violations and considerations listed in the Contract are not all-inclusive.

b. CMP Point System, Waiving Points

In cases where the Contractor is believed to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), the Department may assess or levy points on the Contractor. The Department will mitigate or consider waiving sanctions solely at its discretion for the following reasons:

- 1) The infraction is due to an unforeseen circumstance (including but not limited to acts of nature, DMAS IM issues, circumstances beyond the Contractor’s control, etc.); 2) for instances when the Contractor identifies and self-reports infractions to the Department in writing within thirty (30) business days of discovery; and, 3) the first time the Contractor incurs the infraction.

c. CMP Point System, Deducting Points

As an incentive for compliance with the provisions of this contract, the Department at its own discretion may deduct one point from the Contractor’s total point bank, for each quarter no punitive compliance action is taken against the Contractor. This deduction of points will not result in the refund of any financial penalties previously imposed, but will only impact the Contractor’s total point bank with regard to compliance actions going forward.

10.1.D CMP Deficiency Identification System - Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent compliance violation/incident. The compliance violation, unless otherwise defined, will be at the Department’s discretion based on the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident. Financial sanctions shall be imposed based on the infraction type and the Contractor’s accumulated points total. A Corrective Active Plan (CAP), MCO Improvement Plan (MIP), or other sanctions may be imposed in addition to the fines listed below. The Department has a seven (7) level compliance point system within its CMP. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	0-10	See 10.1.E	None
2	11-25	See 10.1.E	\$5,000
3	26-50	See 10.1.E	\$10,000
4	51-70	See 10.1.E	\$20,000
5	71-100	See 10.1.E	\$30,000

6	101-150	Suspend Enrollment	N/A
7	> 150	Possible Agreement Termination	N/A
Other	Specific Pre-Determined Sanctions	See Section 10.1.E.d, as the situation requires.	See Section 10.1.E.d.

10.1.E Compliance Violation Types

a. One (1) Point Violations

The Department may, at its discretion, assess one (1) point per incident of non-compliance when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor’s failure, as determined by the Department, impairs the Department’s ability to properly oversee and/or analyze Contractor performance. Examples of one point violations include, but are not limited to, the following:

1. Noncompliance with Encounter Submissions – Critical Errors: If the Department finds that the Contractor is unable to comply with the critical error standards related to encounter data submissions following the Department’s EDI requirements.
2. Failure to use the most current Contract as the basis for reporting, including all Contract Amendments to-date at the time of submission.
3. Failure to comply with the reporting format reflected in the most current Technical Manual.
4. Failure to meet reporting requirements of the Virginia All-Payer Claims Databased (to be assessed monthly until corrected).
5. Untimely, inaccurate, or improperly formatted submissions of reporting deliverables.

b. Five (5) Point Violations

- The Department may, at its discretion, assess five (5) points per incident of noncompliance when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor’s failure, as determined by the Department, has one of the following impacts: 1) Impairs a member or potential member’s ability to obtain accurate information regarding services, 2) violates a care coordination process, or 3) infringes on the rights of a member or potential member.

Examples of five (5) point violations include, but are not limited to, the following: With regard to five (5) point violations the Compliance Review Committee will take into consideration violations that:

1. Failure to provide accurate provider panel information.
2. Failure to provide Member materials to new Members in a timely manner.
3. Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a Member of his or her right to a state hearing when the

Contractor proposes to deny; reduce, suspend or terminate a Medicaid-covered service.

4. Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
5. Failure to meet the monthly call-center requirements for either the Member services or the 24-hour call-in system lines.
6. Provision of false, inaccurate or materially misleading information to health care providers, the Contractor's Members, or any eligible individuals.
7. Use of unapproved marketing or Member materials.
8. Failure to appropriately notify the Department, or Members, of provider panel terminations.
9. Failure to comply with a CAP (Corrective Action Plan) or MIP (MCO Improvement Plan).
 - a. Failure to actively participate in quality improvement projects or performance improvement projects facilitated by the Department and/or the EQRO.
 - b. Failure to meet provider Access to Care & Network Standards.
 - c. Failure to comply with the Department's defined critical encounter submission requirements (e.g., timeliness, failed voids, rebate date, etc.).

If the Department finds that the Contractor is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance. If the Department has identified specific instances where the Contractor has failed to take the necessary steps to comply with the requirements specified in this Contract by (1) failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance.

c. Ten (10) Point Violations

The Department may assess ten (10) points per incident of noncompliance when the Contractor fails to meet a program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts: 1) affects ability of the Contractor to deliver, or a member to access, covered services, 2) places a member at risk for a negative health outcome, or 3) jeopardizes the safety and welfare of a member and/or the continued viability of Virginia's Medicaid program.

Examples of ten (10) point violations include, but are not limited to, the following:

- Discrimination among Members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a Member in accessing needed services in a timely manner after receiving a request from the Members.
- Failure to provide medically-necessary Medicaid covered services to Members.
- Failure to comply with the oversight requirements of Subcontractors.

- Failure to comply with the Program Integrity Requirements set forth in the Contract.
- Failure to participate in transition of care activities or discharge planning activities.
- Failure to process prior authorization requests with the prescribed time frames.
- Repeated failure to comply with an ongoing or previously implemented CAP (Corrective Action Plan) or MIP (MCO Improvement Plan).
- The imposition of cost-sharing or copays on Members that are in excess of the cost-sharing limits or copays permitted under the Medicaid program.
- The imposition of any copays on Native American Members.
- Misrepresentation or falsification of information that the Contractor furnishes to the Department.
- Misrepresentation or falsification of information that the Contractor furnishes to a Member, potential Member, or health care provider.
- Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 AND 422.210.

d. Other – Specific Pre-Determined Sanctions

Adequate Network-Minimum Provider Panel Requirements

Any deficiencies in the Contractor’s provider network, as specified in Sections 4 and 5 of this Contract, may result in the assessment of a \$1,000 nonrefundable fine for each deficient provider category (e.g., PCPs, pediatricians, OB/GYNs). Compliance will be assessed at least quarterly.

The Department may assess additional sanctions (e.g. CAPs, points, fines) if (1) the Contractor violates any other provider panel requirements or (2) a Contractor’s member has experienced problems accessing necessary services due to lack of an adequate provider panel.

Submissions of Reporting Deliverables

All submissions, data, and documentation submitted by the Contractor must be received by the Department as specified in this contract and must represent the Contractors in an honest and forthright manner. If the Contractor fails to provide the Department with any required submission, data or documentation (including failure to use the proper templates contained in the Managed Care Technical Manual), the Department may assess points on a “per report” basis, unless the Contractor requests and is granted an extension by the Department. Assessments for late submissions will occur based on the frequency requirement of the submission (monthly, quarterly, annually).

Noncompliance with Claims Adjudication Requirements- 5 points

If the Department finds that the Contractor is unable to (1) electronically accept and adjudicate claims to final status, or (2) notify providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance. If the Department has identified specific instances where the Contractor has failed to take the necessary steps to comply with the requirements specified in this Contract by (1)

failing to notify non-contracting providers of procedures for claims submissions when requested or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the Contractor may be assessed five (5) points per incident of noncompliance.

10.1.F Compliance Letters

The Department will assess Contractor performance for potential areas of non-compliance on a monthly basis. Enforcement is determined by the Compliance Review Committee described in 10.1.B.

The Contractor will receive compliance letters as formal notice of identified non-compliance. Each compliance notification type described below is subject to point issuance and financial sanction collection outlined in 10.1.D excluding a Notice of Non-Compliance. Compliance letters include the following:

a. Notice of Non-Compliance (NONC):

The Department may issue Notices of Non-Compliance to document small or isolated problems not resulting in the issuance of any points, financial penalties, or the request of a MCO Improvement Plan or Corrective Action Plan. NONCs will not contain specific language regarding further compliance escalation or other consequences should the behavior/non-compliance continue. The MCO is required to acknowledge receipt of the notice, but is not required to submit a formal corrective plan.

b. Warning Letter:

The Department may issue Warning Letters when the MCO has already received a NONC, yet the problem persists. In addition, Warning Letters may be issued for a first offense for larger or more concerning issues where the Department determines the necessity to issue compliance points, financial penalties, or the Department requests a MCO Improvement Plan or Corrective Action Plan. Unlike NONCs, Warning Letters will contain language about compliance enforcement action (points, financial sanctions, etc.), as well as the potential escalation of compliance enforcement action to the MCO in the event the non-compliant performance continues.

c. Warning Letter with MCO Improvement Plan or Corrective Action Plan Request:

The Department may issue Warning Letters with a request for a MCO Improvement Plan (MIP) or a Corrective Action Plan (CAP) when the MCO has already received a NONC and a Warning Letter, yet the problem persists. In addition, Warning Letters with a MIP or CAP request may be issued for a first offense for larger or more concerning issues. The Contractor will be required to submit a MIP or a CAP to provide a plan of action to address the concern as described below.

d. MCO Improvement Plans (MIPs):

The Department may require the MCO to submit an MCO Improvement Plan to address minor compliance violations/failures/deficiencies.

A MIP is only used for issues that do not rise to the level of a formal Corrective Action Plan and are not intended to be disclosed by the Contractor in its business outside of the

Commonwealth of Virginia. For all other purposes, a MIP functions as a Corrective Action Plan.

MIPs must always include the necessary information and be submitted in the method as required in the MCTM. The Contractor must submit a completed MIP to the Department within fifteen (15) calendar days from the date of the received compliance violation notification.

The MIP must identify how the Contractor plans to remedy the issue within a thirty (30) calendar-day timeframe, which will begin from the date the Contractor submits the proposed MIP. If the Contractor's proposed MIP does not contain the necessary information to fully resolve the identified non-compliance, an additional sanction or violation point value may be assessed, and the Contractor may be required to submit a Corrective Action Plan.

e. Corrective Action Plans (CAPs):

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

The Contractor's first step in preparing a CAP is to review the specific findings and/or observations noted in the communication received from the Department and determine the root cause of the deficiency.

CAPs must always include the necessary information and be submitted in the method as required in the MCTM. If a CAP does not contain the necessary information, an additional sanction or violation point value may be assessed.

The Contractor must submit a completed CAP to the Department within thirty (30) calendar days from the date of the received compliance violation notification. The CAP must identify how the Contractor plans to remedy the issue within a sixty (60) calendar-day timeframe, which will begin from the date the Contractor submits the proposed CAP to the Department. During such time as the Contractor is under a CAP with the Department, the Contractor will not receive any additional compliance violation points for the specific issue under a Corrective Action Plan unless the Contractor fails to meet the terms of the Department-approved CAP.

In the event the Contractor requires more than sixty (60) calendar days, justification for an extended timeframe must be presented in the CAP. Additional time is subject to the Department's approval.

The Contractor's Corrective Action Plan must include milestone dates for progress and an anticipated date of resolution for the issue. The Contractor must provide the Department with updates on the dates listed to ensure operational compliance with the

CAP as proposed. The implementation of a Corrective Action Plan does not preclude the Contractor from the accumulation of non-CAP related violations.

Corrective Action Plan (CAP) Review Process

All proposed Corrective Action Plans must be reviewed and approved by both a member of the Department's compliance team and an appropriate subject matter expert (SME) from the Department. The Contractor shall respond to any and all inquiries and requests for further information from the Department compliance and SME experts. Financial penalties associated with Corrective Action Plan submissions shall be assessed as outlined below:

- \$500 per calendar day for each day the Corrective Action Plan submission is late, or for each day the Contractor fails to comply with an accepted CAP as required by the Department;
- \$2,000 for failure to provide an acceptable initial Corrective Action Plan as prescribed by the Department;
- If subsequent CAPs are determined deficient or delinquent the Department shall assess a \$500 per calendar day penalty until an acceptable plan has been received as determined by the Department.

10.1.G Financial Sanctions Associated with Compliance Letters

Financial sanctions issued through the process described in 10.1.D will be deducted from the Contractor's monthly capitation payment. Deductions shall be initiated within 30 calendar days from the end of the Comment Period described in any issued compliance letters.

10.1.H Other Financial Sanctions

In the event that the Department determines that the Contractor failed to provide a service or administrative function required under this Contract, the Department may impose financial sanctions/penalties upon the Contractor of at least the amount of payment required in the Contractor's contract with the disputing party.

a. Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department must submit to the Contractor a list of the members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the Contractor in the following situations:

- Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary covered contract services, the Department may direct the Contractor to provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days' written notice prior to the withholding of any capitation payment.

- 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.

b. Procedure

In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

1. The Department shall notify the Contractor of the Contractor’s failure to perform required administrative functions under the Contract.
2. The Department shall give the Contractor thirty (30) calendar days’ notice to develop an acceptable plan for correcting this failure.
3. If the Contractor has not submitted an acceptable Correction Action Plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.
4. The Department shall notify the Contractor when it is determined that the Contractor is not in compliance with a provision in this Contract. Notice shall be sent requesting a corrective action plan to resolve the error. If the Contractor fails to respond to the Department’s request in three (3) business days, the Department shall notify the Contractor in writing of its failure to respond to the Department is a violation of this Contract. If the Contractor continues to withhold corrective action within one (1) week of the date of the letter, the Department’s Director shall notify the Contractor that its continued failure to act will result in one or a combination of the following remedies to the Department:
 - a. Withhold of capitation;
 - b. Withhold/suspension of future enrollment;
 - c. Fines for violation not to exceed \$10,000 per occurrence; and/or termination of the Contract.

c. Suspension of Medicaid Payments in Cases of Fraud

In accordance with 42 CFR § 455.23, Managed Care Organizations are subject to payment suspensions in cases of fraud. The Department will suspend payments to the Contractor if Department determines there is a credible allegation of fraud against the Contractor for which an investigation is pending. Credible allegation of fraud is defined under 42 CFR § 455.2 as any allegation, which has been verified by the State, from any source, including: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and judiciously on a case-by-case basis. The Department does not have to notify the Contractor first of suspension of payments. The Contractor must be granted an

administrative review where state law requires this.

d. Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid members and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor Medicaid activities.

10.1.I Public Disclosure on Compliance Activity

In order to provide transparency to the public surrounding MCO compliance performance, the Department reserves the right to place MCO-specific information on the Medallion 4.0 website and any other Department-approved, public-facing locations.

The information provided will include identified best practices and compliance successes.

In addition, information regarding identified Contractor non-compliance will also be presented. Information may include, but is not limited to the following:

- Violated Contract Areas (Encounters, Reporting, Claims Payment, Appeals/Grievances, Program Integrity, etc.)
- Number of Compliance Points Issued
- Financial Sanctions Issued
- Warning Letters with Corrective Action Plans Information

10.1.J Report of Transactions Between the Contractor and a Party in Interest

In accordance with Section 1903(m)(4)(A) and Section 1318(b) of the Social Security Act, the Contractor shall report to the Department and, upon request, to the Secretary of the Department of Health & Human Services (DHHS), the Inspector General of the DHHS, and the Comptroller General a description of transactions between the Contractor and a party in interest (as defined in section 1318(b) of such Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the Contractor and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit between the Contractor and such a party.

10.2 MANAGED CARE TECHNICAL MANUAL AND REPORTING REQUIREMENTS

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 submit all required report deliverables as specified in this Contract and in the current the Managed Care Technical Manual. In the event that report deliverables are returned to the Contractor due to errors, the Contractor agrees to correct the incorrect data and resubmit within ten (10) business days.

Within this and other sections of the Contract, certain reports are detailed. However, the majority of the required reports are reflected in the Medallion 4.0 Managed Care Technical Manual. The Contractor shall adhere to delivery of all reports established by the Department and noted within the Medallion 4.0 Managed Care Technical Manual and this Contract. The Contractor shall refer to Medallion 4.0 Managed Care Manual for the appropriate reporting formats, instructions, submission timetables, and technical assistance.

If the Department changes the content, format, or frequency of reports, or requires the Contractor to submit additional ad hoc or recurring reports the Contractor will be given 60 days' notice.

Unless otherwise specified, the Contractor shall submit all reports to the Managed Care secure FTP server at: <https://vammi-filetransfer.com>. All submissions must comply with the Code of Virginia § 32.1-325, 12 VAC 30-20-90, §1902(a)(7) of the Social Security Act, and 42 CFR § 431.300 et seq.. The Contractor shall ensure that all reports are complete and accurate or may be subject to liquidated damages as specified in the this contract for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by this Contract until all deficiencies have been corrected.

As part of this Contract, the Contractor shall review all reports submitted to the Department to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward

10.3 MANAGED CARE TECHNICAL MANUAL – USE OF MOST CURRENT VERSION

The Department will post the current version of the Managed Care Technical Manual on the Virginia Medicaid Medallion SharePoint site. The version number of the Managed Care Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

The Managed Care Technical Manual will be updated no more frequently than monthly. The revised Managed Care Technical Manual will be posted to the Virginia Medicaid Medallion SharePoint site no later than the last calendar day of each month. The MCOs must check the site at the beginning of each month to ensure use of the most current version of the program specs for the next submission to the Department. The Contractor is required to use the most current version of the MCTM before the due date of each individual submission, including any reports (annual or other reports) due after the end of the Contract year.

10.4 ALL PAYERS CLAIM DATABASE

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the Code of Virginia for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically,

the Contactor shall be responsible for the submission of claims data related to services provided under this contact. Such data submission, pursuant to §32.1-276.7:1 of the Code of Virginia, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the Social Security Act.

10.5 HIPAA COMPLIANCE: SECURITY AND CONFIDENTIALITY OF RECORDS

10.5.A HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the Contractor with this Contract or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the Contractor from the Department or from any other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

To the extent that the Contractor uses one or more providers and/or subcontractors to render services under this Contract, and such providers/subcontractors receive or have access to protected health information (PHI), each such provider/subcontractor shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers/subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract in accordance with 42 CFR Part 431, Subpart F.

10.5.B Use or Disclosure of Information

The use or disclosure of information concerning Contract services or members obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, Federal regulations to include 42 CFR 431.302, and provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

For purposes of this Contract, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this Contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member.

Except as otherwise limited in this Contract, Contractor may use or disclose protected health information (PHI) to perform functions, activities, or services for, or on behalf of, the Department as specified in this Contract. In performance of Contract services, Contractor agrees to:

- Not use or further disclose protected health information (PHI) other than as permitted or required by the terms of this Contract or as required by law;

- Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Contract;
- Report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware;
- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Department as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the American Recovery and Reinvestment Act (P.L. 111-5) when effective;
- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it;
- Report to the Department any security incident of which it becomes aware;
- In the event of impermissible use or disclosure by Business Associate (to include the contractor and any subcontractors) of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

For purposes of this paragraph, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member. The Contractor shall:

- Impose the same requirements and restrictions contained in this Contract on its subcontractors and agents to whom Contractor provides PHI received from, or created or received by a Contractor on behalf of the Department;
- Provide access to PHI contained in a designated record set to the Department, in the time and manner designated by the Department, or at the request of the Department, to a member in order to meet the requirements of 45 CFR § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the Department;
- Document and provide to the Department information relating to disclosures of PHI as required for the Department to respond to a request by a member for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528;
- Make its internal practices, books, and records relating to use and disclosure of PHI received from, or created or received by a Contractor on behalf of the Department, available to the Secretary of the U.S. Department of Health and Human Services Secretary for the purposes of determining compliance with 45 CFR Parts 160 and 164, subparts A and E;
- At termination of the Contract, if feasible, return or destroy all PHI received from, or created or received by a Contractor on behalf of the Department that the Contractor still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the Contract to the information and

limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Contractor may use or disclose PHI received from the Department, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business if: the disclosure is required by law, or if Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and that person will notify the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

Written notices regarding any impermissible use or disclosure by the Business Associate shall be sent to the Department through general mail to:

Contact: Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

a. Disclosure and Confidentiality

The Contractor must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Attachment II of this Contract. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

b. Disclosure to Workforce

The Contractor shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contractor, therefore, must ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

c. Safeguards – Business Associate Agreement

The Contractor shall be required to enter into a DMAS-supplied Business Associate Agreement (BAA) with the Department to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all state and federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 CFR 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 attached to this Contract, including any future changes to the DMAS BAA.

d. Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the member's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 CFR § 164.528. The Contractor shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

e. Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this Contract.

f. Reporting

The Contractor shall report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware. Moreover, the Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief

description of what Contractor is doing to investigate the breach, mitigate harm to members, and protect against any future breaches.

In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

g. Access to PHI

The Contractor shall provide access to PHI contained in a designated record set to the Department, in the time, manner, and format designated by the Department, or at the request of the Department, to an individual in order to meet the requirements of 45 CFR Part 164.

h. Amendment to PHI

The Contractor shall make PHI available for amendment and incorporate any amendments to PHI in its records at the request of the Department in a time and manner as designated by the Department.

Further, the Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement, Attachment IV.

10.5.C Access to Confidential Information

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

The Contractor will not be held accountable to provide care coordination under Addiction and Recovery Treatment Services (ARTS) if it has not received written disclosure from the member's provider.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records and member information and appointment records for treatment

of sexually transmitted diseases and submit prior to signing the initial contract, upon revision or on request to the Department.

The Contractor shall comply with the Department's security requirements for vendors.

10.5.D Audits, Inspections, and Enforcement

With reasonable notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA. The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any member who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any rights such individual may have under this HIPAA, the Agreement, or any other law relating to or arising out of the Contractor's violation any provision of HIPAA.

11. PROGRAM INTEGRITY (PI) & OVERSIGHT

The Contractor shall establish and maintain a comprehensive Program Integrity program that begins upon provider enrollment and will focus on detection, prevention, and correction regarding any and all program vulnerabilities. The program shall be developed and executed through the implementation of written policies and procedures, submitted to the Department for review and approval. The Contractor shall work with the Department on all initiatives relative to Program Integrity and shall submit all applicable reports as required in this contract and the Managed Care Technical Manual.

11.1 GENERAL PRINCIPLES

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste, and abuse. The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct and prevent fraud, waste, and abuse; and supports correction and prevention efforts. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal government. All policies and procedures required as a part of this Contract must be approved by the Department prior to implementation. The policies

and procedures must be reviewed and approved prior to the original contract signing, at time of revision (if any), and must be made available upon request by the Department for additional review and/or approval.

11.1.A Regulatory Compliance Committee

Pursuant to 42 CFR 438.608 (a)(1)(iii), The Contractor shall also establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract. Pursuant to 42 CFR 438.608 (a)(1)(vii), The Compliance Officer shall maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis. Lastly, pursuant to 42 CFR § 438.608, the Compliance Officer and Regulatory Compliance Committee shall coordinate with the Department on any fraud, waste, or abuse case.

11.2 PROGRAM INTEGRITY PLAN, POLICIES & PROCEDURES

The Virginia Medicaid Program Integrity Plan (the PI Plan) must define how the Contractor will adequately identify and report suspected fraud, waste, and abuse by members, by network providers, by subcontractors, and by the Contractor. The Contractor shall develop a written integrity plan specific to this contract that identifies the specific resources dedicated to program integrity activities related to claims, members, providers and subcontractors involved in delivering the services outlined in this contract. The PI Plan must be submitted annually (See the Managed Care Technical Manual) and must include all items listed in this section. The Contractor may choose to submit a draft plan prior to the beginning of the contract year for preliminary approval.

11.2.A Written Policies and Procedures

The Contractor shall have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection, and reporting of incidents of potential fraud, waste, and abuse by Members, by network providers, by subcontractors and by the Contractor. The Contractor shall have administrative and management arrangements or procedures to the extent that the Contractor delegates responsibility for coverage of services and payment of claims under the contract to a subcontractor, the Contractor shall include policies and procedures utilized by the subcontractor to detect and prevent fraud, waste, and abuse.

The Contractor should have, at a minimum, the following policies and procedures in place:

1. A commitment to comply with applicable statutory, regulatory, and contractual commitments;
2. A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules, and regulations in a timely basis (no later than thirty (30) days after the determination that there is a potential violation of civil, criminal or administrative law may have occurred);
3. Procedures for the identification of potential fraud, waste, and abuse in a Contractor's network;

4. A process to ensure the Contractor, agents and brokers are marketing in accordance with applicable Federal and State laws, including state licensing laws, and CMS policy;
5. A process to identify overpayments at any level within the Contractor's network and properly recover such overpayments in accordance with Federal and State policy;
6. Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct. The Contractor shall conduct appropriate corrective actions in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct but must, at a minimum, include repayment of any identified overpayments;
7. Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary;
8. Provider contracts that require a network provider to report to the Contractor when it has received an overpayment, and defined procedures for the provider to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment in accordance with 42 CFR § 438.608(d)(2);
9. Written policies for all employees of the Contractor, and any Contractor or agent of the Contractor that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste, and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19;
10. The Contractor shall provide information and a procedure for members, network providers and subcontractors to report incidents of potential or actual fraud, waste, and abuse to the Contractor and to the Department;
11. The Contractor shall have a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as recoveries of identified overpayments. This process must assure that appropriate decisions are made as promptly as possible;
12. If the Contractor makes or receives annual payments of at least \$5,000,000 under this Contract, the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, to implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including the information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Act; 42 CFR § 438.608(a)(6)]

11.2.B Program Integrity Staffing and Contractors

The PI Plan must include the Contractor PI Lead and contact information. The PI Plan must also include the following elements, described in more detail in this section, and follow the template in the Managed Care Technical Manual:

1. PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
2. The Contractor shall submit an organizational chart annually that outlines the Medallion 4.0 Program Integrity division within its chart. The organizational chart should include all divisions that handle the Medallion 4.0 program (operations, claims, member services, outreach/marketing, health services, etc.);
3. A listing of the health plan PI contractors (unless proprietary);
4. An internal monitoring and audit plan with set goals and objectives that describe the processes involved and areas of review.

11.2.C Internal Monitoring and Audit - Annual Plan

The Contractor shall establish and implement provisions for ongoing program integrity activities to assess performance in, at a minimum, areas identified as being at risk. The Internal Monitoring and Audit plan shall demonstrate a coordinated, cohesive strategy to assess and address program integrity risks. The Contractor will be expected to explain the current year Internal Monitoring and Audit plan as it relates to the results of the prior year's program integrity activity. The review will consist of the following major components:

1. Description of risk evaluation methodology and identified areas of program integrity risk;
2. A detailed schedule of planned investigations for the current year, with explanations for how evaluation of risk and results of prior year investigations resulted in adjustments from the prior year's Internal Monitoring and Audit plan; and,
3. A detailed review and projections for other PI activities that do not lend themselves to the traditional allegation/investigation format of reporting.

In developing the types of program integrity activities to include in the plan, the Contractor shall:

1. Determine which risk areas will most likely affect the organization and prioritize the monitoring and investigation strategy accordingly;
2. Identify methods used to select facilities, pharmacies, providers, claims, and other areas for review, specifying type of data analysis (outliers, billing irregularities, fraud modeling, etc.) or source of referrals (EOBs, member complaints, internal referrals, etc.); and,
3. Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The Internal Monitoring and Audit plan shall include a schedule that includes a list of all planned monitoring activities, investigations, and other program integrity activities for the calendar year. Contractors shall consider a combination of desk and on-site investigations, including unannounced investigations or "spot checks," when developing the schedule. For all program integrity investigations planned for the upcoming year, the annual plan should include the following information:

- Monitoring Activity Title/Type;
- Description;
- Priority/Risk Level;

- Method of provider/claim selection;
- Manner in which investigations will be conducted;
- # of Investigations Planned.

The Contractor shall also include in its plan a process for responding to all monitoring and investigation results. Corrective action and follow-up shall be led by the Compliance Officer and/or Program Integrity Lead and shall consist of, at a minimum, recovery of any identified overpayments.

Pre-payment Review

The Contractor must choose to utilize a pre-payment review process as a part of their program integrity plan and these activities should be included as planned activities in the Annual Plan. Pre-payment review, for the purposes of this section refers specifically to a process in which the plan pends payment of a claim and then requests and reviews medical record documentation prior to releasing the claim for payment.

Verification of Services

Pursuant to 42 CFR §§ 438.608(a)(5) and 455.1, the Contractor's Internal Monitoring and Audit Plan must include a method to verify whether services reimbursed were actually furnished to the Member. The Contractor must utilize a survey (telephonic or mail), explanation of benefits (EOB) mailing, or other method approved by the Department to accomplish this requirement. Regardless of the method utilized (EOB, member survey, etc.), the Contractor's verification method must include a statistically valid sample of Members based upon a percentage of the Contractor's paid claims. The Contractor may exclude certain 'sensitive' services from these verification activities.

Oversight of Subcontractors

The Contractor shall include as part of its work plan, monitoring and audit activities specific to subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors and separate investigations should be conducted by the Contractor to ensure that the subcontractor program integrity controls are providing adequate protection against improper payments. The Contractor shall include routine and random investigations as part of its contractual agreement with subcontractors. The Contractor shall include in its work plan a process for auditing all subcontractors and how the subcontractors will be reviewed. The Contractor is required to conduct a certain number of direct investigations to verify that subcontractor program integrity processes are adequately identifying improper payments.

Program Integrity Collaborative

The Contractor shall participate with the Department on a quarterly program integrity collaborative. The Department shall establish the program integrity focused agenda and host the quarterly collaborative meeting. In addition, the Contractor shall agree to work with Program Integrity on a financial analytics pilot as well as on joint provider and/or member fraud investigations.

11.3 MINIMUM INVESTIGATION REQUIREMENTS

A minimum number of investigations shall be conducted annually based on total dollars in medical claims expenditures. If the Contractor fails to meet this minimum standard, or is found to lack adequate program integrity controls, the Department reserves the right to impose a corrective action plan on the Contractor. If the Contractor subsequently fails to implement corrective action, the Department reserves the right to impose financial and non-financial penalties. For this Contract, investigations conducted by the Contractor shall involve the review of medical records for claims representing at least 3 percent of total medical expenditures.

11.4 TRAINING AND EDUCATION

The Contractor shall establish an effective system of program integrity training and education for the Compliance Officer, the organization's senior management, the Program Integrity Lead, all Contractor staff and subcontractors for the Federal and State standards and requirements under the contract. Contractor PI staff shall attend any required training offered by the Department. The Contractor shall be prepared to have staff members who are assigned to perform desk audits and/or field audits, to attend on-site training and orientation programs provided by DMAS and in accordance with 42 CFR § 438.608(a)(1)(iv).

11.5 EFFECTIVE LINES OF COMMUNICATION BETWEEN CONTRACTOR STAFF

Pursuant to 42 CFR § 438.608 (a)(1)(vi) the Contractor shall establish effective lines of communication between the Compliance Officer, Program Integrity Lead, other Contractor staff, Members, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality. The Contractor shall also establish effective lines of communication with its members.

11.6 ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

11.7 COOPERATION WITH STATE AND FEDERAL INVESTIGATIONS

The Contractor shall cooperate with all fraud, waste, and abuse investigation efforts by the Department and other State and Federal offices. The Contractor shall cooperate with Department auditors on any Recovery Audit activity/findings.

DMAS will carry out statistical sampling and other data analysis techniques to audit the contractor to ensure that Medicaid expansion members are being placed in the appropriate managed care program as a result of the appropriate utilization of the medically complex screening processes and other processes.

11.8 MEDICAID FRAUD CONTROL UNIT (MFCU)

Some program integrity activities may identify issues that constitute potential fraud. DMAS and the Contractor are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). The Contractor shall cooperate fully with any request for information or technical support made by the MFCU to support their investigations. MFCU investigations may verify that some of these referrals constitute a "credible allegation of fraud." In these instances,

Contractors will be notified by the Department and shall suspend payments to those providers as set forth in 42 CFR § 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.

11.9 INVESTIGATING AND REPORTING SUSPECTED FRAUD, WASTE AND ABUSE TO THE DEPARTMENT

In reporting on program integrity activities conducted under this contract, the Contractor is required to use the templates, formats, and methodologies specified by the Department in the Managed Care Technical Manual and on the Medallion 4.0 SharePoint site.

11.9.A Allegations

The Contractor will be required to notify DMAS in a timely manner regarding all internal (such as identified patterns of outliers, audit concerns, critical incidences) and external (such as hotline calls) allegations of potential improper payments and/or safety concerns of enrollees. The Contractor will be expected to promptly perform a preliminary review of all allegations of fraud, waste, or program abuse. The Contractor shall track each of these allegations and the outcome of the preliminary review and report them to Department on the Quarterly Fraud/Waste/Abuse Report. A unique Case ID should be created for each allegation that is consistently used to identify that case in all reporting to the Department.

11.9.B Investigations

Once an allegation has been vetted and determined to warrant a full investigation, the Contractor shall notify the Department within forty-eight (48) hours, using the Notification of Provider Investigation form via the email address provided on the form. This is regardless of whether the target of that allegation is scheduled to be investigated immediately, or is merely being placed in the queue to be investigated when resources become available. The Department reserves the right to direct the Contractor to halt investigatory activity at its discretion. The Department may identify providers through data mining or other processes and may direct the Contractor to investigate providers in their network identified through this analysis.

The Contractor shall produce, and provide to the Department upon conclusion of each investigation, a standard report for each completed investigation. This report should include, at a minimum, the following:

- Purpose;
- Methodology;
- Findings (including identified overpayments);
- Proposed Action and Final Resolution;
- Claims Detail List/Spreadsheet

As noted in Section 10.2.A of this contract, final resolution should include, at a minimum, repayment of any identified overpayments.

The Department will conduct reviews of these reports to ensure that investigations are being conducted effectively; overpayments are being identified accurately, and validate the general quality of Contractor PI activities.

The Contractor may choose to utilize a pre-payment review process as a part of their program integrity plan. The Contractor shall notify the Department of each provider subject to pre-payment review within forty-eight (48) hours of initiating a pre-payment review process, using the Notification of Provider Investigation form. Any claims that are not paid as a result of these reviews shall be reported by the Contractor through the quarterly fraud/waste/abuse report. If pre-payment review indicates a pattern of fraud, waste, or program abuse, the Contractor shall conduct a retrospective review of that provider to identify any prior overpayments.

11.9.C Fraud

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). When the Contractor identifies suspected fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, it shall be reported to the Department within forty-eight (48) hours of discovery on the Referral of Suspected Provider Fraud form. This notification should be sent to DMAS via the email address provided on the form. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU). Submission of the Referral of Suspected Provider Fraud form does not mean the MCO is to cease their investigation of the provider. Unless formally notified by DMAS or MFCU to cease the MCO's investigation, the MCO is expected to continue their investigation

11.9.D Suspected Recipient Fraud or Misconduct

All suspected member fraud or other program-related misconduct shall be reported to the Department within forty-eight (48) hours of discovery on the Notice of Suspected Recipient Fraud or Misconduct form. This notification should be sent to DMAS via the email address provided on the form.

11.9.E Marketing Fraud and Abuse

The Contractor shall report to the Department all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

11.10 QUARTERLY FRAUD/WASTE/ABUSE REPORT

The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must follow the format specified in the Managed Care Technical Manual. This report will serve as the annual report of overpayment recoveries required under 42 CFR §§ 438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following:

1. Allegations received and results of preliminary review;
2. Investigations conducted and outcome;
3. Payment Suspension notices received and suspended payments summary;
4. Claims Edits/Automated Review summary;
5. Coordination of Benefits/Third-Party Liability savings and recoveries;

6. Service Authorization/Medical Necessity savings;
7. Provider Education Savings;
8. Provider Screening reviews and denials;
9. Providers Terminated;
10. Unsolicited Refunds (Provider-identified Overpayments);
11. Archived Referrals (Historical Cases);
12. Other Activities.

Upon submission, DMAS will review the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation will examine ongoing reporting as well as the contents of the report to ensure that all contractual requirements are being met. DMAS will evaluate progress towards the Internal Monitoring and Audit Plan required under section 10.2.C of this contract identify any major changes or shortcomings to projected program integrity activity. The Department will evaluate this submission and provide feedback to the Contractor.

11.11 PROVIDER INVESTIGATIONS, OVERPAYMENTS, AND RECOVERIES

11.11.A Formal Initiation of Recovery

The Contractor shall notify the Department prior to formal initiation of a recovery from an investigation by the Contractor on its own network. Submission of the Completed Investigation Form will serve as this notification. The Contractor shall not proceed with any recoupment or withholding of any program integrity-related funds until the Department confirms that the recoupment or withhold is permissible. The contractor shall submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered) and report to the Department via the Quarterly Fraud/Waste/Abuse Report on any overpayments that have not been collected.

a. Treatment of Recoveries

Generally, MCOs will be permitted to retain recoveries of overpayments identified and established through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three years prior to the date that the Contractor formally notified the Department of the overpayment will be retained by the Department. In addition, one year from the date the Contractor is notified that they are permitted to recover an overpayment, the outstanding remainder of that overpayment will revert to the Department for collection and retention.

11.11.B Class Action & Qui Tam Litigation

The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

11.11.C Provider Network Investigations

The Department, pursuant to 42 CFR § 455, et. seq. may conduct investigations of the Contractor's provider network and as a result of those investigations recover and retain identified overpayments. At the request of the Department, the Contractor will provide any information the Department deems necessary to conduct such investigations including, but not limited to fee

schedules, provider contracts, and claim payment data.

11.11.D Fraudulent Provider Recovery with MFCU

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

11.11.E Payment Suspension

Pursuant to 42 CFR §§ 455.23 and 438.608(a)(8), the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. Upon notification from the Department that such a determination has been made, and provided the Department has not determined good cause exists to not suspend payments or to suspend payment only in part, the Contractor must suspend payment as soon as possible and no later than the date indicated in the notice from the Department. If the Contractor believes there is good cause, as defined in 42 CFR § 455.23, to not suspend payments or to suspend payment only in part to such provider or subcontractor, the Contractor must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider or subcontractor from payment suspension. The Department will evaluate the merit of the request for good cause exemption and notify the Contractor of the decision. Upon notification from the Department of a determination that good cause does not exist, the Contractor shall suspend payments as of the date in the Department's notice.

11.11.F Notice of Suspension

The contractor must send a letter of the suspension of program payments to the suspended provider and a copy of the letter to the agency within 5 business days of receiving notice from the Department unless requested in writing by a law enforcement agency to temporarily withhold such notice. The letter must address all points in 42 CFR 455.23(b)(2) and must set forth the provider's right to the State's administrative appeals process.

11.11.G Required Reporting Procedures

Under 42 CFR §§ 438.608(a), the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract:

- Implement and maintain a compliance program that includes all of the elements identified in 42 CFR § 438.608(a)(1);
- Implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department;
- Implement and maintain arrangements or procedures for prompt notification to the Department when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or death of the member;
- Implement and maintain arrangements or procedures for notification to the Department when it receives information about a change in the network provider's circumstances that

may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;

- Implement and maintain arrangements or procedures that include provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department or any potential fraud to the Virginia Medicaid Fraud Control Unit.
- Implement and maintain arrangements or procedures that include provisions for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23.

12. MEMBER AND PROVIDER GRIEVANCES AND APPEALS

The Contractor shall have a system in place to respond to grievances, internal appeals, reconsiderations, and claims received from members and providers. Additionally, the Contractor shall ensure that members and providers are sent written notice of any adverse benefit determination or adverse action that informs members and providers of their rights to appeal through the Contractor as well as their rights to access the Department's State fair hearing and provider appeal systems after they have exhausted their appeals with the Contractor. This process shall ensure that appropriate decisions are made as promptly as possible. The member internal appeals process shall include provisions for expedited appeals for members within seventy-two (72) hours from receipt of the appeal request. The Contractor shall develop policies and procedures regarding the grievance and internal appeal processes. These shall be reviewed and approved by DMAS prior to implementation. The Contractor shall notify providers and members of their rights to grievances and appeals with the Contractor. The Contractor shall ensure that all network providers are informed, at the time they enter into a contract, about all member grievance, appeal, and fair hearing procedures, timeframes, and associated member rights as specified in 42 CFR 438.400 through 42 CFR 438.424 and described within this section of this Contract. As described in the Managed Care Technical Manual, the Contractor shall provide DMAS with monthly reports indicating the number of grievances and internal appeal requests received as well as the detailed analysis and disposition.

Written materials for members shall use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs or those who are not English language proficient. Members shall be informed that information is available in alternate formats and how to access those formats.

The Contractor shall provide appeals, grievance forms and/or written procedures to members or providers who wish to register written appeals or grievances. Additionally, the Contractor shall provide reasonable assistance to members in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures shall provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action.

The Contractor shall ensure that neither the individual nor a subordinate of any such individual who makes decisions on grievances or appeals was involved in any previous level of review or decision-making. In any case where the reason for the grievance or appeal involves clinical

issues or is related to denials of expedited resolution of an appeal, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

The Contractor shall ensure that decision-makers on member grievances and appeals take into account all comments, documents, records, and other information submitted by the member or the member's authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

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

The Contractor and its subcontractors, as appropriate, shall include the minimum elements identified on the DMAS templates for 1) adverse benefit determinations and 2) internal appeal decisions. DMAS shall review and approve the form and content of the Contractor's adverse benefit determinations and internal appeal decisions prior to implementation. The minimum elements for adverse benefit determinations are found in Section 12.4, Notice of Adverse Benefit Determination and the minimum elements for internal appeal decisions are found in Section 12.5, Contractor Internal Appeals.

12.1 GRIEVANCES

The DMAS Appeals Division does not handle grievances. A member may file a grievance and a provider may file a complaint with the Contractor. In accordance with 42 CFR §438.408, the Contractor shall be responsible for properly responding to all grievances and complaints. In accordance with 42 CFR §438.400 et seq. and as directed by DMAS, the Contractor shall have a system in place for addressing member grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. As part of that process, the Contractor shall have written policies and procedures that describe the grievance process and how it operates, and the process shall comply with federal requirements and NCQA standards. The Contractor shall also have a system in place to address provider complaints and shall have written policies and procedures that describe the provider complaint process. These written directives shall describe how the Contractor intends to receive, track, review, and report all member inquiries and grievances and provider complaints. The Contractor shall make any changes to its grievance and complaints procedures that the Department requires. The Contractor shall submit the procedures and any changes to the procedures to DMAS prior to signing the original Contract, at revision, upon request, and as needed. The Contractor shall maintain written records of all member grievance and provider complaint activities and notify DMAS of all internal grievances through a reporting format approved by DMAS.

The Contractor's grievance process shall allow a member, an attorney, or a member's authorized representative (provider, family member, etc.) acting on behalf of the member, to file a grievance at any time, either orally or in writing. With the exception of an attorney, an authorized

representative must have the member's written consent to file a grievance. The Contractor shall acknowledge receipt of each grievance. Grievances received orally can be acknowledged orally.

The Contractor shall resolve a grievance and provide notice as expeditiously as the member's health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the Contractor receives the grievance in a format and language that meets, at a minimum, the standards described in 42 CFR § 438.10. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is need for additional information and that a delay in rendering the decision is in the member's interest. If the Contractor extends the timeline for a grievance not at the request of the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay, within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe, and inform the member of the right to file a grievance if he or she disagrees with that decision and resolve the grievance as expeditiously as the member's health condition requires and no later than the date the extension expires.

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures that provide the basis for the decision; and a clear explanation of any further rights available to the member or provider under the Contractor's grievance process.

12.2 GENERAL APPEALS REQUIREMENTS

The Contractor shall maintain written records of all member and provider appeal activities at all levels in the manner and format reflected in the Managed Care Technical Manual. The Contractor is required to respond promptly, unless DMAS requests a response within twenty-four (24) hours, to any requests made by DMAS pertaining to appeals.

The Contractor shall attend and defend the Contractor's decisions at all DMAS appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division. Contractor travel and telephone expenses in relation to appeal activities 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 remedies as set forth in this Contract.

The Contractor does not have the right to appeal decisions from DMAS State fair hearings or provider informal or formal appeals.

12.3 MEMBER APPEALS

As a prerequisite to filing an appeal to DMAS, any member, member's attorney, or member's authorized representative (provider, family member, etc.) acting on behalf of the member, wishing to appeal an adverse benefit determination must first file an internal appeal with the Contractor within sixty (60) calendar days from the date on the notice of adverse benefit determination. The Contractor shall have procedures in place to handle standard and expedited internal appeals.

A member may request continuation of services during the Contractor's internal appeal and DMAS' State fair hearing. A determination on continuation of services shall be made in accordance with 42 CFR § 438.420 and the regulations governing the Medallion 4.0 program. If the determination is made to continue benefits, the Contractor must continue the member's benefits so long as all of the requirements of 42 CFR § 438.420(b) are met. If the final resolution of the appeal upholds the Contractor's action and services to the member were continued while the internal appeal of State fair hearing was pending, the Contractor may recover the cost of the continuation of services from the member.

12.4 NOTICE OF ADVERSE BENEFIT DETERMINATION

In accordance with 42 C.F.R. § 438.404, the Contractor shall give the member 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 action. For denial of payment, such notice shall be provided at the time of action. For standard service authorization decisions that deny or limit services, the notice is required as expeditiously as the member's condition requires and within the timeframes referenced in Section 8.1.D. For cases in which a provider indicates or the Contractor determines that following the standard authorization timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

At a minimum, the notice shall explain:

1. The action the Contractor has taken or intends to take;
2. The reasons for the action, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
3. The citation to the law or policy supporting such action;
4. The member's or the member's representative's right to file an internal appeal with the Contractor, including information on exhausting the Contractor's appeal processes and an explanation that the member and/or representative has a right to file an appeal with DMAS for a State fair hearing only after the Contractor's internal appeal process has been exhausted;
5. The procedures for exercising the member's rights to appeal;
6. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
7. If applicable, the member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and
8. The right to be represented by an attorney or other individual.

The written notice shall be translated for individuals who speak prevalent languages. Additionally, written notices shall include language explaining that oral interpretation is available for all languages and how to access it.

12.5 CONTRACTOR INTERNAL APPEALS

The Initial appeals shall be filed with the Contractor. The filing of an internal appeal and exhaustion of the Contractor's internal appeal process is a prerequisite to filing an appeal to DMAS. The Contractor's appeals process shall include the following requirements:

- Acknowledge receipt of each appeal;
- An appeal may be submitted orally or in writing by the member, member's attorney, or member's authorized representative.
- Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The Contractor shall inform the member of the limited time available for this, especially in the case of expedited resolution;
- Provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor or at the direction of the Contractor in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for standard (thirty (30) calendar days) and expedited (seventy-two (72) hours) internal appeals; and consider the member, representative, or estate representative of a deceased member as parties to the appeal.

The Contractor shall respond in writing to standard internal appeals as expeditiously as the member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal. In accordance with § 438.408(c)(1), the Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is a need for additional information and that a delay in rendering the decision is in the member's interest. In accordance with § 438.408(c)(2), if the Contractor extends the timeframe for an appeal not at the request of the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay. In addition, the Contractor shall resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. For any internal appeals decisions not rendered within thirty (30) calendar days where the member has not requested an extension, the Contractor shall make reasonable efforts to provide oral notice and shall within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

The Contractor shall establish and maintain an expedited review process for internal appeals when the Contractor determines (on a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In accordance with 42 CFR § 438.410(b), the Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports a member's internal appeal. In instances where the member's

request for an expedited internal appeal is denied, the internal appeal shall be transferred according to the timeframe for standard resolution of internal appeals, and the member shall be given prompt oral notice of the denial. Within two (2) calendar days of the oral notice of denial, the member shall be sent written notice of the reason for the decision to deny the request for an expedited appeal and informed of the right to file a grievance if the member disagrees with that decision.

The Contractor shall provide written notice and make reasonable efforts to provide oral notice, of the resolution of an expedited internal appeal within seventy-two (72) hours from the initial receipt of the appeal. For standard internal appeals, the Contractor shall issue its internal appeal decision as expeditiously as the member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal request in a format, that meets, at a minimum, the standards described in 42 CFR § 438.10. In accordance with 42 CFR § 408, the Contractor may extend the timeframe for expedited or standard appeals by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is a need for additional documentation and that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay; written notice within two (2) calendar days to the member of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The Contractor shall resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. All Contractor decisions to internal appeals shall be 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 any adverse benefit determination, including citations to the policies, procedures, and/or authority that support the decision;
2. The date the member's appeal request was received;
3. The date of the decision; and,
4. For appeals not resolved wholly in favor of the member:
5. The right to request an appeal of the Contractor's final denial through the DMAS State fair hearing process. The final denial letter shall clearly identify that the Contractor's internal appeal process has been exhausted, and include the timeframe for filing an appeal to DMAS, the submission methods and related address and phone numbers to file an appeal, and list pertinent statutes/regulations governing the appeal process; and,
6. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
7. The right to request to receive benefits while the State fair hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the State hearing decision upholds the Contractor to the extent that services were furnished (continued) solely because of the requirements of this section. [42 CFR § 438.420(d)];
8. A list of titles and qualifications, including specialties, of individuals participating in the appeal review; and,
9. The right to be represented by an attorney or other individual.

12.6 MEMBER APPEALS TO DMAS

In general, Medicaid and FAMIS members who have received an internal appeal decision that upholds the Contractor's denial in whole or in part have the right to appeal the internal appeal decision to DMAS by requesting a State fair hearing. Members also have the right to appeal DMAS's decision to move them to a different Contractor directly to DMAS without first having to seek an internal appeal decision from the Contractor.

12.6.A For Cause Disenrollment Determinations

In accordance with 42 CFR § 438.56(e)(2), members who are dissatisfied with DMAS' determination on the member's for cause request to dis-enroll from one health plan to another shall have the right to appeal DMAS' decision through the State fair hearing process.

12.6.B Contractor Adverse Internal Appeal Decisions

Members have the right to appeal the Contractor's appeal decision upholding its adverse benefit determinations to DMAS. However, the Contractor's appeal process must be exhausted or deemed exhausted due to the Contractor's failure to adhere to the notice and timing requirements prior to a member filing an appeal with the DMAS Appeals Division. Denials of benefits that are offered by the Contractor beyond those covered by the State Plan and not included in the capitation rate calculation are not appealable to a State fair hearing.

12.6.C State Fair Hearing Process

DMAS member appeals are conducted in accordance with 42 CFR § 431 Subpart E and DMAS' Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include reductions in service, suspensions, terminations, and denials. 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 member or the member's authorized representative. Expedited appeals may be filed by telephone or in writing. The appeal may be filed at any time after the Contractor's internal appeal process is exhausted but must be requested no later than 120 calendar days from the date of the Contractor's internal appeal decision.

Within twenty-four (24) hours of a request by DMAS, the Contractor shall either: fax (or email if requested by email) a copy of the member's internal appeal decision to the DMAS Appeals Division at 804-452-5454; or, if there has been no internal appeal decision, notify the Appeals Division in writing that the member has not exhausted the Contractor's appeal process.

Upon receipt of notification by DMAS of an appeal, the Contractor shall prepare and submit an appeal summary describing the **rationale for maintaining the denial** 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. In addition, the Contractor shall e-mail a complete copy of the appeal summary to DMAS on the same day that it files an appeal summary with the DMAS Appeals Division. The summary shall 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 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. The appeal summary must also demonstrate that any additional documents submitted with the appeal request were considered and explain why those documents do not meet the requirements for approval.

For standard appeals, the DMAS Appeals Division requests that the Contractor submit the appeal summary to DMAS within twenty-one (21) calendar days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all standard appeals, the summary shall be received by DMAS at least ten (10) calendar days prior to the scheduled hearing date and mailed to the member on the date submitted to the DMAS Appeals Division. For expedited appeals that meet the criteria set forth in 42 CFR § 438.410, the appeal summary shall be faxed to DMAS and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) hours after DMAS informs the Contractor of the expedited appeal. Failure to submit appeal summaries within the required timeframe or with the required content shall result in performance penalties as described in this Contract.

DMAS client appeals are conducted as *de novo* hearings, which means that the DMAS appeal decision is based on the totality of the documents submitted during the appeal, even if the documents were not available for review during the initial request. Therefore, DMAS will forward all documents to the Contractor that are received during the DMAS appeal. The Contractor must review these documents. If the documents can result in a full approval, the Contractor must issue a new notice of action to the appellant and send a copy to the DMAS Appeals Division. The DMAS Appeals Division will then determine if the appeal is resolved. If the documents cannot result in a full approval, the Hearing Officer may request that the Contractor submit a written response addressing the new evidence submitted by the member during the appeal process. The written response by the Contractor must be sent to the DMAS Appeals Division and the appellant, explaining the Contractor's position on why the documents do not meet the criteria for approval.

Appeals 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 member filed the internal appeal with the Contractor, not including the number of days the member took to subsequently file for a State fair hearing. 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 CFR § 431.244(f)(4) and 12 VAC 30-110-30 relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays.

Appeals to DMAS that qualify as expedited appeals shall be resolved within seventy-two (72) hours or as expeditiously as the member's condition requires.

In accordance with 42 CFR § 438.424, if the appeal decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor shall authorize the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision. If the appeal decision reverses a decision to deny

authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.

If the appeal decision remands the case back to the MCO, the MCO shall follow the remand instructions, after which it shall promptly issue a written notice to the member in accordance with the requirements described throughout this Contract.

DMAS' 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 shall 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.

12.7 PROVIDER APPEALS

The first level of a provider appeal is a reconsideration with the Contractor. For services that have been rendered, providers have the right to appeal adverse actions. The provider shall exhaust the Contractor's reconsideration process prior to filing an appeal with the DMAS Appeals Division, except in the case of an appeal of a payment suspension notice. Provider payment suspension notices are appealed directly to DMAS with no internal appeal to the MCO.

12.7.A Reconsiderations

The Contractor shall have a reconsideration process in place available to providers who wish to challenge adverse actions made by the Contractor. This process shall assure that appropriate decisions are made as promptly as possible. The Contractor shall submit its reconsideration process to DMAS for review and approval prior to implementation.

If a provider has rendered services to a member enrolled with the Contractor in a Medicaid program and has either been denied authorization or reimbursement for the services or has received reduced authorization or reimbursement, that provider can request a reconsideration of the denied or reduced authorization or reimbursement. Before appealing to DMAS, providers must first exhaust the Contractor's reconsideration process. Providers in the Contractor's network may not appeal the Contractor's enrollment or terminations decisions to DMAS.

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

1. Provide a reasonable amount of time for a provider to submit an reconsideration request;
 2. Acknowledge receipt of each reconsideration request;
 3. Ensure that the individuals who make decisions on reconsiderations were not involved in any previous level of review or decision making;
 4. A reconsideration request shall be submitted in writing;
 5. Provide the provider a reasonable opportunity to present evidence and allegations of fact or law. The Contractor shall inform the provider of the limited time available for this;
- and,

6. Allow the provider the opportunity, before and during the reconsideration process, to examine the provider's case file, including any medical records and any other documents and records considered during the reconsideration process.

All Contractor reconsideration decisions shall be 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 any adverse action, including citations to the policies, procedures, and/or authority that support the decision;
2. The date the provider's appeal request was received;
3. The date of the decision; and,
4. For appeals not resolved wholly in favor of the provider, the right to request an appeal to DMAS of the Contractor's reconsideration decision through the DMAS informal appeals process. The final decision shall clearly identify that the Contractor's reconsideration process has been exhausted and include the timeframe for filing an appeal to DMAS, the submission methods and related address and facsimile number to file an appeal, and list pertinent statutes/regulations governing the appeal process, and the right to be represented by an attorney.

12.7.B Provider Appeals to DMAS

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

All provider appeals to DMAS shall be submitted in writing and within thirty (30) calendar days of the Contractor's adverse reconsideration decision to the DMAS Appeals Division, 600 East Broad Street, Richmond, VA 23219. The Contractor's reconsideration decision shall include a statement that the provider has exhausted its reconsideration rights with the Contractor and that the next level of appeal is with DMAS. The reconsideration decision shall include the standard appeal rights to DMAS, including the time period and address to file the appeal.

DMAS' normal business hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, Eastern time. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the DMAS Appeals Division after 5:00 p.m. shall be date stamped on the next day DMAS is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely.

Upon receipt of notice that DMAS has received an appeal from a provider involving services provided or being provided to the Contractor's member, the Contractor shall verify that the provider has exhausted the Contractor's reconsideration process. Further the Contractor shall

verify, based upon the Contractor's records, that the appeal to DMAS meets the DMAS timeliness requirements (i.e., within thirty (30) calendar days of the Contractor's last date of denial). The Contractor shall notify the DMAS Appeals Division within twenty-four (24) hours of the receipt of the appeal notice to DMAS, of any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal does not appear to meet DMAS' timeliness requirements based upon the Contractor's records.

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 this Contract.

a. Informal Appeals

Providers appealing a Contractor's reconsideration decision shall file a written notice of informal appeal with the DMAS Appeals Division within thirty (30) calendar days of the provider's receipt of the Contractor's reconsideration decision. The provider's notice of informal appeal shall identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within thirty (30) calendar days of receipt of the Contractor's reconsideration decision shall result in an administrative dismissal of the appeal.

The Contractor shall file a written case summary with the DMAS Appeals Division within thirty (30) calendar days of the filing of the provider's notice of informal appeal. For each adjustment, patient, and service date or other disputed matter identified by the provider in its notice of informal appeal, the case summary shall explain the factual basis upon which the Contractor relied in making its reconsideration decision and identify any authority or documentation upon which the Contractor relied in making its reconsideration decision. The Contractor shall e-mail a complete copy of the case summary to DMAS on the same day that it files the case summary with the DMAS Appeals Division.

The DMAS Informal Appeals Agent (IAA) shall conduct the conference within ninety (90) calendar days from the filing of the provider's notice of informal appeal. If the Contractor, the provider, and the IAA agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the IAA shall specify the time within which the provider may file written submissions, not to exceed ninety (90) calendar days from the filing of the notice of informal appeal. If a provider submits written submissions after filing the notice of appeal, the Contractor is

responsible for submitting a response within the time period set by the IAA. Only written submissions filed within the time specified by the IAA shall be considered.

The conference may be recorded at the discretion of the IAA and solely for the convenience of the IAA. Because the conference is not an adversarial or evidentiary proceeding, no other recordings or transcriptions shall be permitted. Any recordings made for the convenience of the IAA shall not be released to DMAS, the Contractor, or the provider.

Upon completion of the conference, the IAA shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 calendar days. Only documentation or information filed within the time specified by the IAA shall be considered.

The informal appeal decision shall be issued within one hundred eighty (180) calendar days of receipt of the notice of informal appeal. Providers have the right to appeal the DMAS informal appeal decision in accordance with 12 VAC 30-20-560, as a formal appeal.

b. Formal Appeals

Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within thirty (30) calendar days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within thirty (30) calendar days of receipt of the informal appeal decision shall result in dismissal of the appeal.

At the formal level, the Contractor assists DMAS' staff counsel in preparing DMAS' evidence and acts as a witness at a hearing before a hearing officer appointed by the Virginia Supreme Court. The Contractor shall supply the necessary expertise to defend its actions and shall assist the Formal Appeals Agent in the preparation of all hearing matters leading to the Final Agency Decision.

DMAS and the provider shall file with the DMAS Appeals Division all documentary evidence on which DMAS or the provider relies within twenty-one (21) calendar days of the filing of the notice of formal appeal. Simultaneous with filing, the filing party shall transmit a copy to the other party and to the hearing officer. Only documents filed within twenty-one (21) calendar days of the filing of the notice of formal appeal shall be considered. DMAS and the provider shall file any objections to the admissibility of documentary evidence within seven (7) calendar days of the filing of the documentary evidence. Only objections filed within seven (7) calendar days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven (7) calendar days of the filing of the objections.

The hearing officer shall conduct the hearing within forty-five (45) calendar days from the filing of the notice of formal appeal, unless the hearing officer, DMAS, and the provider all mutually agree to extend the time for conducting the hearing. Notwithstanding the foregoing, the due date for the hearing officer to submit the recommended decision to DMAS' Director shall not be extended or otherwise changed.

If there has been an extension to the time for conducting the hearing, the hearing officer is authorized to alter the due dates for filing opening and reply briefs to permit the hearing officer to be in compliance with the due date for the submission of the recommended decision.

Within thirty (30) calendar days of the completion of the hearing, DMAS and the provider shall file their opening briefs with the DMAS Appeals Division. Any reply brief from DMAS or the provider shall be filed within ten (10) calendar days of the filing of the opening brief to which the reply brief responds. Simultaneous with filing either the opening brief or the reply brief, the filing party shall transmit a copy to the other party and to the hearing officer.

Formal hearings shall be transcribed by a court reporter retained by DMAS. The hearing officer shall submit a recommended decision to DMAS Director with a copy to the provider within one hundred twenty (120) calendar days of the filing of the formal appeal notice. If the hearing officer does not submit a recommended decision within one hundred twenty (120) calendar days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

Upon receipt of the hearing officer's recommended decision, DMAS Director shall notify DMAS and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed with the DMAS Appeals Division within fourteen (14) calendar days of receipt of DMAS Director's letter. Only exceptions filed within fourteen (14) calendar days of receipt of DMAS Director's letter shall be considered. The DMAS Director shall issue the Final Agency Decision within sixty (60) calendar days of receipt of the hearing officer's recommended decision.

c. Court Review

The provider may appeal DMAS' Final Agency Decision through the court system in accordance with the Administrative Process Act at Va. Code § 2.2-4025, et. seq. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, 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. However, the Contractor is not a party to the lawsuit because the issue being contested is DMAS' Final Agency Decision. The Contractor shall 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.

12.8 EVALUATION OF GRIEVANCES AND APPEALS

The Contractor shall, at a minimum, track, trends in grievances, internal appeals, and reconsiderations. The Contractor's internal appeals, reconsiderations, and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards. The grievances, internal appeals, and reconsiderations process shall include the following:

1. Procedures for registering and responding to grievances in a timely fashion;
2. Documentation of the substance of the grievance or appeal and the actions taken;
3. Procedures to ensure the resolution of the grievance;
4. Aggregation and analysis of these data and use of the data for quality improvement.
5. The Contractor shall maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish Medicaid from commercial members if the Contractor does not have a separate system for the Medicaid program.

12.9 GRIEVANCE AND APPEAL REPORTING

By the 15th day of each month, the Contractor shall submit a report to DMAS of all of the previous month's provider and member grievances and appeals as reflected in the Managed Care Technical Manual. The Contractor may use reports from its existing Member Services system if the system meets DMAS' criteria.

Grievance categories identified shall be organized or grouped by the following general guidelines:

- Transportation
- Access to Services/Providers
- Provider Care and Treatment
- Care Coordination
- MCO Customer Service
- Payment and Reimbursement Issues
- Administrative Issues

Appeal categories identified shall be organized or grouped by the following general guidelines:

- Transportation
- MCO Administrative Issues
- Benefit Denial or Limitation
- Provider Enrollment

12.10 RECORDKEEPING AND DOCUMENT PRESERVATION

Recordkeeping and document preservation are important to ensure the integrity of the appeals process, to assist in identifying and responding to trends, and to meet federal and state legal requirements.

12.10.A Recordkeeping and Reporting Requirements

In accordance with 42 CFR § 438.416, the Contractor shall maintain records of grievances and appeals and must review the information as part of its ongoing quality improvement strategy. The record shall be accurately maintained in a manner accessible to DMAS and shall be made

available upon request to CMS. The record of each grievance or appeal must contain, at a minimum, all of the following information:

1. A general description of the reason for the appeal or grievance.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the appeal or grievance, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person for whom the appeal or grievance was filed.

12.10.B Document Preservation

The Contractor is responsible for the preservation and production of documents associated with any Appeal. The Contractor shall be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, FOIA request, or any litigation involving the Contractor or DMAS, including but not limited to, external Appeals.

13. INFORMATION SYSTEMS MANAGEMENT

13.1 SYSTEMS MANAGEMENT

In accordance with 42 CFR § 438.242, the Contractor must maintain a health information system that collects, analyzes, integrates, and reports data. The Contractor must comply with Section 6504(a) of the ACA, which requires that state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the state to meet the requirements of section 1903(r)(1)(F) of the Act. The Contractor's management information systems must be capable of furnishing the Department with timely, accurate, and complete information. Such information systems shall:

1. Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;
2. Accept and process provider claims as set forth in this Contract;
3. Generate and submit encounter data as set forth in this Contract;
4. Track provider network composition and access as set forth in this Contract;
5. Track grievances and appeals as set forth in this Contract;
6. Perform quality improvement activities, as set forth in this Contract;
7. Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract.

13.1.A Medicaid Enterprise System (MES)

Implementation of the Medicaid Enterprise System (MES) will include multiple changes to the information management exchanges between the Department and the Contractor this contract year. The Contractor must integrate its information management systems with MES.

a. Care Review Management System (CRMS)

The Contractor shall work closely with the Department in the implementation of the Care Review Management System (CRMS). Beginning July 1, 2021, the Contractor must abide by meeting all requirements as noted outlined in the CRMS Technical Manual. All Contractors must be on a daily load approval by July 1, 2021 for submission of SA Medical, SA Pharmacy, HRA and ICP data and must be in compliance with the requirements outlined in

the CRMS Technical Manual. Defaulting of mandatory field requirements are not acceptable only with the exception of DMAS approval. The phased-in approach for this platform will continue through April 4, 2022 with further guidance in the CRMS Technical Manual.

b. Provider Services Solution (PRSS)

The Contractor shall work closely with the Department to accommodate the new Provider Services Solution (PRSS). PRSS will manage provider data and network relationships including the requirements for Cures Act compliance identified in Section 4.6.E Provider Enrollment into Medicaid of the contract.

13.1.B Data Accuracy Verification

Ensure that data received from providers is accurate, and complete by:

1. Verifying the accuracy and timeliness of reported data;
2. Screening the data for completeness, logic, and consistency; and
3. Collecting service information in standardized formats as set forth in this Contract.

13.2 ELECTRONIC DATA SUBMISSION

The Contractor may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 CFR § 142.308(d). If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

13.2.A Electronic Data Interchange (EDI)

Each party will transmit electronic files directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.

Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing, or handling electronic files. Each party is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

13.2.B Test Data Transmission

The Contractor shall be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Contractor shall pass the testing phase for all encounter claim type submissions within twelve (12) calendar weeks from the effective date of the change or start-up of a newly contracted MCO.

The Contractor shall submit the test encounters to the Department's Fiscal Agent electronically according to the specifications of the HIPAA Implementation Guide, DMAS Companion Guide, and the Managed Care Technical Manual.

An MCO (or subcontractor) can lose production privileges due to high volume of compliance errors and/or critical errors (as determined by the Department). Both the Department and its Fiscal Agent can remove production privileges. When an MCO (or subcontractor) loses its production privileges, then the MCO (or subcontractor) must actively test with the Department and its Fiscal Agent. Production privileges are expected to be regained within thirty (30) days.

13.2.C Garbled Transmissions

If a party receives an unintelligible transmission, that party will promptly notify the sending party (if identifiable from the received transmission)

13.2.D Enforceability and Admissibility

Any document/file properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be “a writing” or “in writing,” and (2) to constitute an “original” when printed from electronic records established and maintained in the ordinary course of business. Any document/file which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed.

Documents/files introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

13.2.E Collected Data Available to CMS on Request

In accordance with 42 CFR 438.242(b)(4), the contractor must make all collected data available to the state and upon request to the Centers for Medicare & Medicaid Services (CMS).

13.3 ENROLLMENT PROCESSING

The Department, or its duly authorized representative, shall provide the Contractor on a monthly basis a listing of all members who have selected or been assigned automatically to the Contractor’s plan. The listing, or “enrollment file,” shall be provided to the Contractor sufficiently in advance of the member’s enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, as described in this Contract. Should the enrollment report be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment report is delayed. The MMIS eligibility cut-off schedule is documented in the Managed Care Technical Manual. The MCO Enrollment reports shall provide the Contractor with ongoing information about its members and enrollees and shall be used as the basis for the monthly capitation payments.

13.3.A Enrollment File (834)

An 834 enrollment file will be sent to the Contractor weekly on the 6th and 13th of each month, and monthly on the 19th (known as mid-month) and on the last day of the month. The weekly 834 files will contain any changes of Member information, and enrollment adds and terminations (drops) for Medallion 4.0; Plus MCO program dis-enrollments. The monthly 834 file will contain information about the Contractor’s Medallion 4.0 membership, including audit, add and termination records for full eligibility/enrollment for current and future enrollment dates. The Member’s coverage begin date with the Contractor will depend upon whether Medicaid eligibility and/or an MCO plan change information is entered/uploaded into VAMMIS on or

before the 18th or on or after the 19th of the month. Medicaid expansion members will be included in the enrollment files described in this section. There will be no separate enrollment file for this population.

13.3.B Medical Transition Report File (MTR)

The Department 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, as outlined in this contract.

13.3.C Capitation Payment File

The 820 payment file will list all of the Contractor's members for the enrollment month who are known on the report generation date. The 820 payment file will be provided to the Contractor the month after the member is enrolled as detailed in the Managed Care Technical Manual.

13.3.D Reconciliation of Enrollment

The Contractor shall work with the Department to ensure that the enrollment databases of the Department and the Contractor are reconciled. The Department may audit the Contractor's Medicaid enrollment database.

13.3.E Retroactive Adjustments

Retroactive adjustments to enrollment and payments shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to enrollment without regard to timeliness of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment update/correction. The Department shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

13.4 PROVIDER IDENTIFICATION NUMBERS (NPIs)

In accordance with requirements set forth in 1932(d)(4) and 1173(b)(2) of the Social Security Act, the Contractor must ensure that all encounters are identified with an active National Provider Identification (NPI) for all health care providers. Monthly, the Department produces a provider file that includes all active and terminated Virginia Medicaid Providers. The Contractor is responsible for maintaining the correct provider identification number for the claim and service date. The Contractor will make best effort that as part of its credentialing process all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), apply for enrollment in the Medicaid program.

13.5 DATA QUALITY REQUIREMENTS

13.5.A General Requirements

The Contractor shall meet all data requirements as defined by the Department and in compliance with 42 CFR §§ 438.604, 438.606, 438.818, 438.116, and 438.206-207. All data shall be transmitted in a HIPAA-compliant manner. The Department will require all data to be submitted based on Uniform Data Specifications that will be described by the Department in future guidance. This guidance will include, but will not be limited to; electronic data interchange

(EDI) companion guides, EDI implementation guides, Managed Care Technical Manual, CRMS Technical Manual, Medallion 4.0 reporting requirements, or other documents that refer to this section of the Contract. All deadlines and schedules for data submissions shall be as set forth in this Contract, unless a later date is agreed to between the parties.

The Department may require any data inclusive or relevant to the Members from the Contractor within sixty (60) calendar days' notice, in accordance with the format, mode of transfer, schedule for transfer, and other requirements detailed by the Department in its supporting documentation. All supporting documentation may be modified at the discretion of the Department, and the Contractor shall have sixty (60) days from the date of the document's modification to comply. As described by the Department in its supporting documentation, the Contractor shall successfully exchange all required data with the Department no later than one hundred and eighty (180) calendar days after the start of the contract. For newly required data, the Contractor shall have sixty (60) calendar days to implement the exchange of each data set as specified by the Department. The Contractor shall produce any required or requested data according to the specifications, format, and mode of transfer established by the Department, or its designee, within sixty (60) calendar days of notice.

At a minimum, the Contractor shall transmit all data files in the format described in the Uniform Data Specifications guidance documentation including, but not limited to the following:

1. All encounter data;
2. Financial data and reports for payments to providers contracted to provide services to Members;
3. Service authorizations (approved, denied, and pending); and,
4. Provider network data for any providers who are eligible to provide services to the Members.

The Department may also require additional data sets, which shall be defined in supporting documentation at the time requested. The Contractor shall have sixty (60) calendar days from the date of the request to provide such requested additional data, which may include, but is not limited to, the following:

1. Clinical data;
2. Visit verification data;
3. Assessment data;
4. Medical record data.

All data submissions are required to be certified. Data certification forms shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall keep track of every record submitted to the Department or its designee and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification.

The Contractor shall disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor shall provide prior notification to the Department of any anticipated changes that may have an impact on the

substance or process of data exchanges between the parties, and shall engage with testing in order to ensure continuity of existing data exchanges.

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

1. Collect and maintain 100% of the data required by the Department;
2. Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which shall include:
 - a. Metrics that measure completeness, timeliness, and accuracy of the data;
 - b. Benchmarks that describe whether the Contractor's performance is compliant with the Department's requirements;
 - c. A description of how each measure is calculated by the Department;
3. Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation;
4. Participate in user acceptance testing with the Department in order to measure the level at which the test submissions meet data and data quality requirements before routine submissions from the Contractor begin (See the Encounter Technical Manual for specific testing requirements);
5. Ensure that Contractor data can be individually linked to Department data at the record level (e.g. Contractor data on Members can be linked to the Department's unique Member identifier) and
6. Provide any reports on required data as requested by the Department.

The Department may, at its discretion, change the content, format or frequency of reports.

In addition, the Department may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If the Department requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format required by the Department

13.5.B Data Reconciliation and Potential Audit Requirements

Department, or its designee, for the purpose of evaluating the completeness of the Contractor's data inventory as disclosed to the Department, and to evaluate the collection and maintenance of data required by the Department. Upon request by the Department, or its designee and with thirty (30) calendar days' notice, the Contractor shall provide DMAS-specified Member records in order to permit the Department to conduct data validation assessments.

The Department, or its designee, may investigate suspected data quality issues including, but not limited to, deviations from expected data volume, or expected data corrections, voids or adjustments. Suspected data quality issues discovered by such investigations may result in the addition of metrics to the Data Quality Scorecard or the requirement that the Contractor replace data with suspected data quality issues at no cost to the Department. Any cost incurred by the Department to reprocess replacement data that the Department determines has data quality issues shall be passed through in its entirety to the Contractor. Costs for replacing such data with

replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

13.5.C Data Inventory and Data Quality Strategic Plan Requirement

At least twice yearly or as otherwise requested by the Department, the Contractor shall submit to the Department a data inventory including, but not limited to:

- The data's origin (i.e. what entity originally generated the data);
- The business purpose of the data and reason for its existence;
- A comprehensive description of all metadata elements, including:
 - A list of all data fields
 - A business description of the content of each field
 - The field's format
 - A list of valid values (where the data field is defined by a limited value set) and
- Description of the format, schedule, and any other required details regarding how the data is transmitted to DMAS, if that source is required by the Department.

Should the Contractor possess a new data source with data on the members, the Contractor shall inform the Department sixty (60) calendar days prior to that data source's acquisition or creation.

The Contractor shall provide the Department with an Annual Data Quality Strategic Plan in accordance to the specifications of the Department that addresses:

1. The Contractor's plan for ensuring high quality data that complies with the Department's standards for accuracy, timeliness, and completeness as described in the Data Quality Scorecard or other supporting documentation;
2. Plans and timelines for improving performance on the metrics in the Data Quality Scorecard, unless the Contractor is compliant on all measures;
3. What procedures and automated checks exist in the Contractor's systems to prevent transmission of non-compliant data and
4. The compliance actions and data quality standards expected of service providers, billing providers, sub-contractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

13.5.D Data Quality Penalties

Where DMAS determines that the Contractor has failed to comply with the Departments' data exchange requirements or is non-compliant with data quality benchmarks, DMAS may impose the sanctions set out below. The process for the Department's imposition of sanctions shall comply with the requirements of 42 CFR §§ 438.700(c) and 438.704(b)(1).

The Department shall develop for the Contractor a Data Quality Scorecard, which shall be described in supporting documentation. The Data Quality Scorecard may include up to 40 data quality performance metrics, and performance by the Contractor on the scorecard shall be communicated monthly by the Department to the Contractor. If a new data quality metric is to be added to the Data Quality Scorecard, the Contractor shall have ninety (90) calendar days before data quality withholds may occur based on the Contractor's performance on that metric.

Where DMAS determines that the Contractor has failed to submit required data or meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department shall send a notice of non-compliance. The Department reserves the right to apply penalties for non-compliance.

A Notice of Non-Compliance by the Department to the Contractor shall include:

1. A description of the data quality issue and the Contractor's performance on any metrics that triggered the non-compliance notice;
2. The action that shall be taken by the Contractor in order to cure the performance failure;
3. Financial withhold or penalties as a result of non-compliance as prescribed by the data quality scorecard;
4. The Department may require the Contractor to replace any non-compliant data with compliant data at no cost to the Department. Any cost incurred by the Department to reprocess replacement data shall be passed through in its entirety to the Contractor. Costs for replacing non-compliant data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

13.6 RISK MANAGEMENT AND SECURITY

The Contractor shall implement and maintain security controls designed to provide a secure environment for Content and any hardware and software in accordance with applicable federal and state regulations.

DMAS requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that is compliant with the most stringent requirements from the standards listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 Health and Insurance Reform; Security Standards: Final Rule (latest version);
- CMS MARS-E v2.0 (latest version); and
- DMAS policies specifically identified.
- VITA security standards, which may be found on the VITA website at <http://www.vita.virginia.gov> including:
 - COV SEC 520-00 (or latest) IT Risk Management Standard
 - COV SEC 525-02 Hosted Environment Information Security Standard
 - COV SEC 501-11.3 (or latest) IT Information Security Standard
 - COV SEC 514-03 (or latest) Removal of Commonwealth Data from
 - Electronic Media Standard

The contractor shall ensure the Risk Management and Security plan for the information system:

1. Is consistent with the organization's enterprise architecture;
2. Explicitly defines the authorization boundary for the system;
3. Describes the operational context of the information system in terms of missions and business processes;
4. Provides the security categorization of the information system including supporting rationale;

5. Describes the operational environment for the information system and relationships with or connections to other information systems;
6. Provides an overview of the security requirements for the system;
7. Identifies any relevant overlays, if applicable;
8. Describes the security controls in place or planned for meeting those requirements including a rationale for the tailoring and supplementation decisions; and
9. Is reviewed and approved by the authorizing official or designated representative prior to plan implementation.

The Risk Management and Security Plan document must be delivered to the Department 30 days before implementation. The Plan will also be made available to appropriate State and Federal agencies as deemed necessary by DMAS. The contractor shall review Risk Management and Security Plan on an annual basis or more frequently if required to address an environmental change. The Plan shall be made available to the Department with every change or at the minimum on an annual basis.

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 reporting 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. The report shall be compliant with the AICPA Statement on Standards for Attestation Engagements (SSAE) No 18, Reporting on Controls at a Service Organization, Service Organizations Controls (SOC 2®), Type 2 Report-Reporting on Controls at a Service Organization Relevant to Security, Availability, Processing Integrity, Confidentiality, or Privacy (AICPA, Attestation Standards, AT-C section 105, Concepts Common to All Attestation Engagements, and AT-C section 205), and include the Contractor and its third-party service providers. The (SOC 2®), Type 2 audit reports must be provided to the DMAS Contract Administrator annually, no later than 30 days after the report is issued.

Secure Email and File Transfers

The contractor shall provide a secure email transfer connection between DMAS and contractor's email services, to allow for encryption in transit for all messages. Contractor will establish a bi-directional TLS encryption path between its own and DMAS email servers, and will be configured for current best security practices and standards.

The contractor shall provide acceptable means to encrypt individual email messages containing PHI that are sent to DMAS. Solution will not require a software to be installed on DMAS

equipment. The Contractor shall provide a solution to securely receive and transfer files to DMAS's current and future file transfer or sharing capabilities.

13.7 CONTINUITY OF OPERATIONS PLAN

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.

13.8 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 BC/DR Plan shall be submitted in the manner and format as outline in the Managed Care Technical Manual.

14. 14. ENCOUNTER DATA

For the purposes of this Contract, an encounter is any service received by the member and processed by the Contractor and/or its subcontractors. The Contractor shall submit paid and denied encounter data for all services. Encounter Data must comply with all requirements as defined in the Uniform Data Specifications for Encounters and in section 13.5 (Data Quality Requirements) of this contract, and is subject to Data Quality Penalties as described in that section.

14.1 UNIFORM DATA SPECIFICATIONS FOR ENCOUNTERS

Encounter data must be submitted in a compliant format according to the Department's Uniform Data Specifications for Encounters, which consists of the following documents:

- TR3 Healthcare and NCPDP Implementation Guides (by transaction type)
- DMAS EDI Companion Guides (by transaction type)
- DMAS EDI Procedure Manual
- Encounter Technical Manual

The Contractor must comply with all submissions guidelines and restrictions for volume, frequency, and schedule as documented in the Uniform Data Specifications. Any deviations from the documented submission guidelines require prior approval by the Department.

14.2 ENCOUNTER DATA QUALITY STANDARDS

The Contractor must ensure that all electronic encounter data submitted to the Department are timely, accurate and complete. Encounter data quality will be assessed as described below and in Section 14.2.A of this Contract.

The Contractor shall fully cooperate with all Departmental efforts to monitor the Contractor's compliance with the requirements of encounter data submission. The Contractor shall comply with all requests related to encounter data monitoring efforts in a timely manner. [42 CFR §§ 438.242(c)(1)-(4) and 438.818].

14.2.A Data Quality Requirements

The Contractor shall submit encounter data for member services on which the Contractor incurred a financial liability, and shall include claims for provided services that were eligible to be processed, but where no financial liability was incurred. The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:

- Expected utilizations;
- Actual visits to expected visits;
- Service date lag time benchmarks;
- Expected EDI fail amounts and
- Average paid amount per service, by billing code.

The Contractor shall also:

1. Collect and maintain one-hundred percent (100%) of all encounter data for each covered service and supplemental benefit services provided to members, including encounter data from any sub-capitated sources. Such data must be able to be linked to the Department's eligibility data;

2. 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;
3. Participate in site visits and other reviews and assessments by The Department, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of encounter data. The Department may request a sample extract of 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 thirty (30) days' notice, the Contractor shall provide Department specified member records in order to permit the Department to conduct data validation assessments;
4. Develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 USC 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program as directed in Section 8.7A.IX(Drug Rebates) of this Contract. Managed care encounter claims are required to be submitted in a timely manner and in full compliance with the DMAS published Companion Guide (NCPDP Payor Specifications). Any impact to the collection of manufacturer rebates allowed under Federal law that is the result of delayed encounter claim submissions to DMAS or the omission of required claim level data elements will be assessed as a contract penalty at the full amount of lost manufacturer rebates;
5. Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) days of the Contractor's payment cycle and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in its supporting documentation and
6. The Contractor's systems shall generate and transmit encounter data files according to the Encounters Technical Manual and any additional specifications as may be provided by the Department and updated from time to time.
7. Payment cycle data must be submitted and certified according to the EDI Procedure Manual.

In following with 42 CFR §438.602(e), the Contractor shall comply with any audit arranged for by the Department to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by Contractor, under penalty of perjury. The Contractor shall cooperate with the DMAS designated auditor(s) to ensure the audit is completed within the timeframe specified by the Department.

If the Department or the Contractor determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

1. Notify DMAS, prior to encounter data submission and within forty-eight (48) hours of discovery, that the data is not complete or accurate, and provide an action plan and timeline for resolution and approval;
2. Submit for DMAS approval a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level. Timeframe for submission shall be established by the Department, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements;

3. Implement the DMAS-approved corrective action plan within DMAS approved timeframes. Implementation completion shall not exceed thirty (30) calendar days from the date that the Contractor submits the corrective action plan to the Department for approval;
4. Participate in a validation review to be performed by the Department, or its designee, following the end of a twelve (12) month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. The Department, or its designee, shall determine whether the Contractor is financially liable for such validation review.

14.3 SUBCONTRACTOR ENCOUNTER DATA

The Contractor is responsible for submission of all its subcontracted encounter data. Subcontracted encounter data must comply with all Department specifications and requirements. Subcontracted encounter data have the same requirements as those for Contractor encounter data. The Contractor must evaluate the completeness and quality of subcontractor encounter data on a periodic basis, and document these evaluation procedures and the results in the annual Data Quality Strategic Plan (Section 13.5.C) that is submitted to the Department.

14.4 ENCOUNTER DATA CERTIFICATIONS

All encounter data must be certified by an authorized agent of the Contractor in accordance with 42 CFR §436.606. Refer to the Uniform Data Specifications for Encounters and to section 13.5 of this contract for additional details about data certification processes and requirements.

15. FINANCIAL STATEMENTS, INFORMATION, REPORTING AND PAYMENTS

15.1 BUREAU OF INSURANCE FILINGS

The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance. Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

15.1.A Annual Audit by Independent Contractor

The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. [42 CFR § 438.3(m)] The Contractor shall provide the Department a copy of such an audit within sixty (60) calendar days of completion of the audit.

15.1.B Financial Report to the Department

The Contractor shall agree to work with the Provider Reimbursement Division of the Department to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative

expenses associated with the Medallion 4.0 Program, to include Medicaid and FAMIS populations. The Department reserves the right to approve the final format of the report. The report shall be submitted on a quarterly basis to the Department following the same schedule as reports for the BOI with the exception of the 4th quarter report also known as the annual report which must be submitted within two weeks after the BOI due date. The first quarterly reporting period shall begin on July 1 and end on September 30th. This report is subject to audit and verification by the Department

For Contractors with multiple lines of business in Virginia, the quarterly report should segregate and report data for each program (CCC Plus, Medallion, etc.), line of business, eligibility groups (FAMIS, Base Medicaid, Medicaid Expansion), and reconcile to the annual BOI reports.

On an annual basis, each contractor shall submit supplemental information related to administrative expenses that (1) identify all non-allowable expenses for Medicaid reimbursement and (2) allocate its administrative expenses across major eligibility groups. In reporting expenses to the Department, the Contractor must ensure that expenses must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

Non-allowable expenses for Medicaid reimbursement include but are not limited to:

- Related party management fees in excess of actual cost;
- Lobbying expenses;
- Contributions;
- State and Federal income taxes;
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs;
- Management fees relating to non-Virginia operations;
- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific MCO enrollees;
- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs;
- Accruals for future losses;
- Reserves based on estimates for bankrupt providers;
- Unsupported medical expenses.

In accordance with 42 CFR 438.8 when reporting expenses the contractor must ensure that each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

15.1.C General Financial Reporting

The Department will be working to develop enhanced level financial reporting modeled closely after BOI reports. Report specifications and templates can be found in the Managed Care Technical Manual.

15.2 FINANCIAL RECORDS

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Department prior to making any changes to its basis of accounting.

15.3 FINANCIAL SOLVENCY

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards. [Section 1903(m)(1) of the Act and § 438.116(b)]

15.4 CHANGES IN RISK BASED CAPITAL REQUIREMENTS

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in risk based capital requirements imposed by the Bureau of Insurance or any other entity.

15.5 PAYMENT TO MCOS

The Department shall issue capitation payments on behalf of members at the actuarially sound rates established in this Contract and modified during the contract renewal process. Capitation payments may only be made by the State and retained by the Contractor for Medicaid-eligible members as set forth in 42 CFR § 438.3(c)(2). The Contractor shall accept the established capitation rate paid monthly by the Department and any “kick payments” defined below as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The Contractor shall submit data, as requested by the Department, on the basis of which the state certifies the actuarial soundness of capitation rates. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month’s enrollment (e.g., payment for June enrollment will occur in July, July payment will be made in August, etc.). If an individual is enrolled with the Contractor the first day of any given month, that MCO has the responsibility of providing services to that member no matter if they move to another locality. If the member moves to a locality outside of the MCOs service area, the member will be dropped from the plan’s enrollment at the end of the month of change. The capitation payment is based on several factors (e.g., sex, age, aid category and FIPS) and is automatically generated by the system using the information in the system at the time of payment. Individuals who have their FIPS changed even towards the end of the month of enrollment will be dis-enrolled at the end of the month from the MCO if that individual’s FIPS is outside of the MCOs service area/region. Any and all costs incurred by the Plan in excess of the capitation payment will be borne in full by the Plan. The Contractor shall accept the Department’s electronic transfer of funds to receive capitation payments.

Under 42 CFR 438.608(c), the Contractor and any subcontractor shall report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Contract. The contractor shall provide the Department with its policies and procedures for identifying excess payments.

15.5.A Schedule of MCO Monthly Payments

Monthly capitation payments to the MCOs shall be paid retrospectively by the Department for the previous monthly MCO enrollment (Payment for August enrollment will occur in September). The capitation payment schedule for the current contract year is documented in the Managed Care Technical Manual.

15.5.B Maternity Delivery Kick Payments

In addition to monthly capitation payments, the Department shall make a “kick payment” for all maternity deliveries. The maternity payment reimburses health plans for their inpatient and professional payments associated with a live birth. A delivery is defined based on the following surgical procedure codes:

- 10D00Z0: Classical C-Section
- 10D00Z1: Low Cervical C-Section
- 10D00Z2: Extraperitoneal C-Section
- 10D07Z3: Low Forceps Vaginal Delivery
- 10D07Z4: Mid-Forceps Vaginal Delivery
- 10D07Z5: High-Forceps Vaginal Delivery
- 10D07Z6: Vacuum Vaginal Delivery
- 10D07Z7: Internal Version for Vaginal Delivery
- 10D07Z8: Other Vaginal Delivery
- 10E0XZZ: Delivery, Products of Conception, External, No Device, No Qualifier

A maternity kick payment will be triggered upon receipt of a valid encounter with one of the qualifying procedure codes above. Maternity kick payments will be generated once a month for all qualifying encounters in the prior month.

15.5.C Legislative Mandated Rates

To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid services/providers and as identified by the Department, and these rate adjustments are incorporated into the Medallion 4.0 capitation payment rates during the Contract period, where required by the Department and/or regulation, the Contractor is required to increase its reimbursement to providers at the same percentage as Medicaid’s increase as reflected in the revised fee-for-service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Department shall make every reasonable effort to provide at least sixty (60) days advance notice of such increases. The Contractor shall provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format. A copy of such notification shall be provided to the Department.

Under 1932 (b) of the SSA the Contractor must establish an internal grievance procedure by which a Member, or a provider on behalf of such a Member, may challenge the Contractor's decisions including, but not limited to, the denial of payment for services.

15.5.D Modifications to Rates

The Department may propose modifications, additions, or deletions to the rate cell structure over the course of the Contract or in future contracts. Any changes will be reflected in a modification to the Medallion 4.0 Contract.

Effective January 1, the Department will do a mid-year update to risk adjustment using an enrollment snapshot from the previous October.

Rates will be updated using a similar process for each contract year. Rate changes during the contract year will be considered if the changes, as a whole, are material. Changes would be deemed material if they result in an increase to any specific rate cell in excess of 0.3 percent for any eligibility category. Changes will be applied, if necessary on a retrospective basis, to effectuate accurate payments for each month

15.5.E Payment for Indian Health Care Providers

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

The Contractor shall reimburse non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Member at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider. [42 CFR § 438.14 (c)(1)-(2)]

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

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

- Adjudication (pay or deny) of ninety percent (90%) of all clean claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 CFR § 447.45 for timeframe exceptions.) This requirement shall not

apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

15.6 INCREASED PAYMENTS TO ENSURE ACCESS

The Contractor shall provide a uniform percentage increase to the base health plan payments made to the following providers and services:

- Private acute care hospitals for actual inpatient and outpatient hospital services provided to Medicaid managed care enrollees. For purposes of the uniform percentage increase, private acute care hospitals excludes public hospitals, freestanding psychiatric and rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals, and critical access hospitals. The Department shall establish the uniform percentage increases consistent with the "managed care organization hospital payment gap" as defined in Section 3-5.16 of the 2018 Appropriation Act.
- Non-state government owned acute care hospitals (Chesapeake Regional Medical Center) for actual inpatient and outpatient hospital services provided to managed care members. The Department shall establish the uniform percentage increase consistent with the State Plan supplemental payment methodology.
- Physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth for actual physician services provided to managed care members. The Department shall establish the uniform percentage increase consistent with the State Plan average commercial rate as a percent of Medicare for the same physician practice.
- Physicians affiliated with state university teaching hospitals (University of Virginia Health Center and Virginia Commonwealth University Health System) for actual 246 physician services provided to managed care members. The Department shall establish the uniform percentage increase consistent with the State Plan average commercial rate as a percent of Medicare for the same physician practice.

The uniform percentage increases are subject to approval by CMS consistent with 42 CFR § 438.6(c)(1)(iii)(B). These payments are intended to improve access to and the quality of services.

Following the end of each quarter, the Department shall calculate the amounts the Contractor shall pay each provider based on encounters reported in the immediate prior quarter. Funding for these payments will be included in quarterly supplemental capitation payments. The Contractor shall make payments to providers within seven (7) days of receipt of the supplemental capitation payments. The Department shall provide the Contractor instructions for making these payments. The Contractor shall collect and provide to the Department such information as is required to support the administration and distribution of the uniform percentage increases.

15.7 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 while the enrollee was not eligible and instruct the provider to invoice the Department 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 or FAMIS eligibility, or transfer to a non-managed care eligible Medallion 4.0 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. In these cases the total capitation payment for the month will be rescinded.

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

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

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or disenrollment. If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after Contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile newborn payments on a monthly basis; all other payments are reconciled on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter. See the MCTM for detailed information.

15.8 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 Related Grouping (DRG) payment methodology, the Contractor is responsible for the full inpatient medical hospitalization from time of admission to discharge. This will be effective for any member who is actively enrolled in the MCO on the date of admission regardless if the member is dis-enrolled from the MCO during the course of the inpatient hospitalization. This is an exception to loss of eligibility rules in Section 6.

Similarly, for FAMIS members who are hospitalized under fee-for-service at the time of admission, the Department is responsible for the full DRG, admission to discharge, in accordance with DMAS established coverage criteria and payment rules.

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.

15.9 PAYMENT FOR NEWBORNS

Until such time that a newborn is assigned a Medicaid, FAMIS, or FAMIS Plus identification number, the charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor for the birth month plus two (2) months. Where enrollment errors occur that are

later corrected, regardless of the time frame to correct such error, the Contractor is required to cover the newborn member and related charges. The Department will reimburse the Contractor the appropriate capitation payment.

15.10 BILLING MEMBERS FOR COVERED SERVICES

The Contractor, including its network providers and subcontractors, shall not bill a member for any services provided under this Contract. The Contractor shall assure that all in-network provider agreements (Reference Attachment IIV. Section A. Number 2) includes requirements whereby the member shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor can bill the member for the service

15.10.A Billing Members for Medically Necessary Services

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a member under the State Plan or under this Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as members are withdrawn from assignment to the Contractor.

Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), and 42 CFR § 438.106(a)(b)(1)(2)(c), the Contractor and all of its subcontractors shall not hold a member liable for:

a. Debts of the Contractor

Debts of the Contractor in the event of the Contractor's insolvency.

b. Payment for services provided by Contractor

Payment for services provided by the Contractor if the Contractor has not received payment from the Department for the services or if the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor.

c. Excessive Payments

Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the member if the service had been received directly from the Contractor.

d. Balance Billing

No balance billing is allowed for covered services.

e. Financial Transactions Data Requirements

The Contractor shall:

1. Collect and maintain 100% of all Health Care Claim Payment and Remittance Advice data for payments to providers contracted to provide services to Members and
2. Submit complete, timely, reasonable, and accurate financial data to the Department within forty-eight (48) hours of the Contractor's payment cycle and

in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

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

The Contractor shall be subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a contract specific basis and any refund amounts due will be based solely on revenue and expense experience applicable to Base Medicaid members (excluding Medicaid Expansion members). The MLR is calculated first followed by the calculation of the Underwriting gain limit.

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

The Contractor is required to report a MLR annually based on 42 CFR § 438.8 for both Base Medicaid members as well as Expansion members, 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 may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

In accordance with 42 CFR §§438.8(k) and 438.8(m) and, in any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and meeting the applicable requirements. Additionally, in any instance where a state makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the MCP must submit a new MLR report meeting the applicable requirements.

The MLR shall reflect the following, if applicable:

- a. Expenditures that benefit multiple contracts or populations (such as Medicaid Expansion and Base Medicaid), or contracts other than those being reported, must be reported on a pro rata basis [per 42 CFR§438(g)(1)(ii)];
- b. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract and/or population incurring the expense [per 42 CFR§438(g)(2)(ii)]; and,
- c. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities[per 42 CFR§438(g)(2)(iii)].

The Contractor shall report to the Department the following information for each MLR reporting year based on data through the ninth (9th) month following the MLR reporting year:

- Total incurred claims;
- Expenditures on quality improving activities;
- Expenditures on activities related to fraud prevention;
- Non-claims costs;
- Premium revenue;
- Taxes, licensing and regulatory fees;
- Methodology for allocation of expenditures;
- Any credibility adjustment applied;
- The calculated MLR;
- Any remittance owed to the State;
- A reconciliation of the information reported in this report with the audited financial report;
- A description of the aggregation method by covered population and
- The number of member months.

If the Contractor is required to make a payment to the Department the payment shall be due to the Department no later than twelve (12) months following the MLR reporting year.

The Contractor shall be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid adjusted premium revenue. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid adjusted premium revenue for the MLR reporting year developed in the same manner as the MLR (i.e. with data through the ninth (9th) month following the MLR reporting year). Such amounts shall be determined consistent with the reporting requirements for the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance with two exceptions. First, the non-claims costs should exclude the amount, if any, of non-allowable expenses as described in Section 15.1.B, Financial Report to the Department. Second, the benefit claims, administrative expense experience and adjusted premium revenue associated with the Medicaid Expansion members shall be excluded.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds three percent (3.00%) then the Contractor shall make payment to the Department equal to one-half of the underwriting gain in excess of three percent of Medicaid adjusted premium revenue up to 10 percent. The Contractor shall return 100 percent of the underwriting gain above 10 percent. Such amount will be remitted to the Department as a refund of an overpayment. To illustrate, if the underwriting gain is nine percent (9%) then the Contractor shall refund to the Department three percent (3.0%) of Medicaid adjusted premium revenue. If the underwriting gain is eleven percent (11%) then the Contractor shall refund to the Department 4.5% of Medicaid adjusted premium revenue. If the underwriting gain is four percent (4.0%) then the Contractor shall refund to the Department 0.5% of Medicaid adjusted premium revenue.

All of the variables used in the calculation of the underwriting gain limit and the amount of any resulting payment 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 MLR reporting year if the Contractor has fewer than 10,000 members per month during the MLR reporting year.

If the Contractor or the Department is required to make a payment under this Contract provision, the payment shall be due to the Department or Contractor no later than twelve (12) months following the MLR reporting 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 shall report a medical loss ratio (MLR) annually for Medallion 4.0 for each contract/reporting year based on 42 CFR § 438.8 and any additional CMS guidance. The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. Reporting specifications will be included in the MCTM and the Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

Pursuant to 42 CFR § 438.8 in any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must:

1. Re-calculate the MLR for all MLR reporting years affected by the change and
2. Submit a new MLR report meeting the applicable requirements.

15.12 REINSURANCE

15.12.A Pharmacy Reinsurance Pool

The Department will operate a Pharmacy Reinsurance pool. The objective of the pool is to spread the risk of excessive pharmacy claims equitably across all participating Contractors. Ninety percent (90%) of a member's annual prescription drug costs above a \$200,000 attachment point will be aggregated/pooled across all Contractors participating in the Medallion 4.0 program. Such claims will be referred to as pharmacy reinsurance claims.

The amount to be used in the computation of a member's annual prescription drug costs (including prescription drugs administered in a physician's office or outpatient hospital setting) will be the Contractor paid amount after reduction by any TPL payment. The Department will notify the Contractor quarterly of all members whose prescription drug costs have exceeded the

\$200,000 attachment point during the contract year. All reinsurance claims are subject to medical review by the Department. The pooled amount is not combined with other DMAS Managed Care programs, even if, during a contract year, the Contractor participates in more than one program and a member incurred costs while covered by the Contractor in another program, his/her eligibility changes, moves into the Medallion 4.0 and incurs additional costs.

The Department will allocate the aggregate/pooled reinsurance claims to each MCO on the basis of premium revenue. Contractors whose total pharmacy reinsurance claims in the contract year exceed the allocated pooled amount will be reimbursed for the excess. Contractors whose total pharmacy reinsurance claims are less than the allocated pooled amount will be required to reimburse the Department for the deficiency. The total of the excess and deficient amounts for all Contractors will offset such that the Department bears no risk with regard to the underlying pharmacy reinsurance claims. The Department will send each Contractor a report documenting pharmacy reinsurance claims within thirty (30) calendar days of each quarter end for the first three quarters of the contract year. The Department's report will use the file format and guidelines as specified in the MCTM. The quarterly periods end on March 31, June 30, September 30 and December 31 of the contract year. The deadline for the final quarter, ending June 30, will be (3) months following the quarter end to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will determine and report the allocated/pooled amount quarterly by Contractor or provide notice to each Contractor if additional information is required.

The Department reserves the right to perform audits on reinsurance claims. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

15.12.B Risk Corridor for Medicaid Expansion Population

A risk corridor program for Medicaid Expansion Members will be utilized under this contract. The risk corridor program creates a mechanism for sharing risk for projected benefit costs between DMAS and the Contractor. If the Contractor incurs benefit costs that are less than 98 percent (98%) of the target amount, the Contractor will refund a percentage of those savings to DMAS. If the Contractor incurs benefit costs that are greater than 102 percent (102 %) of the target amount, the Contractor will receive payments from DMAS to offset a percentage of those losses. Benefit cost is an amount equal to the total costs paid by the Contractor in providing benefits covered by the plan. Benefit cost excludes allowable administrative costs paid by the Contractor. The risk corridor calculation shall be made based on the Contractor's experience during the contract year.

a. DMAS Payments to the Contractor.

The Contractor will receive payment from DMAS in the following amounts under the following circumstances: (1) When the Contractor's benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii) in any contract year are more than 102 percent but not more than 106 percent of the target amount, DMAS pays the Contractor an amount equal to 50 percent of the target amount in excess of 102 percent of the target amount; and (2) When the Contractor's benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii) in any contract year are more than 106 percent of the target amount, DMAS pays to the

Contractor an amount equal to the sum of 2 percent of the target amount plus 100 percent of benefit costs in excess of 106 percent of the target amount.

b. Contractor's Remittance of Charges

The Contractor must remit charges to DMAS in the following amounts under the following circumstances: (1) If the Contractor's benefit costs for services allowed under 42CFR 438.3(c)(1)(ii) in any contract year are less than 98 percent but not less than 94 percent of the target amount, the Contractor must remit charges to DMAS an amount equal to 50 percent of the difference between 98 percent of the target amount and the benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii); and (2) When the Contractor's allowable costs for any benefit year are less than 94 percent of the target amount, the Contractor must remit charges to DMAS an amount equal to the sum of 2 percent of the target amount plus 100 percent of the difference between 94 percent of the target amount and the benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii).

Target amount means an amount equal to the total capitation payments for benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii) paid by DMAS for the contract year to the Contractor based on the actuarially determined projected benefit cost PMPM. The target amount will be determined by DMAS and will not be affected by any service level agreement penalties described in Section VIII.

The Department will send the Contractor a report on the amount of benefit costs for services allowed under 42CFR 438.3(c)(1)(ii) for the contract year within eleven (11) months of each contract anniversary. Such amount shall be calculated based on data through the ninth month following the contract year. The amount of benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii) will not be affected by any service level agreement penalties described in Section VIII. Such reporting is required to be certified by the Contractor. Any charges owed to DMAS or payments owed to the Contractor will be paid to the respective party no later than twelve (12) months after the end of each contract year.

15.13 "NEVER EVENTS" AND HEALTH CARE ACQUIRED CONDITIONS

The Contractor shall comply with 42 CFR § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The Contractor's reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR § 447.26.

15.13.A Hospital Acquired Conditions Adjustments

Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Department. For example, an inpatient claim with forty-five (45) covered days identified with an HAC diagnosis having an ALOS of 3.4, shall

be reduced to forty-two (42) covered days.

15.13.B Services Which Shall Receive No Payment

No payment shall be made for services for inpatients for the following Never Events: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or otherwise invasive procedure performed on the wrong patient.

15.13.C Provider Preventable Conditions

No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider

Under 42 CFR §§ 438.3(g), 434.6(a)12(i), and 447.26(b), the Contractor is prohibited from making a payment to a provider for provider-preventable conditions that meet the following criteria:

- Is identified in the State Plan;
- Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the beneficiary;
- Is auditable;
- Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additionally, the Contractor must require all providers to report provider preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. Further, the Contractor must report all identified provider preventable conditions to the Department.

15.13.D Reduction Limits for Provider Payments

Reductions in provider payment may be limited to the extent that the following apply; 1) The identified provider-preventable conditions would otherwise result in an increase in payment or 2) The Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

15.13.E Nonpayment Shall Not Prevent Access

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

15.13.F Adjustments

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

15.14 CRITICAL INCIDENTS AND PREVENTABLE READMISSIONS

The Contractor shall develop and implement policies and procedures for review and approval regarding the finding, reporting and management of critical incidents that members experience. A critical incident is any incident that threatens or impacts the well-being of the member. Critical incidents shall include, but are not limited to, the following: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a member.

The policies and procedures shall reflect how the Contractor identifies, documents, tracks, reviews, and analyzes critical incidents. In addition, the policies and procedures shall address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including Adult Protective Services (APS) and Child Protective Services (CPS)), 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 participating program 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 process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting 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 from the start of the incident.

The Contractor shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers and direct service providers comply with critical incident requirements.

15.15 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) & RURAL HEALTH CLINICS (RHCs)

Prior to FQHC or RHC contract signature, the Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Contractor must establish the following type of contractual arrangement:

If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHC's or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of Medallion 4.0 members.

The Contractor must provide assurances that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the Contractor shall provide supporting documentation at the Department's request.

Within ten (10) business days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of arrangement it has established.

15.16 CERTIFICATION (NON-ENCOUNTERS)

Any payment information from the Contractor that is used for rate setting purposes or any payment related data required by the state must be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor must use Attachment X, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

16. ENFORCEMENT AND REMEDIES

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or non-compliance with State or federal laws or regulations including, but not limited to, the requirements of 12 VAC 30-120-380, as amended, the remedies outlined below may be imposed.

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. Such remedies are joint and severable and may be exercised concurrently or consecutively. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

The Department's administrative procedures shall not supersede the administrative procedures set forth in herein and those required by the Federal government.

The Department will work with the Contractor and the Contractor's network providers to correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner, as determined by the Department.

16.1 DAMAGES

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

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 enforcement of the Contract requirement at issue and any associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

16.1.A Federally-Prescribed Sanctions for Noncompliance

a. Intermediate sanctions

Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. The Department will provide the Contractor with timely written notice before imposing an intermediate sanction (other than required temporary management) that explains the basis. In accordance with 42 CFR 438.700, intermediate sanctions may be imposed if the managed care organization:

- Fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to a member covered under the Contract;
- Imposes premiums or charges members in excess of the premiums or charges permitted under Title XIX of the Act or applicable waiver;
- Acts to discriminate among members on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this title, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible members whose medical condition or history indicates a need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or the state
- Misrepresents or falsifies information that it furnishes to a member, a potential member or a health care provider; or
- Fails to comply with the requirements for physician incentive plans as set forth (under Medicare) in 42 CFR. §§422.208 and 422.210.

In addition, 2 CFR §§ 438.700(c) and 438.704(b)(1) specify that the State may impose sanctions against a Managed care organization if the State determines that the entity distributed directly or indirectly through any agent or independent Contractor marketing materials that have not been approved by the Department or that contain false or misleading information.

b. Civil Money Penalties:

Section 1932(e)(2)(A) of the Act allows the State to impose the following civil money penalties:

- a. For each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of \$25,000.
- b. For each determination that the MCO discriminates among members on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible members based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, a maximum of

- \$100,000. For each determination that the MCO misrepresents or falsifies information furnished to member, potential member, or health care provider, a maximum of \$25,000.
- c. For each determination that the MCO has discriminated among members or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as \$15,000 for each member not enrolled as a result of the practice, up to a maximum of \$100,000.
 - d. With respect to a determination that the MCO has imposed premiums or charges on members in excess of the premiums or charges permitted, the money penalty may be a maximum of \$25,000 or double the amount of the excess charges; whichever is greater. The excess amount charged must be deducted from the penalty and returned to the member concerned.

All civil money penalties shall be imposed in accordance with 42 CFR § 438.70.

c. Appointment of Temporary Management:

Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management:

- Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the members. Temporary management may also be imposed if there is a need to assure the health of the organization's members during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.
- Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur. [42 CFR §438.706]

d. Other Sanctions

Sections 1932(e)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed:

- a. The State may permit members enrolled in a Managed care organization to dis-enroll without cause.
- b. The State may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932(e) of the Act.
- c. The State may suspend payment to the entity under Title XIX for individual members after the date the Secretary of Health and Human Services or the State notifies the entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur. [42 CFR §§438.700(d)(1) and 438.702(a)(3)-(5)]

e. Department Requirement

Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and

notify and allow members to dis-enroll without cause. The Department may not delay imposition of temporary management to provide a hearing before imposing this sanction. In accordance with 42 CFR §438.706(b)-(d), the Department may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not occur.

f. Contract Termination

Section 1932(e)(4) of the Act allows the State to terminate contracts of any Managed care organization that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity’s members with other managed care entities or allow members to receive medical assistance under the State Plan other than through a managed care organization.

In accordance with 42 CFR § 438.710(b) the State must give the managed care organization a hearing before termination occurs, and the State may notify the members enrolled with the managed care organization in writing of the hearing and allow the members to dis-enroll if they choose without cause.

g. Denial of Payment

Title 42 CFR § 438.730 describes the circumstances under which CMS may, based upon the recommendation of the State to impose the denial of payment sanction for new members of the managed care organization under Section 1903(m)(5)(B)(ii) of the Act. In accordance with 42 CFR § 438.726(b), the Department will deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS.

16.1.B Other Specified Sanctions

In addition to the sanctions authorized by Federal law, the Department’s regulations provide sanction authority (12VAC30-120-410). If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the Contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

a. Suspensions of New Enrollment

The Department may suspend the Contractor’s right to enroll new Medicaid and FAMIS members (voluntary, automatically assigned, or both) under this Contract (12VAC30-120-410(A)). The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option, must notify the Contractor in writing of its intent to suspend new Medicaid and FAMIS enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite.

The Department may also suspend new Medicaid and FAMIS enrollment or dis-enroll Medicaid and FAMIS members in anticipation of the Contractor not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its

current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify members of Contractor non-compliance and provide such members an opportunity to enroll with another MCO.

b. Department-Initiated Disenrollment

The Department may reduce the number of current members by dis-enrolling the Contractor's Medicaid and FAMIS members. The Contractor shall be given at least thirty (30) calendar days' notice prior to the Department taking any action set forth in this paragraph.

c. Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid and FAMIS members. The Contractor shall be given at least thirty (30) calendar days' notice prior to the Department taking any action set forth in this paragraph.

d. Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities which are geared toward potential members. The Contractor shall be given at least ten (10) calendar days' notice prior to the Department taking any action set forth in this paragraph.

e. Additional Sanctions

In accordance with 42 CFR §438.702(b), the Department may impose additional sanctions provided for under Virginia statutes or regulations to address noncompliance. Sanctions are addressed in DMAS' regulations at 12 VAC30-120-410.

16.2 PROHIBITED ACTIONS

16.2.A Prohibited Affiliations with Entities Debarred by Federal Agencies

In accordance with 42 USC § 1396 u-2(d)(1), and further explained in 42 CFR §§ 438.610 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 or its subcontractors shall not knowingly have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse

In accordance with 42 CFR 438.610(d)(3); 42 CFR 438.610(a); Exec. Order No. 12549, if the Department finds that the Contractor is not in compliance and has a prohibited relationship with

an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR), or from participating in non-procurement activities under regulations issued under Executive Order No. 12549, or if the Contractor has a relationship with an individual who is an affiliate of such an individual, the Department:

1. Shall notify the Secretary of the noncompliance;
2. May continue an existing agreement with the Contractor unless the Secretary directs otherwise and
3. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

In accordance with 42 CFR 438.610(d)(3) and 42 CFR 438.610(b) if the Department learns that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act, the Department may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Department's and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

16.2.B Other Categorical Prohibited Affiliations with Entities

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

- a. Entities which could be excluded under § 1128(b)(8), as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has:
 - a. Been convicted of any of the following crimes:
 - i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);
 - ii. Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);
 - iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (as provided in § 1128(b)(1) of the Act, as amended);
 - iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal

offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended) or

- v. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in §1128(b)(3) of the Act, as amended).
- b. Been excluded from participation in Medicare or a State health care program;
- c. Been assessed a civil monetary penalty under Section 1128A of the Social Security Act [42 U.S.C. § 1320a-7(a)-(f)]; or (Civil monetary penalties can be imposed on an individual provider, as well as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General and may be imposed in the event of false or fraudulent submittal of claims for payment and certain other violations of payment practice standards.)
- d. Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 CFR Part 76 or under guidelines implementing such an order or is an affiliate (as defined in such Act) of a person described in clause (a).

The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

- b. Entities which have a direct or indirect substantial contractual relationship with an individual or entity described in Paragraph 1, above. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:
 - i. The administration, management, or provision of medical services;
 - ii. The establishment of policies pertaining to the administration, management, or provision of medical services or
 - iii. The provision of operational support for the administration, management, or provision of medical services. [42 CFR § 431.55(h)(3)]

The Contractor attests by signing this Contract that it excludes from participation in the Contract activities all entities which could be included in the categories listed in b. i. through iii. above.

- c. Entities who are to be excluded per Code of Virginia § 32.1- 325.
- d. Prohibited Affiliations with Entities Debarred by Federal Agencies, see §13.3(a).

16.2.C Prohibited Affiliations with Contractor and Subcontractor Service Providers

In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 CFR § 438-610 and § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by the Department for fraud, waste and abuse. Additional guidance may be found in the Department's

4/7/09 Medicaid Memo titled Excluded Individuals/Entities from State/Federal Healthcare Programs.

The Contractor must inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov/>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s), have written policies and procedures outlining provider enrollment and/or credentialing process.

17. TERMS AND CONDITIONS

Through submittal of the response of the Department’s request for Proposals and by signing this Contract, the Contractor shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their Attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the Contractor as to the contents of the Department’s RFP and this Contract.

Delegation of Primary Authority to Manage Networks and Maintain Operational Consistency:

The Director of the Department hereby delegates most of the Department’s authority to establish, maintain, monitor, sanction, credential, re-credential, and terminate network providers to the Contractor. The Department maintains oversight capacity on the Contractor’s provider networks as necessary to enforce the provisions and terms contained herein this Contract. In order to maintain operational consistency, any area where the Contract and all sources of law/guidance described in Section 2.1 “Applicable Laws, Regulations& Interpretation,” are silent, reflects the Department’s intent for the Contractor to follow its own clearly delineated policies and procedures.

Contract Requirement Exemptions Process:

The Contractor may request to be exempted from any contract requirement; however, such request for exemption must be requested in writing as required by this Contract and the MCTM. Any release by the Department of any contractual requirement must be approved by the Department’s management and the Health Care Services Compliance Unit. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

17.1 ADDITIONAL SOURCES OF LAW

17.1.A Governing Law (Virginia)

The Contract shall be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

Specific State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including, but not limited to: (1) the Code of Virginia Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 211 and Chapter 5-210; (3) Virginia Administrative Code, 12 VAC 30-120-360 through 12 VAC 30-120-420; and (4) Code of Virginia, Title 32.1, Chapter 10.

Governing Law (Federal)

a. Uniform Administrative Requirements

In accordance with 45 CFR § 74, the Contractor shall comply with all of the following Federal regulations.

b. Environmental Protection Rules

Each Contractor shall comply with all applicable standards, orders, or requirements issued under § 306 of the Clean Air Act (42 U.S.C. § 7606, § 508 of the Clean Water Act [33 U.S.C. § 1368]), which prohibits the use, under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

c. Copeland “Anti-Kickback” Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 18 U.S.C. § 874 and 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 CFR Part 3. See also 48 CFR Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

d. Davis-Bacon Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 CFR Part 5. See also 48 CFR Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

e. Contract Work Hours and Safety Standards Act

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C §§ 327-333, and as supplemented by Department of Labor regulations, 29 CFR Part 5. See also 48 C.F.R.CFR Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

f. Rights to Inventions Made Under a Contract or Agreement

Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and State of Virginia in any resulting invention in accordance with 37 CFR Part 401 “Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements, and any further implementing regulations issued by U.S. Department of Health and Human Services.

g. Byrd Anti-Lobbying Amendment

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. § 1352 and 45 CFR Part 93. No appropriated funds may be expended by the member of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a

member of Congress in connection with any of the following covered Federal actions: the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

h. Debarment and Suspension

Each Contractor shall comply with all applicable standards, orders, or requirements issued under Executive Orders 12549 and 12689 and 45 CFR part 76. Executive Order (E.O.) 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for non-procurement debarment and suspension. A person who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect.

i. Energy Policy and Conservation Act

The Contractor shall comply with any mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act, Public Law 94-163.

17.2 ATTORNEY FEES

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Contractor shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

17.3 AUDIT FINDINGS

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the Contractor to the Department. If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department.

17.4 RECORDS & LITIGATION HOLDS REQUESTED BY THE COMMONWEALTH

Pursuant to a request from the Department, the Medicaid Fraud Control Unit, or other relevant Commonwealth entity, or when the Department is served a Request for Discovery, the Contractor must make any and all records and documents available, whether maintained in electronic or hard copy format. The Contractor must also have the ability to implement a litigation hold to preserve such records and search for relevant documents, if so directed by the Commonwealth.

17.5 CONFLICT OF INTEREST

Nothing in this Contract shall be construed to prevent the Contractor from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this Contract, provided, however, that the Contractor furnishes the Department

with full prior disclosure of such other activities, or upon discovery of a conflict of interest. The Contractor shall comply with Federal conflict of interest provisions and requirements described in 42 CFR § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

In accordance with 1932(d)(3) of the Social Security Act and 42 CFR 438.3 (f)(2), the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Department having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. Section 423) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

17.6 CONTRACT TERM AND RENEWAL

The effective date of this Contract is July 1, 2020. This Contract will be effective until June 30, 2021.

The service areas and capitation rates for this Contract are referenced the Attachments.

The Contract may be renewed or extended annually by the Commonwealth for up to six successive twelve (12) 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. If the Contractor does not intend to seek a renewal, the Contractor must notify the Department in writing at least twelve (12) full calendar months prior to the renewal.

17.7 CONTRACTOR LIABILITY

The Contractor assumes full financial liability for developing and managing a health care delivery system that will arrange for or administer all covered services outlined in this Contract.

17.8 COVENANT AGAINST CONTINGENT FEES

The Contractor shall warrant that no person or selling agency has been employed or retained to solicit and secure the Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency, excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the Contract without liability or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

17.9 CHANGES TO LEGAL AUTHORIZATION FOR STATE PROGRAMS

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by

law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to {managed care plan}, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

17.10 COVID-19

The Contractor will work with the Department on covid-19 activities for members and providers including, but not limited to, implementing service delivery flexibilities detailed in guidance issued outside of this contract. This includes, but is not limited to, memorandum issued by the Department.

17.10.A Payment for COVID Vaccine Administration

The Department shall pay the Contractor, on a quarterly, non-risk basis for the costs of COVID vaccine administration to Medicaid-eligible members enrolled with the Contractor on the date the service was rendered. This payment shall be separate from the monthly capitation payments in Section 15.5 of this Contract and will be based on actual service utilization. Payment will be based on service utilization as recorded in the Department's enterprise warehouse. Encounters for this service shall be reported separately from services covered under the monthly capitation payments and must clear all systems edits in the MMIS to be eligible for payment to the Contractor. This non-risk arrangement is subject to federal Medicaid rules for payments under non-risk managed care contracts at 42 CFR 447.362 and the Contractor shall pay providers according to the Medicaid fee-for-service fee schedule. Federally Qualified Health Centers (FQHC) are eligible to receive the COVID vaccine administration rate in addition to an encounter fee. No payments to the Contractor or payments from the Contractor to providers shall be included in the calculation of the Minimum MLR or Underwriting Gain in Section 15.11 of this contract.

17.11 DELIVERY DATES FOR INFORMATION REQUIRED BY THE DEPARTMENT

When the last day for submission of any contractually required information or reports to the Department by the Contractor falls on a Saturday, Sunday, or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday, or legal holiday.

17.12 DRUG-FREE WORKPLACE

The Contractor shall acknowledge and certify that it understands that the following acts by the Contractor, its employees, and/or agents performing services on State property are prohibited from:

- The unlawful manufacture, distribution, dispensing, possession, or use of alcohol or other drugs and
- Any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

The Contractor shall further acknowledge and certify that it understands that a violation of these prohibitions constitutes a breach of contract and may result in default action being taken by the Commonwealth in addition to any criminal penalties that may result from such conduct.

17.13 INDEMNIFICATION

The Contractor hereby agrees to defend, hold harmless, and indemnify the Department, its officers, agents and employees from any and all claims by third parties, regardless of their nature or validity, arising out of the performance of this Contract by the Contractor or its agents, employees, or subcontractors including, but not limited to, any liability for costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this Contract or based on any libelous or other unlawful matter contained in such data.

The Contractor is not required to defend, hold harmless or indemnify the Department, its officers, agents, and employees from claims resulting from services provided by an Agency of the Commonwealth of Virginia or its officers, agents, and employees when and if the Agency is expressly serving as a subcontractor under the provisions of this Contract.

17.14 INDEPENDENT CAPACITY

The Contractor and the agents and employees of the Contractor, in the performance of this Contract, shall act as independent Contractors and shall not act or represent themselves as officers, employees or agents of the Department or of the Commonwealth.

17.15 INSURANCE

The Contractor agrees to indemnify, defend, and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using the Department or to failure of the using the Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

Before delivering services under this Contract, the Contractor shall obtain the proper insurance coverage during the term of the Contract and ensure that all insurance coverage shall be provided by insurance companies authorized by the Virginia State Corporation Commission to sell insurance in the Commonwealth of Virginia. The Contractor shall have the following insurance coverage at the time the Contract is awarded and during the Contract period and submit documentation verifying coverage to the Department prior to initial contract signature, upon revision by the Contractor, or at the Department's request:

17.15.A Professional Liability Insurance for the Contractor's Medical Director

Insurance in the amount of at least one million dollars (\$1,000,000) for each occurrence shall be maintained by the Contractor for the Medical Director.

17.15.B Workers' Compensation

The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees working in the Commonwealth of Virginia. In the event any work is subcontracted, the Contractor shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working in the Commonwealth. Any subcontract executed with a firm not having the requisite workers'

compensation coverage will be considered void by the Commonwealth of Virginia.

17.15.C Employer’s Liability

The Contractor shall maintain at least one hundred thousand dollars (\$100,000) in liability coverage.

17.15.D Commercial General Liability

The Contractor shall maintain one million dollars (\$1,000,000) in combined single-limit liability coverage. The Commonwealth of Virginia is to be named as an additional insured with respect to the services to be procured. This coverage is to include Premises/Operations Liability, Products and Completed Operations Coverage, Independent Contractor’s Liability, and Personal Injury Liability.

17.15.E Automobile Liability

The Contractor shall maintain five hundred thousand dollars (\$500,000) per occurrence in automobile liability insurance for its corporate employees who use an automobile for business purposes.

17.16 LIABILITY NOTIFICATION

The Contractor shall notify the Department immediately in writing when it or one of its subcontracts is involved in a situation where the Contractor or its subcontractor may be held liable for damages or claims against the Contractor. Such situations include automobile accidents caused by an employee of the Contractor or subcontractor where a third party is injured or dies.

17.17 MEDICAL RECORDS: ACCESS TO AND RETENTION OF RECORDS

The Contractor shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled members. The Contractor shall require compliance of all providers and subcontractors with HIPAA security and confidentiality of records standards, as detailed in Section 16.5 of this Contract. Each report must contain the valid member Medicaid identification number. If the ID number is not valid, the report will be returned to the Contractor for correction. Additionally, the Contractor shall maintain standards for medical records that are congruent with current NCQA guidelines.

17.17.A Access and Retention Requirements

The requirements shall:

a. Include written policies

Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The Contractor shall have written procedures for release of information and obtaining consent for treatment.

b. Include procedures to ensure individual medical records are available to the Department

Include procedures maintained by the Contractor or maintained by network provider(s) so that individual medical records for each member are made readily available to the Department, the contracted External Quality Review Organization (EQRO), and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- network or out-of-network providers for the medical management of the member. The Contractor shall use its best efforts to assist members

and their authorized representatives in obtaining records within ten (10) business days of the record request. The Contractor will identify an individual who can assist members and their authorized representatives in obtaining records. The Contractor shall use its best efforts, when a member changes PCPs, to assure that his or her medical records or copies of medical records are made available to the new PCP within ten (10) business days from receipt of request from the member.

c. Include procedures to ensure timely access

Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider; Contractor-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the Contractor shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all members' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The Contractor may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week notice, with the remaining list of records presented at the time of audit.

d. Provide transfer procedures to provide transition of care

Provide for adequate information and record transfer procedures to provide transition of care when members are treated by more than one provider.

17.17.B HIPAA Security and Confidentiality of Records Standards

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards, detailed in this Contract. See also Section 10.5 "HIPAA Compliance: Security and Confidentiality of Records."

a. Access to Records

The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors or network providers.

The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any medical and/or financial records of the Contractor, its subcontractors and its network providers.

b. Retention of Records

All records and reports relating to this Contract shall be retained by the Contractor for a period of ten (10) years after final payment is made under this Contract or in the event that this Contract is renewed, ten (10) years after the renewal date. When an audit, litigation or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of ten (10) years following resolution of such action. Copies on microfilm or other appropriate media of the documents

contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

The contractor and any applicable subcontractors retain, as applicable, enrollee grievance and appeal records in accordance with 42 CFR 438.416, base data in 42 CFR 438.5(c), MLR reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

17.17.C Content of Medical Records

The Contractor must ensure that each member's medical record(s) include(s) the required elements pursuant to 42 CFR §§ 456.111 and 456.211, including but not limited to: member ID, physician name, admission dates, and dates of application for and authorization of Medicaid benefits if application is made after admission, plan of care as required under 42 CFR §§ 456.80 and 456.180, initial and subsequent continued stay review dates as required by 42 CFR §§456.128 456.133,456.233, and 456.234 date of operating room (if applicable), justification of emergency admission (if applicable), reasons and plan for continued stay (if physician believes continued stay is necessary), and other supporting material as necessary and appropriate.

17.18 MISREPRESENTATION OF INFORMATION

Misrepresentation of a Contractor's status, experience, or capability in the performance of this Contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate Contract termination and/or replacement.

17.19 NON-DISCRIMINATION

The Contractor shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to individuals with disabilities pursuant to persons § 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 CFR Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act of 1990 as amended, title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1967, the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, sexual orientation, gender identity, physical condition, developmental disability, or national origin. The Contractor shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 CFR Chapter 60).

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

17.20 OMISSIONS

Professional Liability/Errors and Omission insurance in the amount of at least one million dollars (\$1,000,000) per occurrence, three million dollars (\$3,000,000) aggregate shall be maintained by the Contractor.

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

17.21 PRACTICE GUIDELINES

The Contractor shall establish practice guidelines as described in this section, in accordance with 42 CFR § 438.236(d), and that are congruent with current NCQA Standards for establishing guidelines.

17.21.A Adoption of Practice Guidelines

In accordance with 42 CFR § 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:

- a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- b. Consider the needs of the members;
- c. Are adopted in consultation with contracting health care professionals; and
- d. Are reviewed and updated periodically, as appropriate.

17.21.B Dissemination of Guidelines

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Additionally, the Contractor shall provide a copy of its practice guidelines prior to signing the initial contract, upon revision, or on request to the Department. [42 CFR § 438.236(c)]

17.21.C Application of Guidelines

Contractor decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

17.22 RIGHT TO PUBLISH

The Department agrees to allow the Contractor to write on subjects associated with the work under this Contract and have such writing published, provided the Contractor receives prior written approval from the Department before publishing such writings.

17.22.A Presentations & Publications Involving Virginia Data and Information

The Contractor shall submit for review any presentation or publication that will be given to outside parties and contains Virginia data and information at least thirty (30) days in advance. Right to Recovery in All Matters Arising Under the Virginia Fraud Against Taxpayers Act
The Contractor hereby acknowledges that it has no course of action pursuant to the Virginia Fraud Against Taxpayers Act (Va. Code §§ 8.01-216.1 through 8.01-216.19) for fraud matters pursued by the Virginia Medicaid Fraud Control Unit (MFCU) and/or Office of the Attorney

General of the Commonwealth (OAG). The Contractor is not entitled to any portion of the recoveries or penalties and the funds will be returned to the Department unless the Contractor qualifies as a person under Va. Code § 8.01-216.2 and brings an action on behalf of the Commonwealth under Va. Code § 8.01-216.5, in which case the Contractor would be entitled to an award of the proceeds from such action as set forth in § 8.01-216.7.

17.23 SEVERABILITY, ASSIGNABILITY, AND INTERPRETATION

All provisions contained in this Contract are contingent upon Federal approval unless explicitly stated otherwise. If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

Except as allowed under subcontracting, the Contract is not assignable by the Contractor, either in whole or in part, without the prior written consent of the Department.

Any article, section, or subsection headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

17.24 TERMINATION OF CONTRACT

17.24.A Pre-Termination Hearing

In accordance with 42 CFR § 438.710(b) and 438.710(b)(2)(i)-(iii), the Department:

- a. Will provide the Contractor with a pre-termination hearing before terminating the Contractor's contract;
- b. Must give the Contractor written notice of its intent to terminate and the reason for termination;
- c. Must provide the Contractor with the time and place of the pre-termination hearing;
- d. Must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract;
- e. For an affirming decision, the Department will give enrollees of the Contractor notice of the termination and information, consistent with § 438.10, on their options for receiving Medicaid services following the effective date of termination.

17.24.B Suspension of Contractor Operations

The Department may suspend a Contractor's operations, in whole or in part, if the Department determines that it is in the best interest of Medallion 4.0 members to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

17.24.C Terms of Contract Termination

This Contract may be terminated in whole or in part:

1. By the Department or the Contractor, for convenience, with one hundred and eighty (180) days advance written notice;

2. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of Medallion 4.0 services and continued performance of the Contractor's responsibilities or
3. 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:

a. Termination for Convenience

The Contractor or the Department may terminate this Contract with or without cause, upon 180 days advance written notice. In addition, the Contractor may terminate the Contract, as provided in Section 17.6 of this Contract, by opting out of the renewal clause.

b. Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are withdrawn, restricted, limited, or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. Determinations by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

c. Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

d. Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as “Termination for Default.”

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract has been terminated, in full or in part, for default. This written notice will identify all of the Contractor’s responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, and liability for medical claims.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor’s failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling Contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

17.24.D Termination Procedures

a. Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for members hospitalized at the time of termination.

b. Refunds of Advanced Payments

If the Contract is terminated under this Section, the Contractor shall be entitled to be paid a pro-rated capitation amount for the month in which notice of termination was effective to cover the services rendered to members prior to the termination. The Contractor shall not be entitled to be paid for any services performed after the effective date of the termination. The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

c. Notification of Members

In all cases of termination, the Contractor shall be responsible for notifying members about the termination and the Department shall be responsible for reassigning members to new MCOs, as appropriate. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

d. Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the Contract and about the reassigning of its members to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

e. Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

1. Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;
2. Place no further orders or subcontracts for materials, services, or facilities;
3. Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

4. Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
5. Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;
6. Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;
7. Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and,
8. Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged. The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

17.25 TRANSITION

The Contractor shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its Medicaid and FAMIS populations. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this Contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The Contractor shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively affect an orderly and efficient transition to a successor.

17.26 WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by

the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

17.27 QUALIFIED SIGNATORY

The Contractor must, in order to meet the necessary requirements to qualify as a signatory to this Contract, meet all the requirements required in Section 3 and outlined in this contract to the Department's satisfaction, including but not limited to the following subject areas: credentialing, policies and procedures for member and provider treatment, readiness reviews, enrollment verification, encounters, data security plans, insurance verification requirements, and NCQA Accreditation (or already be in progress of achieving NCQA accreditation for the Virginia Medicaid Program).

Documents Constituting the Contract

The documents that constitute this Contract are the following:

This document and

Subsequent modifications approved in writing by the Contractor and the Department.

The Contract hereby incorporates the attachments and additional documents below:

- Authorized Workforce Confidentiality Agreement;
- Summary of Medicaid and Medallion 4.0 Covered Services;
- Network Provider Agreement;
- Confidentiality Agreement;
- Format for Business Associate Agreements;
- Annual Notice of Health Care Rights;
- Health Status Survey Questionnaire;
- Managed Care Entry or Expansion Requirements;
- MCO Specific Contract Terms/Signature Pages and Disclosure of Ownership and Control Interest Statement (CMS 1513);
- The Managed Care Technical Manual;
- The Virginia Medicaid and FAMIS Performance Incentive Awards (PIA) Program Technical Specifications;
- RFP 2017-03;
- Any MCO specific terms & conditions negotiated and approved by the Department.

18. CONTRACTOR CERTIFICATIONS

18.1 GENERAL

The Contractor understands that all procurement procedures are to be conducted in a fair and impartial manner with avoidance of any impropriety or appearance of impropriety (VA Code § 2.2 – 4300).

18.2 CONTRACTOR CERTIFICATIONS

By executing this Contract the Contractor makes the following certifications:

The Contractor did not solicit or receive, whether intentionally or unintentionally, any non-public information concerning the Medallion 4.0 procurement from an employee, subcontractor, or any other source at any time prior to the execution of this Contract.

The Contractor understands that this is an ongoing certification, and if at any time the Contractor becomes aware that non-public information about the procurement was solicited or received from an employee, subcontractor, or any other source, the Contractor certifies it will inform DMAS in writing immediately.

ATTACHMENTS

ATTACHMENT I – SUMMARY OF COVERED MEDALLION 4.0 (MEDICAID) SERVICES

The Contractor shall provide benefits as defined in this Contract within at least equal amount, duration, and scope as available under the State Medicaid fee-for-service program, and as further defined in the Medicaid State Plan, 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 Mental Health Services (MHS)
- Part 2C Addiction and Recovery Treatment (ARTS)
- Part 3A EPSDT Services
- Part 3B Early Intervention 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	No, except in those cases where there would be substantial danger to life of mother	No, with exception.	The Contractor shall not cover services for elective abortion. The Contractor shall provide coverage 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. <i>The Contractor is not required to cover this service except as medically necessary in accordance with EPSDT criteria.</i>
Christian Science Nurses	12 VAC 30-50-300	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.
Christian Science Sanatoria Facilities	12 VAC 30-50-300	Yes	Yes	The Contractor shall cover this service with no limitations.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The 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	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	<i>Code of Virginia</i> Section 37.1-67.4	Yes	Yes	The 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, therefore, these services are carved out of Medallion 4.0 program. 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.
Doula Services		Yes	Yes	<p>In accordance with the 2021 Virginia Acts of Assembly, Chapter 552, the Contractor shall cover certain services covered by certified Doulas. Services shall include up to eight (8) prenatal/postpartum visits, and support during labor and delivery. The Contractor shall also implement up to two (2) linkage-to-care incentive payments for postpartum and newborn care.</p> <p>Covered Services Include:</p> <ul style="list-style-type: none"> • 99600-HD-21 Initial Prenatal Visit; Maximum six units of 15 minutes each (total max of 90 minutes). One date of service only. • 59425-HD Standard care, prenatal visit; Maximum three visits (initial prenatal (see above) and three prenatal visits). Bill in 15 minute increments for a total of 60 minutes per visit. • 59409-HD Labor support, Vaginal birth; one unit. • 59514-HD Labor Support, C-section; one unit. • 59430-HD Postpartum Care, Postpartum Visit; Maximum four visits. Bill in 15 minute increments for a total of 60 minutes per visit. • 99199-HD Incentive Mother Postpartum; one unit. • 99199-HD Incentive Newborn Postpartum; one unit. Must be billed under the newborns Medicaid ID. <p>All claims for Doula services must include diagnosis code Z32.2 (encounter for childbirth instruction)</p>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services See Part 3A of this Attachment				
Early Intervention Services See Part 3B of this Attachment				
Emergency Services	42 CFR § 438.114 12 VAC 30-50-110	Yes	Yes	The Contractor shall cover all emergency services without service authorization. The Contractor shall cover services needed to ascertain whether an

	12 VAC 30-50-300			emergency exists. The Contractor shall not restrict a member's choice of provider for emergency services.
Emergency Services - Post Stabilization Care	42 CFR § 422.100(b)(1)(iv)	Yes	Yes	The Contractor 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 Benefits	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.
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. <i>For those Members <21 years old, 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.</i>
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The 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 Enhanced Benefit as listed in the RFP).
HIV Testing and Treatment Counseling	<i>Code of Virginia</i> Section 54.1-2403.01 12 VAC 30-50-510	Yes	Yes	The Contractor shall comply with 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 is 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 CFR § 440.70 41 CFR § 441.15	Yes	Yes	The 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.
Hospice Services	12 VAC 30-141-830	Yes	No	The Contractor is not required to cover this service. This service will continue to be covered through the DMAS fee-for-service system.
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover immunizations within the most current Center for Disease Control (CDC) guidelines. The Contractor shall educate providers regarding reimbursement of immunizations and shall work with the Department to achieve its goals 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	The 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 <i>Code of Virginia</i> .
Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	The 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	The 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	The Contractor shall cover medical supplies and equipment at least to the extent covered by DMAS. The Contractor shall cover nutritional supplements and supplies for children and adults. The Contractor shall cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual. Additional information can be found in the Durable Medical Equipment & Supplies provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor shall cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
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	The Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-10-280 and 12 VAC 30-50-540 through 12 VAC 30-50-580 within at least equal amount, duration, and scope as Medicaid fee-for-service. Transplant services for kidneys, corneas, hearts, lungs, livers (from living or cadaver donors), and bone marrow/stem cell shall be covered as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. The Contractor shall cover necessary procurement/donor related services. Transplant services shall be covered for children (under 21 years of age) per EPSDT guidelines.
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	The 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 pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR § 441.50 1905(a) of Social Security Act	EPSDT	EPSDT	The 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.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor 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.
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130	Yes	Yes	The 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 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	The 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	The 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 postpartum services for sixty (60) days after pregnancy ends for the Contractor's enrolled members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan 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	The 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.
Private Duty Nursing (PDN)	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR § 441.50 1905(a) of Social Security Act	EPSDT only	EPSDT only	The Contractor shall cover medically necessary private duty nursing services for children up to age 21 when not included in the child's IEP and consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at:

				https://www.viriniamedicaid.dmas.virginia.gov/wps/portal
Prostate Specific Antigen (PSA) and Digital Rectal Exams	12 VAC 30-50-220	Yes	Yes	The 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	The 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	The 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	The Contractor shall cover reconstructive breast surgery.
Local Education Agency (LEA)-Based Services*	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover LEA-Based Services. Services that meet the Department's criteria for LEA-based services will continue to be covered as a carve-out service through the DMAS fee-for-service system. LEA-based services are referred to in DMAS regulations as "school-health services" at 12 VAC 30-50-130 and in the Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population and well-child visits for the FAMIS student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving LEA-based services. Private duty nursing and agency-directed or consumer-directed personal care services authorized outside of Special Education, and provided through EPSDT, are not considered LEA-Based 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	The Contractor is not required to cover skilled nursing facility care. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from Medallion 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.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services.
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	The Contractor shall cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy for Medicaid members.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 CFR §440.170(a)	Yes	Yes	The 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 CFR § 440.170(a).
Vision Services	12 VAC 30-50-210	Yes	Yes	The 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.

Part 2B Mental Health Services (MHS)

Part 2C Addiction and Recovery Treatment (ARTS)
Part 3A EPSDT Services
Part 3B Early Intervention Services

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICA ID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
INPATIENT MENTAL HEALTH TREATMENT SERVICES - Coverage must comply with Federal Mental Health Parity law.				
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 CFR Part 438.6	Yes	Yes	The 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 for no more than 15 days in a calendar month, consistent with the 42 CFR § 438.6, 42 CFR § 438.3(e)(2) and 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	The 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	The Contractor is not required to cover this service. For members aged 21 through 64, the Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor’s overall mental health protocols, policies, and network requirements. If a member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the MCO and reimbursed by the health plan as an in lieu of service. The MCO will notify DMAS of all member admissions to state mental hospitals.
Temporary Detention Orders (TDOs) and Emergency	<i>Code of Virginia</i> § 16.1-340 and 340.1 and §§ 37.2-808 through 810	Yes	Yes	Pursuant to 42 CFR § 441.150 and the <i>Code of Virginia</i> , § 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

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAL ID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
<p>Custody Orders (ECO) (Revenue Codes for TDOs and Service Code 0405 for ECOs)</p>				<p>and admitted to a freestanding facility or if a member of any age is admitted to a Crisis Stabilization Unit.. 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, 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 <i>Code of Virginia</i> , as follows: For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the <i>Code of Virginia</i> , 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 <i>Code of Virginia</i> , 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</p>

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICA ID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
				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 use 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	The 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	The Contractor shall cover medically necessary pharmacological management services.
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	The 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	The Contractor shall cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law.
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	The 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 – MENTAL HEALTH SERVICES (MHS)

The Contractor shall provide coverage for MHS 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). MHS 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	MEDICA ID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE										
Assertive Community Treatment (ACT)	MHS (formerly CMHRS) Manual Chapters 2, 4 & 6	Yes	Yes	<p>Assertive Community Treatment (ACT) is a highly coordinated set of services offered by group of medical, behavioral health, and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals’ needs, and oriented around individuals’ personal goals. A fundamental charge of ACT is for the team to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.</p> <p>Assessment Service Code: H0032-U9 Treatment Service Code: H0040</p> <table border="1" data-bbox="1024 1198 1923 1408"> <tr> <td>U2</td> <td>Contracted as Base Small Team</td> </tr> <tr> <td>U1</td> <td>Contracted as Base Medium Team</td> </tr> <tr> <td>none</td> <td>Contracted as Base Large Team</td> </tr> <tr> <td>U5</td> <td>Contracted as High Fidelity Small Team</td> </tr> <tr> <td>U4</td> <td>Contracted as High Fidelity Medium Team</td> </tr> </table>	U2	Contracted as Base Small Team	U1	Contracted as Base Medium Team	none	Contracted as Base Large Team	U5	Contracted as High Fidelity Small Team	U4	Contracted as High Fidelity Medium Team
U2	Contracted as Base Small Team													
U1	Contracted as Base Medium Team													
none	Contracted as Base Large Team													
U5	Contracted as High Fidelity Small Team													
U4	Contracted as High Fidelity Medium Team													

				U3	Contracted as High Fidelity Large Team
Behavioral Therapy Services	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 Behavioral Therapy Supplement to MHS (formerly CMHRS) Manual	Yes	See green highlight above.		The Contractor shall provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130, and the DMAS EPSDT Behavioral Therapy Provider Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal . Multisystemic Therapy (ABA) (Service Code H2033) Multisystemic Therapy (ABA) SSPI (Service Code H0032-UA)
Crisis Intervention Services	12 VAC 30-50-226 12VAC 30-60-143 12 VAC 30-50-130 12VAC30-60-5 (MHS ((formerly CMHRS) Manual	Yes	See green highlight above.		The 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 12VAC 30-50-130 12VAC 30-60-5 MHS (formerly CMHRS) Manual	Yes	See green highlight above.		The 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.

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Intensive In-Home Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-60-5 MHS (formerly CMHRS) Manual	Yes	See green highlight above.	The Contractor shall cover medically necessary Intensive In-Home Assessment and Treatment services. Comprehensive Needs Assessment Service Code H0031 Treatment Service Code H2012
Mental Health – Intensive Outpatient Program	MHS (formerly CMHRS) Manual Chapters 2, 4 & 6	Yes	Yes	<p>Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6-17 years) and adults (18 years +). MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care.</p> <p>MH-IOP services are appropriate when an individual requires at least six hours of clinical services a week (for youth ages 6-17), or nine hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. A MH-IOP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-IOP tapers in intensity as an individual’s symptoms improve as evidenced by their ability to establish community supports, resume daily activities or participate in a lower level of care.</p> <p>Assessment Service Code: H0032-U7 (pending approval) Treatment Service Code: S9480/ S9480 GO (Occupational Therapy)</p>

Mental Health – Partial Hospitalization Program	MHS (formerly CMHRS) Manual Chapters 2, 4 & 6	Yes	Yes	<p>Mental Health Partial Hospitalization Programs (MH-PHPs) are highly structured clinical programs designed to provide an intensive combination of interventions and services which are similar to an inpatient program, but available on a less than 24-hour basis. MH-PHP are active, focused and time-limited treatment programs intended to stabilize acute symptoms in youth (6-17 years old) and adults (18 years +). The average length of stay may be four to six weeks, though length of stay should reflect individual symptom severity, needs, goals and medical necessity criteria. MH-PHP can serve as a transition program, such as a step-down option following an inpatient hospitalization. MH-PHP can serve as a diversion for an individual from inpatient care, by providing an alternative that allows for intensive clinical services without hospital admission. The target population consists of individuals that would likely require inpatient hospitalization in the absence of receiving this service. MH-PHPs may be occur in either a hospital- or community-based location.</p> <p>MH-PHP services are appropriate when an individual requires at least four hours of clinical services a day, over several days a week and totaling a minimum of 20 hours per week. A MH-PHP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule. MH-PHP tapers in intensity and frequency as an individual’s symptoms improve, they are able to establish/reestablish community supports, and they are able to resume daily activities or are appropriate to participate in a lower level of care.</p> <p>Assessment Service Code: H0032-U7 Treatment Service Code: H0035 / H0035 Rev Code: 0912/0913</p>
Mental Health Case Management	12 VAC 30-50-420 12 VAC 30-50-430 12 VAC 30-60-143 12 VAC 30-60-5 MHS (formerly CMHRS) Manual	Yes	See green highlight above.	The Contractor shall cover medically necessary Mental Health Case Management services. Service Code H0023

Mental Health Skill-building Assessment and Treatment Services	12 VAC 30-50-226 ER 12 VAC 30-60-143 12 VAC 30-60-5 MHS (formerly CMHRS) Manual	Yes	See green highlight above.	The Contractor shall cover medically necessary Mental Health Skill-building Assessment and Treatment Services. Comprehensive Needs Assessment Service Code H0032-U8 Treatment Service Code: H0046
Psychosocial Rehabilitation Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-05 12 VAC 30-60-143 MHS (formerly CMHRS) Manual	Yes	See green highlight above.	The 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 medications. These services are limited to 936 units annually. Comprehensive Needs Assessment Service Code H0032-U6 Treatment Service Code H2017
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-50-226 12 VAC 30-60-5 MHS (formerly CMHRS) Manual	Yes	See green highlight above.	The Contractor shall cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. Comprehensive Needs Assessment Service Code H0032 Service Code H2016 Modifiers: School Based TDT must be billed as H2016 (none) After School TDT must be billed as H2016 UG Summer TDT must be billed as H2016 U7
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 above.	The Contractor shall cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years. To be carved in 4/1/2020 Service Code T1016

	Psychiatric Services Manual			
Peer Support Services	12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160	Yes	See green highlight above.	The Contractor shall cover medically necessary Peer Support Services for children and adults. Service Code H0024 (individual) H0025 (Group)

SUMMARY OF COVERED SERVICES - PART 2 C - 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	The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual.
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7	Yes	Yes	<ul style="list-style-type: none"> The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. Service Codes H2036/Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent Non-covered for FAMIS. MCOs may elect to cover in Inpatient Psychiatric Unit or Free Standing Psychiatric Facility.
Clinically Managed High Intensity Residential Services	ASAM Level 3.5	Yes	Yes	<ul style="list-style-type: none"> The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. Non-covered for FAMIS MCOs may elect to cover in Inpatient Psychiatric Unit or Free Standing Psychiatric Facility. Service Codes H0010 /Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3	Yes	Yes	<ul style="list-style-type: none"> The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. Non-covered for FAMIS Service Codes H0010/Rev 1002 and Modifier TG
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1	Yes	Yes	<ul style="list-style-type: none"> The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. Service Code H2034
OUTPATIENT WITHDRAWAL MANAGEMENT				
ARTS Partial Hospitalization	ASAM Level 2.5	Yes	Yes	<ul style="list-style-type: none"> The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. Service Codes S0201

SUMMARY OF COVERED SERVICES - PART 2 C - 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
				<ul style="list-style-type: none"> • Rev 0913 and S0201
ARTS Intensive Outpatient	ASAM Level 2.1	Yes	Yes	<ul style="list-style-type: none"> • The Contractor shall cover SUD services within ASAM criteria set forth in 12VAC30-130-5000 et al. and the ARTS Provider Manual. • Service Codes H0015 • Rev 0906 and H0015

MEDICATION ASSISTED TREATMENT (MAT)

Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	<table border="0"> <tr> <td>Counseling</td> <td>H0004 – individual and family counseling H0005 - group counseling</td> </tr> <tr> <td>Medication Administration</td> <td>H0020</td> </tr> <tr> <td>Medication Care Coordination</td> <td>S0109 Methadone 5 mg oral billed by provider G9012 Substance Abuse Care Coordination</td> </tr> <tr> <td>Physician Visit - Induction</td> <td>H0014</td> </tr> <tr> <td>Urine Drug Screen Labs</td> <td>80305 to 80307 and G0480-G0483 CPT codes</td> </tr> <tr> <td>Physician Visit – Maintenance</td> <td>Use CPT E&M Established patient</td> </tr> </table>	Counseling	H0004 – individual and family counseling H0005 - group counseling	Medication Administration	H0020	Medication Care Coordination	S0109 Methadone 5 mg oral billed by provider G9012 Substance Abuse Care Coordination	Physician Visit - Induction	H0014	Urine Drug Screen Labs	80305 to 80307 and G0480-G0483 CPT codes	Physician Visit – Maintenance	Use CPT E&M Established patient
Counseling	H0004 – individual and family counseling H0005 - group counseling															
Medication Administration	H0020															
Medication Care Coordination	S0109 Methadone 5 mg oral billed by provider G9012 Substance Abuse Care Coordination															
Physician Visit - Induction	H0014															
Urine Drug Screen Labs	80305 to 80307 and G0480-G0483 CPT codes															
Physician Visit – Maintenance	Use CPT E&M Established patient															
Buprenorphine/Naloxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	Opioid Treatment Programs	Yes	Yes	<table border="0"> <tr> <td>Counseling</td> <td>H0004 – individual and family counseling H0005 - group counseling</td> </tr> <tr> <td>Medication Administration</td> <td>H0020</td> </tr> <tr> <td>Medication</td> <td>J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider</td> </tr> <tr> <td>Care Coordination</td> <td>G9012 Substance Abuse Care Coordination</td> </tr> </table>	Counseling	H0004 – individual and family counseling H0005 - group counseling	Medication Administration	H0020	Medication	J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider	Care Coordination	G9012 Substance Abuse Care Coordination				
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Care Coordination	G9012 Substance Abuse Care Coordination															

SUMMARY OF COVERED SERVICES - PART 2 C - 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
				Physician Visit - Induction H0014 Urine Drug Screen Labs 80305 to 80307 and G0480-G0483 CPT codes Physician Visit – Maintenance Use CPT E&M Established patient
Buprenorphine/Naloxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	Preferred ASAM Office Based Opioid Treatment	Yes	Yes	Counseling H0004 – individual and family counseling H0005 - group counseling Care Coordination G9012 Substance Abuse Care Coordination Physician Visit - Induction H0014 Urine Drug Screen Labs 80305 to 80307 and G0480-G0483 CPT codes Physician Visit – Maintenance Use CPT E&M Established patient
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Abuse Case Management	12 VAC 30-60-185 12 VAC 30-50-431	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. (H0006)
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria (CPT codes)
Peer Recovery Supports	12VAC30-50-130	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria Peer Support Services T1012 and S9445
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-50-180	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria 99408 and 99409

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act	Yes	Yes	The 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	The 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	The 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

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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
				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 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

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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
				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.
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>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:</p> <ul style="list-style-type: none"> • 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.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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
Lead Investigations*	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels (see 8.2 OO).
Personal Care	42 CFR § 441.50 1905(a) of Social Security Act	Yes	Yes	The Contractor shall provide personal care services through the EPSDT benefit for children under the age of 21. Personal care services shall be provided by personal care aides, within the scope of their licenses and/or certificates, as appropriate, under the agency-directed model or by consumer-directed attendants under the CD model of service delivery.
Private Duty Nursing	42 CFR §§ 441.50, 440.80, Social Security Act §1905(a) and 1905(r) I.	Yes	Yes	<p>The Contractor shall cover medically necessary PDN services for children under age twenty-one (21), in accordance with the Department’s criteria described in the DMAS EPSDT Nursing Supplement, and as required in accordance with EPSDT regulations described in 42 CFR §§ 441.50, 440.80, and the Social Security Act §§ 1905(a) and 1905(r) I. The contractor is not required to cover PDN services in the school setting, when included in the Child’s IEP (See Section 8.5.A regarding carved-out services). Medically necessary PDN services, which are not included in the IEP but are requested to be rendered in the school setting will be paid for by the Contractor, in accordance with the Department’s established criteria and guidelines for EPSDT PDN.</p> <p>Members who may qualify for PDN include members who require continuous nursing that cannot be met through home health. Under EPSDT PDN, the member’s condition warrants continuous nursing care including, but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT PDN differs from home health nursing which provides for short-term intermittent care where the emphasis is on member or caregiver teaching. The Contractor shall use the Department’s criteria, as described in the DMAS EPSDT Manual, and as required in accordance with EPSDT regulations described in 42 CFR §§ 441.50, 440.80, and the Social</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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
				Security Act §§1905(a) and 1905(r) 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. 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	The Contractor shall cover medically necessary tobacco cessation services, including 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

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSIS 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
				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 CFR§ 303.12 Code of Virginia § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	<p>The 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.</p> <p>Medical necessity for Early Intervention services shall be defined by the member’s IFSP, including in terms of amount, duration, and scope. Service authorization shall not be required.</p> <p>The Contractor also shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate. No copays shall be applied for FAMIS enrollees.</p>
Early Intervention Targeted Case Management/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	<p>The 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.</p>

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 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	The 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.
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	The 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	The 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	The Contractor shall provide coverage for Early Intervention center-based individual and group (congregate) services.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAL COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
Early Intervention Physical Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The 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	The 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	The 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	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The 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 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
Annual Adult Wellness Exams	CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg-13	No	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: <ul style="list-style-type: none"> • 99385 (New patient, 18-39 years); 1 per calendar year • 99386 (New patient, 40-64 years); 1 per calendar year • 99395 (Established patient, 18-39 years); 1 per calendar year • 99396 (Established patient, 40-64 years); 1 per calendar year *CPT Codes subject to change

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
Smoking Cessation Counseling, Individual and Group	https://www.medicaid.gov/federal-policy-guidance/download/s/cib-01-28-16.pdf 42 U.S.C. § 300gg–13	Limited	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: 99406 (Individual counseling visit, 3-10 minutes); 6 units per calendar year; no preauthorization 99707 (Individual counseling visit, >10 minutes); 6 units per calendar year; no preauthorization S9446 (Group patient education, not otherwise classified, non-physician provider); 6 units per calendar year; no preauthorization *CPT Codes subject to change
Nutritional Counseling for Individuals with Obesity or Chronic Disease	CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/download/s/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations	Limited	Yes	Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations CPT Codes and Limitations*: <ul style="list-style-type: none"> • 97802 (Medical Nutrition Therapy, Initial Assessment and Intervention, Indiv., Face to Face with the patient, each 15 minutes); 12 units per calendar year; no prior authorization • 97803 (Medical Nutrition Therapy Reassessment and Intervention, Indiv., Face to Face with the patient, each 15 minutes); 12 units per calendar year; no preauthorization • 97804 (Medical Nutrition Therapy, Group, 2 or more individual(s), each 30 minutes); 4 units per calendar year; no preauthorization

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
	42 U.S.C. § 300gg-13			<ul style="list-style-type: none"> • G0270 (Medical Nutrition Therapy; Reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes); 8 units per calendar year; no prior authorization • G0271 (Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes); 4 units per calendar year; no prior authorization • S9470 (Nutritional Counseling, Dietician visit); 8 units per calendar year; no preauthorization <p>*CPT Codes subject to change</p>
ACIP recommended adult vaccines	12 VAC 30-50-130 CMS Bulletin 1/28/17 https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force	Yes	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ul style="list-style-type: none"> • 90714 (Td) • 90715 (Tdap) • 90736 (Singles zoster, > age 60) • 90750 (> age 50) • 90620 (Meningococcal, IM, 2 dose)

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

SERVICE	STATE PLAN REFERENCE OR OTHER RELEVANT REFERENCE	MEDICAID COVERED	MEDALLION 4.0 COVERED	CONTRACTOR RESPONSIBILITIES, SCOPE OF COVERAGE
	https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations 42 U.S.C. § 300gg-13			<ul style="list-style-type: none"> • 90621 (Meningococcal, IM, 2-3 dose) • 90733 (Meningococcal, SQ) • 90734 (Meningococcal, IM) • 90707 (MMR) • 90649 (HPV, quadrivalent, 3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90650 (Bivalent, 3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90651 (Nonavalent, 2-3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90716 (Chickenpox) • 90632 (Hepatitis A) • 90739 (Hepatitis B, Adult, 2 dose) • 90746 (Hepatitis B, Adult, 3 dose) • 90647 (Hemophilus influenza, 3 dose) • 90648 (Hemophilus influenza, 4 dose) <p>*CPT Codes subject to change</p>

ATTACHMENT II – AUTHORIZED WORKFORCE CONFIDENTIALITY AGREEMENT

This Agreement between _____ [Business Associate name] and _____ (please print), an employee of _____ hereby acknowledges that [the Entity’s] records and documents are subject to strict confidentiality requirements imposed by state and federal law including 42 CFR § 431 Subpart F, *Code of Virginia* §2.2-3800, *et. seq.*, and 12 VAC 30-20-90, *et. seq.*

I (initial) _____ acknowledge that my supervisor, or whoever administers the data, has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality.

I (initial) _____ acknowledge that my supervisor or, whoever administers the data, has reviewed with me the confidentiality and security policies of our organization.

I (initial) _____ acknowledge that unauthorized use, dissemination or distribution of Virginia Department of Medical Assistance Services (DMAS) confidential information is a crime.

I (initial) _____ hereby agree that I will not use, disseminate or otherwise distribute confidential records or said documents or information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I (initial) _____ also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with [the entity] and may subject me to penalties both civil and criminal.

Signed _____ Date _____

ATTACHMENT III – NETWORK PROVIDER AGREEMENT REQUIREMENTS

RIGHT OF DEPARTMENT TO APPROVE, MODIFY OR DISAPPROVE NETWORK PROVIDER AGREEMENTS

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

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

1. (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid contract) with the Department of Medical Assistance Services. Provider compliance with the Medicaid Contract specifically includes but is not limited to the following requirements.
2. No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract.

At a minimum, MCO Contracts with Providers must include the following:

1. Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the Medicaid contract.
2. Provider agrees to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any

required hospital/emergency department Memorandums of Understanding signed by the Contractor in accordance with the Medicaid Contract.

3. The Provider agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet the Department specifications required by Medicaid Contract.
4. Any conflict in the interpretation of the Contractor's policies and MCO-Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals.
5. The Provider agrees to comply with all non-discrimination requirements in Medicaid Contract.
6. The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in Medicaid Contract.
7. The Provider agrees to provide representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit access to its premises and its Contract and/or medical records in accordance with Medicaid Contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with Medicaid Contract.
8. Provider agrees to disclose the required information, at the time of application, credentialing, and/or re-credentialing, and/or upon request, in accordance with 42 CFR§ 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
9. The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid Contract. Provider agrees to make medical records available to members and their authorized representatives within ten (10) business days of the record request.
10. The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.
11. The Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
12. The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally the Provider agrees to hold the member harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.
13. The Provider agrees not to bill a Medicaid member for medically necessary services covered under the Medicaid contract and provided during the member's period of Contractor enrollment. This provision shall continue to be in effect even if the

Contractor becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then the Contractor, Contractor provider, or Contractor subcontractor can bill.

14. The Provider must forward to the Contractor medical records, within ten (10) business days of the Contractor's request.
15. The Providers shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the members are withdrawn from assignment to the provider.
16. Except in the case of death or illness, the Provider agrees to notify the Contractor at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel members for up to thirty (30) day after such notification, until another PCP is chosen or assigned.
17. The Provider agrees to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in Section 4.6.F of this Contract, to be stated in the network provider agreement.
18. The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered member unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider.
19. The Contractor shall follow prior authorization procedures pursuant to the Code of Virginia § 38.2-3407.15:2 and incorporate the requirements into its provider contracts. The Contractor must accept telephonic, facsimile, or electronic submissions of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests.
20. The Contractor shall disclose that under 42 CFR § 434.6(a)12(i) the Contractor is prohibited from making a payment to the Provider for provider-preventable conditions outlined in 42 CFR § 447.26(b) and require that the Provider report to the Contractor all provider-preventable conditions or health care-acquired conditions associated with claims.

Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

NETWORK PROVIDER AGREEMENT SUPPLEMENT

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Network Provider Agreement. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Network Provider Agreement. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Network Provider Agreement.

If the Contractor uses the Provider Manual as a supplement to the Network Provider Agreement, all sections pertaining to Medicaid must be submitted to the Department for approval prior to signing original contract, upon revision (changes only or with changes highlighted), upon request, and as needed.

REVIEW AND APPROVAL OF NEW NETWORK PROVIDER AGREEMENTS AND IN APPROVED SUBCONTRACTS DURING THE CONTRACT PERIOD

New agreements and changes in approved agreements shall be reviewed and approved by the Department before taking effect. Agreements will be considered approved if the Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.

This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved. Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department. The Contractor shall submit its current provider network to the Department monthly.

Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in the Contract.

ATTACHMENT IV – CONFIDENTIALITY AGREEMENT FORM

This Agreement between the Virginia Department of Medical Assistance Services (DMAS) and _____ (Contractor) sets forth the terms and conditions for the disclosure of information concerning Medicare/Medicaid applicants, members or providers (Data). For purposes of this Agreement, the Contractor includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual agreement with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession.

The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 CFR § 431.302. The Contractor's Security Plan shall be eventually incorporated as an Attachment to this Agreement. No other uses of DMAS Data outside of the purposes stated in Attachment V will be allowed. The Contractor agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The Contractor agrees that there will be no commercial use of the DMAS data which it receives or creates in fulfillment of its contractual obligations.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 CFR 431, Subpart F, and the *Code of Virginia*, § 2.2-3800, *et. seq.* (the Government and Data Collection and Dissemination Practices Act) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Access to information concerning applicants or members must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The Contractor attests that the data will be safeguarded according to the provisions of the written, DMAS approved, Security Plan meeting the general requirements outlined in Attachment V. In no event shall the Contractor provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 CFR 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. Contractor certifies that all Data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The Contractor will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services,

which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services.”

The Contractor acknowledges that the Department reserves the right to audit for compliance with the terms of this agreement and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan. The Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known by the Contractor or an employee, officer, or agent of the Contractor other than the person committing the breach, or as soon as possible following the first day on which the contractor or an employee, officer or agent of the Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes individuals should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches.

In the event of impermissible use or disclosure by the Contractor of unsecured protected health information, the Contractor shall notify in writing all affected individuals as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Contractor shall be responsible for all costs associated with such notification.

The Contractor hereby agrees to comply with all of the requirements set forth herein.

ATTACHMENT V – BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT (BAA) to Contract # _____

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

General Conditions

This BAA (“Agreement” or “BAA”) is made as of (mm/dd/yyyy) by the Department of Medical Assistance Services (“Covered Entity”), with offices at 600 East Broad Street, Richmond, Virginia, 23219, and _____, (“Business Associate”), with an office at _____ . This is a non-exclusive agreement between the Covered Entity, which administers Medical Assistance, and the Business Associate named above.

The Covered Entity and Business Associate, as defined in 45 CFR 160.103, have entered into this Business Associate Agreement to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the current and future Privacy and Security requirements for such an Agreement, the Health Information Technology for Economic and Clinical Health (HITECH) Act, (P.L. 111-5) Section 13402, requirements for business associates regarding breach notification, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements.

DMAS and Business Associate (“parties”) shall fully comply with all current and future provisions of the Privacy and Security Rules and regulations implementing HIPAA and HITECH, as well as Medicaid requirements regarding Safeguarding Information on Applicants and Recipients of 42 CFR 431, Subpart F, and Virginia Code § 32.1-325.3. The parties desire to facilitate the provision of or transfer of electronic PHI in agreed formats and to assure that such transactions comply with relevant laws and regulations. The parties intending to be legally bound agree as follows:

- I. Definitions. As used in this agreement, the terms below will have the following meanings:
- a. Business Associate has the meaning given such term as defined in 45 CFR 160.103.
 - b. Covered Entity has the meaning given such term as defined in 45 CFR 160.103.
 - c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.
 - d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain recipient (*member*), provider, and claims data for administration of the Medicaid program.
 - e. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 CFR 160.103.
 - f. Breach has the meaning as that term is defined at 45 CFR 164.402.
 - g. Required by law shall have the meaning as that term is defined at 45 CFR 160.103.
 - h. Unsecured Protected Health Information has the meaning as that term is defined at 45 CFR 164.402.
 - i. Transport Layer Security (TLS): A protocol (standard) that ensures privacy between communicating applications and their users on the Internet. When a server and client communicate, TLS ensures that no third party may eavesdrop or tamper with any message. TLS is the successor to the Secure Sockets Layer (SSL).

Terms used, but not otherwise defined, in this Agreement shall have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

II. Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate shall be sent via email or general mail to the DMAS Privacy Officer (with a copy to the DMAS contract administrator in II.2) at:
DMAS Privacy Officer, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
hipaaprivacy@dmass.virginia.gov
2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:
Contact: _____

Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

III. Special Provisions to General Conditions

1. Uses and Disclosure of PHI by Business Associate. The Business Associate
 - a. May use or disclose PHI received from the Covered Entity, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business.
 - b. Shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law.
 - c. Shall have a signed confidentiality agreement with all individuals of its workforce who have access to PHI.
 - d. Shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, and who have signed a confidentiality agreement.
 - e. Shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agree in writing to all the same restrictions, terms, special provisions and general conditions in this BAA that apply to Business Associate. In addition, Business Associate shall ensure that any such subcontractor or agent agrees to implement reasonable and appropriate safeguards to protect Covered Entity's PHI. In instances where one DMAS Business Associate is required to access DMAS PHI from another DMAS Business Associate, the first DMAS Business Associate shall enter into a business associate agreement with the second DMAS Business Associate.
 - f. Shall provide Covered Entity access to its facilities used for the maintenance and processing of PHI, for inspection of its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI, for purpose of determining Business Associate's compliance with this BAA.
 - g. Shall make its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of Department of Health and Human Services (DHHS) or its designee and provide Covered Entity with copies of any information it has made available to DHHS under this section of this BAA.
 - h. Shall not directly or indirectly receive remuneration in exchange for the provision of any of Covered Entity's PHI, except with the Covered Entity's consent and in accordance with 45 CFR 164.502.
 - i. Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use, disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.
 - j. Shall comply with 45 CFR 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall

- a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the HITECH Act.
- b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.
- c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.
- d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 CFR 164.312(e).
- e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall

- a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
 - i. the date made,
 - ii. the name of the person or organization receiving the PHI,
 - iii. the recipient's (member) address, if known,
 - iv. a description of the PHI disclosed, and the reason for the disclosure.
- b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. Sanctions - Business Associate shall

- a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
- b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:

- a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer

- i. On the first day on which such breach is known or reasonably should be known by Business Associate or an employee, officer or agent of Business Associate other than the person committing the breach, and
 - ii. Written notification to DMAS Privacy Officer shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Business Associate shall confer with DMAS prior to providing any notifications to the public or to the Secretary of HHS.
- b. Breach Notification requirements.
 - i. In addition to requirements in 5.a above, in the event of a breach or other impermissible use or disclosure by Business Associate of PHI or unsecured PHI, the Business Associate shall be required to notify in writing all affected individuals to include,
 - a) a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
 - b) a description of the types of unsecured PHI that were involved in the breach;
 - c) any steps the individuals should take to protect themselves from potential harm resulting from the breach;
 - d) a brief description of what Business Associate is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches, and, if necessary,
 - e) Establishing and staffing a toll-free telephone line to respond to questions.
 - ii. Business Associate shall be responsible for all costs associated with breach notifications requirements in 5b, above.
 - iii. Written notices to all individuals and entities shall comply with 45 CFR 164.404(c)(2), 164.404(d)(1), 164.406, 164.408 and 164.412.

6. Amendment and Access to PHI - Business Associate shall

- a. Make an individual's PHI available to Covered Entity within ten (10) days of an individual's request for such information as notified by Covered Entity.
- b. Make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within ten (10) days of notification by Covered Entity per 45 CFR 164.526.
- c. Provide access to PHI contained in a designated record set to the Covered Entity, in the time and manner designated by the Covered Entity, or at the request of the Covered Entity, to an individual in order to meet the requirements of 45 CFR 164.524.

7. Termination

- a. Covered Entity may immediately terminate this agreement if Covered Entity determines that Business Associate has violated a material term of the Agreement.
- b. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination.
- c. Within thirty (30) days of expiration or earlier termination of this agreement, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI.
- d. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate by the Covered Entity. If such return or destruction is infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this agreement shall survive with respect to such PHI.

8. Amendment

- a. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement in such manner as Covered Entity determines necessary to comply with such law or regulation.
- b. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.

9. Indemnification. Business Associate shall indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

- a. The names and contact information for at least one primary contact individual from each party to this Agreement.
- b. A complete list of all individuals, whether employees or direct contractors of Business Associate, who shall be authorized to access Covered Entity's PHI

- c. A list of the specific data elements required by Business Associate in order to carry out the purposes of this Agreement.
- d. The purposes for which such data is required.
- e. A description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Business Associate agrees to update the above noted information as needed in order to keep the information current. Covered Entity may request to review the above-referenced information at any time, including for audit purposes, during the term of this Agreement.

11. Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN BUSINESS ASSOCIATE'S POSSESSION OR CONTROL, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL COVERED ENTITY BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATED TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM COVERED ENTITY OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

ATTACHMENT V (CONTINUED) – BUSINESS ASSOCIATE AGREEMENT, ATTACHMENT A

ATTACHMENT A
(To be completed by Business Associate)

DMAS/Contractor or Agency Name _____
Master BAA Contract # _____

Reference Section III Special Provisions to General Conditions

This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

- a. The names and contact information for at least one primary contact individual from each party to this Agreement.

DMAS Contact: _____
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
Contract Administrator Phone # _____
Contract Administrator Email _____

Contractor/Agency Contact:
Name: _____
Address: _____
Phone Number: _____
Email Address: _____

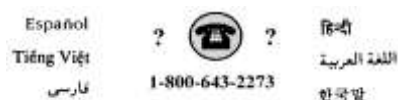
- b. Complete list of all individuals, whether employees or direct contactors, of Business Associate who shall be authorized to access Covered Entity's PHI.

- c. List of the specific data elements required by Business Associate in order to carry out the purpose of this Agreement.

- d. Purposes for which such data is required.

- e. Description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

ATTACHMENT VI – ANNUAL NOTICE OF HEALTH CARE RIGHTS (English Translation)



You have the RIGHT to ask your Managed Care Organization (MCO):

- What medical services your MCO offers.
- How to get covered services that your MCO does not offer.
- How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
- How to get approval from your MCO to see doctors who are not in your MCO.
- What to do if you have a medical emergency or need medical advice after office hours.
- How to make an official complaint about your MCO or appeal a medical decision by your MCO directly to the Department of Medical Assistance Services (DMAS).
- How to get information about your MCO’s doctors, other providers, translation services or transportation.

You have the RIGHT to:

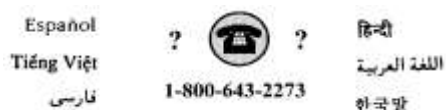
- Have access to health care services
- Receive information about your health care and see your medical records
- Be involved in decisions about your health care
- Receive information about treatment options or other types of care
- Be treated with respect, consideration and dignity
- Expect all information about your health to be confidential
- Tell DMAS about any problems you are having with your MCO
- Change your MCO once a year for any reason during open enrollment
- Change your MCO after open enrollment for an approved reason
- Make an official complaint with your MCO or appeal directly to DMAS

You also MUST:

- Present your MCO Membership Card whenever you seek medical care
- Provide complete and accurate information on your health and medical history
- Follow your MCO’s rules for getting services and follow your doctor’s instructions
- Schedule appointments, be on time, and notify your doctor if you are late or must cancel

- Call the Department of Social Services (DSS) to report any changes such as address, phone number and other personal information (birth, marriage, death, other health insurance, or income changes)
- A monthly premium is paid by the Virginia Medicaid program to your MCO for your coverage. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your worker, you may have to repay these monthly premiums, even if you received no medical services during those months.
- If you have any questions on managed care or your health care rights, call your MANAGED CARE HELPLINE at 1-800-643-2273

ATTACHMENT VI (CONTINUED) – ANNUAL NOTICE OF HEALTH CARE RIGHTS (BACK- SPANISH TRANSLATION)



ANUAL DE DERECHOS DE ATENCIÓN MÉDICA

Usted tiene el DERECHO de preguntar a su Organización de Cuidados Administrados (MCO – Managed Care Organization):

What medial services your MCO offers. Qué servicios médicos ofrece su MCO.

How to get covered services that you MCO does not offer. Cómo obtener servicios cubiertos que su MCO no ofrezca. How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).

Cómo obtener un referimiento para atención especializada y otros servicios no provistos por su proveedor de cuidados primarios (PCP).

Cómo obtener la aprobación de su MCO para que lo(a) atiendan médicos que no pertenezcan a su MCO.

Qué hacer cuando tenga una emergencia médica o necesite consejo médico fuera de horario de atención.

Cómo presentar una queja oficial de su MCO o apelar a una decisión médica realizada por su MCO directamente al Departamento de Servicios de Asistencia Médica (DMAS – Department of Medical Assistance Services).

Cómo obtener información sobre los médicos, otros proveedores, servicios de traducción o transporte de su MCO.

Usted tiene el DERECHO de:

Have access to health care services Obtener acceso a servicios de cuidado de la salud

Recibir información sobre su atención médica y ver sus registros médicos

Participar en las decisiones sobre su atención médica

Recibir información sobre opciones de tratamiento u otros tipos de cuidado

Ser tratado(a) con respeto, consideración y dignidad Expect all information about your health to be confidential

Esperar que toda la información relacionada con su salud sea confidencial

Informar al DMAS sobre cualquier problema que pudiera tener con su MCO Change your MCO once a year for any reason during open enrollment

Cambiar de MCO una vez al año, por cualquier motivo, durante la inscripción abierta

Cambiar de MCO después de la inscripción abierta por un motivo aprobado

Presentar una queja oficial a su MCO o apelar directamente al DMAS

Usted también DEBE:

Present your MCO Membership Card whenever you seek medical care Presentar su Tarjeta de Miembro del MCO siempre que reciba atención médica

Proveer informaciones completas y precisas sobre su historia de salud y médica Follow your MCO's rules for getting services and follow your doctor's instructions

Respetar las reglas del MCO para la obtención de servicios y seguir las instrucciones de su médico

Marcar citas, llegar en horario y notificar a su médico si se atrasará o necesita cancelar la cita

Llamar al Departamento de Servicios Sociales (DSS – Department of Social Services) para informar sobre cualquier cambio, tal como de dirección, número de teléfono y otras informaciones personales (nacimiento, casamiento, fallecimiento, otro seguro de salud o cambios en sus ingresos)

Virginia Department of Medical Assistance Services paga una cuota mensual (prima) por su cobertura médica a su MCO. Si usted no reunió los requisitos por los meses anteriores de su cobertura, debido a que usted no envió la información correcta o cambios en su situación a su empleador (patrón), usted puede tener que reembolsar (pagar) las cuotas mensuales, si usted recibió servicios médicos durante esos meses.

Si tiene dudas sobre cuidados administrados o sobre sus derechos de atención médica, llame a nuestra LÍNEA DE AYUDA DE CUIDADOS ADMINISTRADOS al 1-800-643-2273

ATTACHMENT VII – HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private— only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head		Case Head SSN		Case Head Language:	
Last Name		First Name		Medicaid ID#	
Address		City	State/Zip	Ph#	
1	Gender			<input type="checkbox"/> Male <input type="checkbox"/> Female	
2	Date of Birth				
3	What MCO are you choosing?		Name:		
4	Do you have a doctor you want to be your Primary Care Provider?		Name:		
5	If you have a regular doctor now, what is the doctor's name?			Names:	
6	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? (If yes) What are the names?			<input type="checkbox"/> Yes <input type="checkbox"/> No List:	
7	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]			<input type="checkbox"/> Yes <input type="checkbox"/> No List:	
8	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine— anything like that? If yes, did a doctor prescribe it?			<input type="checkbox"/> Yes <input type="checkbox"/> No What: <input type="checkbox"/> Yes <input type="checkbox"/> No	
9	Are you pregnant? [If yes], When is the baby due? Does the doctor have any special concerns about this pregnancy?			<input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.					
10	Do you have surgery planned for the future?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

	If yes, what is the date of surgery?	Date:
11	Are you getting home care or home hospice care? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:
12	Are you on an organ transplant list? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:
15	Are you getting physical therapy, or occupational therapy, or speech therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16	Do you have a heart condition--such as congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Do you have a lung disorder--such as asthma or COPD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18	Are you being treated by a psychiatrist or psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19	Do you have diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20	High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Do you have kidney disease or are you on dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22	Do you have cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24	Are you living with HIV or AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26	Do you have tuberculosis (TB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
27	Are any children in the house in Part C services, care coordination for children Any health department program, or Do any children receive Case Manager or Care Coordination services?	<input type="checkbox"/> Yes <input type="checkbox"/> No List program and/or care coordinator:
28	Can you think of any other special medical or mental health needs that the MCO might want to know about?	<input type="checkbox"/> Yes <input type="checkbox"/> No List:
29	Have you been in the hospital in the last 12	<input type="checkbox"/> Yes <input type="checkbox"/> No

	months? [If yes] Why were you admitted?	Reason:
30	What is your height?	Feet_____ inches_____
31	And your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

ATTACHMENT VIII – MANAGED CARE ENTRY OF EXPANSION REQUIREMENTS

The following are Departmental requirements outside the managed care contracts that must be satisfied by the managed care organization (MCO) prior to any expansion or entry into the market being approved.

The MCO must submit a letter of intent at least 6 months in advance of the requested entry/expansion date, from the MCO to the Department requesting to expand/enter the market. The letter must include the regions where the entry/expansion is proposed, a proposed effective date, copies of BOI and VDH approval (if already obtained), a network development plan and a marketing plan. The Department shall direct its focus on MCO network development to assure access is better than what is currently available in the area the MCO seeks to expand into. The letter of intent should specify how the MCO will benefit the members of the Commonwealth and provide additional access. The letter of intent must also make clear the MCO understands that should the Department approve the expansion request, the member lives in the area will not be re-distributed. Requests to expand failing to demonstrate these requirements will not be considered.

Upon approval by the Department of the expansion /entry request, the MCO must provide the following within 30 days of the Department's approval of request to introduce one or more managed care plans into a new area:

- A plan of action to secure advocate and community support in the planned entry/expansion area.
- A project plan for the entry/expansion including completion of network development, information technology requirements, and communication deadlines.
- A list of the entry/expansion team at the MCO with their title and role on the team.
- A designee who will manage the entry/expansion project and will work with the Department as the primary contact.
- An assessment of political ramifications, if any, for the entry/expansion area. The Department will review and respond to this.
- Profit and enrollment projections for the two year period following the planned entry/expansion.
- An outreach and education plan (both long and short term) including the names of the team when available.
- A plan detailing how the entry/expansion will be incorporated in to the MCOs current processes.
- A list of subcontractors impacted and a communication plan for notifying the subcontractor of changes.
- A detailed care transition plan.
- Assurances that all ancillary programs (i.e. prenatal, disease state management) will be operational and in place prior to implementation.
- A detailed request from the Department for information which will assist the MCO in its entry/expansion process.
- A draft of the member, marketing and provider materials at least 120 days before the planned entry/expansion date. The Department will review and respond within 30 days of receipt of the materials.

- A primary care network that includes contracting with all area health departments, major hospitals, community services boards (CSBs), Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.
- A specialty care network plan detailing development for therapy, laboratory, vision, pharmacy, psychiatric, and transportation service providers.

A network development plan must include the specialties listed in this Contract.

The Department will determine network adequacy based on specific utilization for the entry/expansion area not later than 90 days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO must demonstrate adaptability to the special requirements of certain populations like pregnant women in rural areas. The final MCO network must be submitted before assignment deadlines established by the Department.

A written plan indicating the date when BOI and VDH approval will be secured, if at the time of the initial letter of intent BOI and VDH approval are not secured. The MCO must provide the Department with copies of BOI and VDH letters in addition to a written plan outlining a plan for achieving an acceptable accreditation ranking (NCQA), outlining plans for achievement of major milestones as appropriate.

In order to pursue the entry/expansion, if approved by the Department, the MCO will submit a letter accepting the terms of the contract and of these guidelines. The MCO must provide written assurances that it will accept all members, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

ATTACHMENT IX – MCO MEMBER HEALTH SCREENING

(See form beginning next page

MCO Member Health Screening

Document Header Fields

Member Last Name: _____
 Member First Name: _____
 *Member Medicaid ID #: _____
 Member ID # (plan): _____
 Member Contact/Phone: _____
 Member Primary Care Provider: _____
 Member Primary Care Provider NPI: _____
 *Date Screening Completed: _____

Unable to Contact Member	
Member Refused to Answer	
Member Complexity Attestation Completed	

(* fields will be validated and errors returned to plan for correction)

PART 1- Medically Complex Classification Questions:

Question 1: Has a doctor, nurse, or health care provider told you that you had/have any of the following (**please check all applicable boxes**):

<input type="checkbox"/>	1. Cancer (Active)
<input type="checkbox"/>	2. COPD or Emphysema
<input type="checkbox"/>	3. Diabetes
<input type="checkbox"/>	4. Heart Disease, heart attack, heart failure (weak heart)
<input type="checkbox"/>	5. HIV or AIDS
<input type="checkbox"/>	6. Kidney Failure or End Stage Renal Disease (ESRD)
<input type="checkbox"/>	7. Parkinson’s Disease
<input type="checkbox"/>	8. Sickle Cell Disease
<input type="checkbox"/>	9. Stroke, Brain Injury or Spinal Injury
<input type="checkbox"/>	10. Transplant or on a transplant wait list
<input type="checkbox"/>	11. Other chronic (long term) disabling condition – IF YES, Member Complexity Attestation must be completed

Question 2: Do any of the chronic conditions you checked above impact your ability to do everyday things **AND** require you to receive assistance with any of the following (**please check all applicable boxes**):

<input type="checkbox"/>	Bathing
<input type="checkbox"/>	Dressing
<input type="checkbox"/>	Eating
<input type="checkbox"/>	Using the bathroom
<input type="checkbox"/>	Walking

Question 3: Has a doctor, nurse or health care provider told you that you had/have any of the following (please check all applicable boxes):

	12. Alcoholism
	13. Bipolar Disorder or Mania
	14. Depression
	15. Panic Disorder
	16. Post-Traumatic Stress Disorder (PTSD)
	17. Psychotic Disorder
	18. Schizophrenia or Schizoaffective Disorder
	19. Substance Use Disorder or Addiction
	20. Other chronic (long term) mental health condition – IF YES, Member Complexity Attestation must be completed

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

Yes No

Question 5: Do you have an intellectual or developmental disability and require help with any of the following: (please check all applicable boxes):

	Learning or Problem-Solving
	Listening or Speaking
	Living on your own
	Making decisions about your health or well-being
	Self-Care (bathing, grooming, eating)
	Travel/Transportation (driving, taking the bus)

PART 2 - Social Determinants of Health and Health Risk Assessment Triage Questions:

QUESTION 1: What is your housing situation today?

I have housing		
Yes	No	I am worried about losing my housing
I do not have housing (check all that apply)		
		Staying with others
		Living in a hotel
		Living in a shelter
		Living outside (on the street, on a beach, in a car, or in a park)
I choose not to answer this question		

QUESTION 2(a): In the past **3 months**, did you worry whether your food would run out before you got money to buy more?

Yes	No
-----	----

QUESTION 2(b): In the past **30 days**, have you or any family members you live with been **unable** to get any of the following when it was **really** needed? **Check all that apply.**

Yes	No	Prescription Drugs or Medicine
Yes	No	Utilities
Yes	No	Clothing
Yes	No	Child Care
Yes	No	Phone
Yes	No	Health Care (doctor appointment, mental health services, addiction treatment)
		I choose not to answer this question

QUESTION 3: How many times have you been in the Emergency Room or a hospital in the last 90 days for one of the conditions you listed earlier? _____ (enter number from 0-99)

QUESTION 4: How many times have you had a fall in the last 90 days and needed to visit a doctor, Emergency Room, or hospital because of the fall? _____ (enter number from 0-99) (**Adult Population Question**)

QUESTION 5: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

Yes it has kept me from medical appointment or from getting my medications	
Yes it has kept me from non-medical meetings, appointments, work, or from getting things that I need	
No	
I choose not to answer this question	

QUESTION 6: Caregiver Status (**Adult Population Question**)

Yes	No	Do you live with at least one child under the age of 19, AND are you the main person taking care of this child?
Yes	No	Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?

QUESTION 7: What is the highest level of school that you have finished? **(Adult Population Question)**

	Some high school but no diploma
	High school diploma or equivalency (GED)
	Some college but no degree
	Workforce Credential or Industry Certification after High School
	Associate's Degree
	Bachelor's Degree or higher
	I choose not to answer this question

QUESTION 8: Do you have a job? **(Adult Population Question)**

	I have a part-time or temporary job
	I have a full time job
	I do not have a job and am looking for one
	I do not have a job and I am not looking for one
	I choose not to answer this question

QUESTION 9: Do you like your current job? **(Adult Population Question)**

Yes	No	Yes, I like my job
Yes	No	I must work more than one job because I can't find a full time job
Yes	No	I work more than 40 hours per week at two or more part time jobs
Yes	No	I have been looking for a job for more than 3 months and I have not been offered a job
Yes	No	I would like help finding a job that I like more or pays more money

QUESTION 10: In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

	Yes
	No
	Unsure
	I choose not to answer this question

QUESTION 11: Do you have other important health issues or needs that you would like to discuss with someone?

	Yes
	No

QUESTION 12: How soon do you want to be contacted by someone to discuss your health issues or needs?

	1-30 Days
	31-60 Days
	61-90 Days
	91-120 Days
	Do not contact me

ATTACHMENT X – COMMON DEFINITIONS FOR MANAGED CARE TERMS

PER 42 CFR 438.10(c)(4)

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Co-payment: A payment paid by you in order to receive medical care.

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded services: Services that are not covered under the Medicaid benefit.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.
Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Virginia Medicaid coverage rules.

Network: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Non-participating provider: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan.

Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, behavioral health.

Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Preauthorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

Participating provider: Providers, hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports that are contracted with your health plan. Participating providers are also “in-network providers” or “plan providers.”

Premium: A monthly payment a health plan receives to provide you with health care coverage.

Prescription drug coverage: Prescription drugs or medications covered (paid) by your health plan. Some over-the-counter medications are covered.

Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary care physician: Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or

she also may talk with other doctors and health care providers about your care and refer you to them.

Primary Care Provider (PCP): Your primary care provider is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Provider: A person who is authorized to give health care or services. Examples of providers include doctors, nurses, behavioral health providers, nursing homes and specialists.

Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, or major operation.

Skilled nursing care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Urgent care: Care when you need to see a doctor and your doctor is not able to see you or the office is closed. Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away.

ATTACHMENT XI – CERTIFICATION OF DATA (NON-ENCOUNTER)

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR §§ 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR §§ 438.600 (et. al.).

The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance and Title XXI.

OR DELEGATE) _____
(INDICATE NAME AND TITLE OF CFO, CEO

on behalf of

OR DELEGATE) _____
(INDICATE NAME AND TITLE OF CFO, CEO

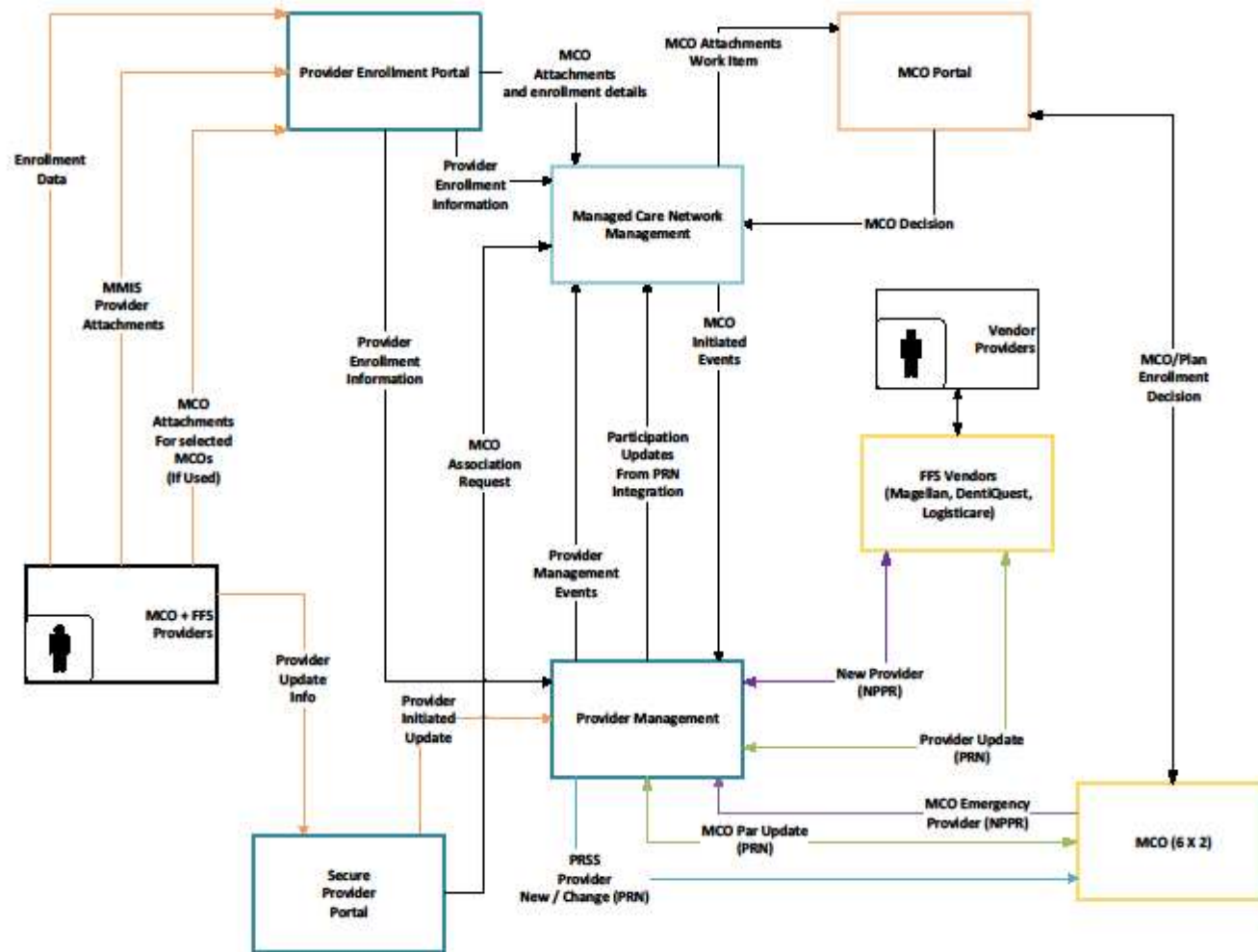
ATTACHMENT XII – MEDALLION 4 REGIONS BY LOCALITY

CENTRAL REGION					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLES CITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
049	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		
TIDEWATER REGION					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK
NORTHERN & WINCHESTER REGION					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
CHARLOTTESVILLE WESTERN REGION					

003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		
ROANOKE/ALLEGHANY REGION					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	071	GILES	750	RADFORD
019	BEDFORD CO	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
063	FLOYD	141	PATRICK		
SOUTHWEST REGION					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

ATTACHMENT XIII – DXC WORKFLOW

Virginia Provider Data Exchanges



ATTACHMENT XIV – FAMIS ADDENDUM

1. Title XXI FAMIS Populations

The following addendum specifies FAMIS children-specific program requirements and exceptions to covered services within the Medallion 4.0 program. See FAMIS State Plan Guidelines available on the website at <http://dmas.virginia.gov/#/med4information>.

For adults enrolled in FAMIS MOMS, covered services are the same as the covered services within the Medicaid Medallion 4.0 program in accordance with 12 VAC 30-141-820, with limited exceptions. FAMIS MOMS are uninsured, pregnant members of any age, 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. Per 12 VAC 30-141-880, FAMIS MOMS are not subject to exemption from MCO participation (e.g. for being hospitalized at the time of MCO enrollment).

Effective July 1, 2021, per Item 312H of the 2021 Special Session I Budget, a new group, pregnant persons who were previously ineligible on the basis of citizenship or immigration status, will be eligible for prenatal and labor and delivery coverage under FAMIS. This group will receive the same comprehensive benefits as FAMIS MOMS throughout the pregnancy and birth under the new FAMIS Prenatal Coverage. DMAS will be issuing specific guidance to the Contractor as it becomes available.

a. FAMIS Children

Children younger than the age of 19 years enrolled in the Commonwealth's separate Title XXI CHIP program.

The Contractor shall adhere to and apply the same standards and expectations outlined in this Contract for the Medicaid child population to the FAMIS population, with the exception of the items listed in this addendum.

1. Cost Sharing

Cost sharing is a component of the FAMIS program, but is limited to 2.5% of gross income (\$180 annual cap) for families with incomes at or below 150% of the federal poverty level (FPL) and to 5% of income (\$350 annual cap) for families with incomes between 150% and 200% of the FPL. The contractor shall apply co-payments in accordance with Attachment I of this contract and Virginia's CHIP State Plan.

2. FAMIS MCO Assignment

FAMIS members are assigned to a MCO in accordance with 12VAC30-141-660. FAMIS members may select an MCO at the time of application. If no enrollment response is received from the member by the last day to enroll, the Department shall assign the members an MCO using the current MCO pre-assignment algorithm during the Medallion contract period.

3. FAMIS-Specific Marketing Requirements

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

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

Contractors can order FAMIS brochures, applications and other materials via the Cover Virginia website at: http://coverva.org/partners_materials.cfm.

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

a. Use of the FAMIS Logo

The MCOs may utilize the Department designed FAMIS logo on member identification cards and member handbooks. All items or materials containing the FAMIS logo must be pre-approved by the Department prior to final printing and distribution. The FAMIS logo shall not be used on non-FAMIS items or materials.

The FAMIS logo must be used exactly as it is designed and shall not be altered in any way. The MCO has the option of using the logo in a black and white format or the color format, however, if the color format is utilized the colors shall not be changed, nor shall it be reversed out.

MCOs may use the logo on member identification cards without the approved tag line. All other use of the logo must include the tag line and FAMIS phone number.

4. FAMIS Primary Care Providers (PCP)

For FAMIS members, the PCP must be a specialty that is appropriate for children.

5. FAMIS Exceptions and Special Provisions for Medallion 4.0 Covered Services

a. Behavioral Health and Substance Use Disorder

The Contractor shall cover behavioral health and substance abuse treatment services in accordance with the FAMIS State Plan, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) (see the CMS State Official Letter dated January 16, 2013; SHO # 13-001; available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>), and the SUPPORT Act Section 5022 (see CMS SHO letter dated March 2, 2020; SHO # 20-002; available at:

<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho20001.pdf>).

b. Behavioral Health Services - Inpatient

The Contractor shall cover medically necessary hospitalization and inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital for FAMIS members. All inpatient mental health admissions for members to general acute care hospitals shall be approved by the Contractor using its own prior authorization criteria. FAMIS benefits do not include services furnished by IMDs, services furnished in freestanding psychiatric hospitals or state psychiatric hospitals, or residential services and other 24-hour therapeutically planned structural services. Psychiatric residential treatment (level C) is not a covered service under FAMIS.

c. Behavioral Health Services - Temporary Detention Order (TDO)

The Contractor is not required to cover inpatient psychiatric treatment as a result of a TDO outside of the coverage guidelines described in the Medallion 4.0 Managed Care Services Agreement for inpatient behavioral health services. Coverage for TDO admissions may be available through the State TDO program.

d. Mental Health Services (MHS)

In addition to traditional outpatient behavioral health services such as individual and group psychotherapy, the Contractor shall provide coverage of the following Mental Health Services (MHS) for FAMIS members: Peer Recovery Support, Behavioral Therapy Services, Intensive In-Home, Therapeutic Day Treatment, Crisis Intervention, and Mental Health Case Management services. For purposes of ensuring parity under financial requirements (FR) provisions in the federal Mental Health Parity and Addiction Equity Act, there will be no copay for outpatient behavioral health services, including MHS services, provided to FAMIS members.

e. Inpatient Substance Use Disorder Treatment Services

Medically necessary inpatient substance use treatment services are covered for 365 days per confinement. This coverage does not include residential services or other 24-hour therapeutically planned structural services.

f. Outpatient Substance Use Disorder Treatment Services

The Contractor shall provide coverage of outpatient, intensive outpatient, partial hospitalization, medication-assisted treatment, case management, and peer support services for the treatment of substance use disorder. For purposes of ensuring parity under financial requirements (FR) provisions in the federal Mental Health Parity and Addiction Equity Act, there will be no copay for outpatient SUD treatment services provided to FAMIS members.

g. Case Management

The Contractor shall cover an alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.

h. Chiropractic Services

The Contractor shall provide coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury up to \$500 per calendar year.

i. Durable Medical Equipment (DME)

For FAMIS members, there shall be no co-payment for disposable medical supplies. Durable medical equipment shall have a \$2 or \$5 co-payment per DME, depending upon the family's income level.

j. Emergency Services

Members who present to the emergency room shall pay the emergency room (outpatient) co-payment of \$2 or \$5, depending on income. If it is determined, using prudent layperson standards for access, that the visit was a non-emergency, the hospital may bill the member only for the difference between the emergency room and non-emergency co-payments, i.e. \$8.00 for members with income at or below 150% of FPL and \$20.00 for incomes above 150% of FPL. The hospital may not bill for additional charges.

k. Family Planning

FAMIS covered services include drugs and devices provided under the supervision of an in-network physician. *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.

l. Hearing Aids

For FAMIS members, the Contractor shall cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five years.

m. Home Health

The Contractor shall cover home health services, including medically necessary nursing and personal care services, home health aide services, physical therapy, occupational therapy, 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. The Contractor is prohibited from paying for home health care provided by an agency or organization unless said agency or organization provides the Commonwealth with a surety bond as specified in Section 1861 (o)(7) of the Social Security Act (42 U.S.C. 1395x).

n. Hospice Services

The Contractor shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six 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.

o. Hospital Services – Inpatient Hospital

The Contractor shall cover inpatient hospital stays in general acute care 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). See Section 15.7 for Contractor payment requirements under Diagnosis Relative Grouping (DRG) payment methodology.

p. Immunizations/Vaccinations

The Contractor shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP) standards.

The Contractor shall report annually to the Department, in accordance with HEDIS, the percent of two (2) year-old FAMIS members who have received each immunization specified in the most recent ACIP standards.

The Contractor is responsible for educating providers, parents and guardians of members about immunization services, and coordinating information regarding member immunizations.

FAMIS eligible members do not qualify for the free Virginia Vaccines for Children (VVFC) program.

q. Laboratory and X-Ray Services

No co-pay shall be charged for a laboratory or x-ray services that are performed as part of an encounter with a physician.

r. Organ Transplants

The Contractor shall cover organ transplantation services as medically necessary per industry treatment standards, including but not limited to transplants of tissues, autologous, allogeneic or syngeneic bone marrow transplants, or other forms of stem cell rescue for children with conditions including but not limited to lymphoma, myeloma or a diagnosis of Aplastic Anemia, Heritable Bone Marrow Syndrome, Paroxysmal Nocturnal Hemoglobinuria, Beta Thalassemia major, or Sickle Cell Disease when a member meets medical necessity criteria. The Contractor shall cover kidney transplants for patients with

dialysis dependent kidney failure, heart, liver, and single lung transplants. The Contractor shall provide coverage for reasonable and necessary procurement/donor related services. The Contractor is not required to cover transplant procedures determined to be experimental or investigational, however, scheduled transplantations authorized by the Department must be honored by the Contractor.

s. Pharmacy

The Contractor may impose the co-payments as outlined in Attachment I of the Medallion 4.0 Managed Care Services Agreement. There is a mandatory generic prescription requirement for FAMIS members.

t. Cosmetic Services

Cosmetic services are not covered except to correct deformity resulting from disease, trauma or congenital abnormalities, which cause functional impairment, or complete a therapeutic treatment as a result of such deformity.

u. Private Duty Nursing (PDN)

The Contractor shall cover medically necessary private duty nursing services for FAMIS children only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN); 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.

v. Screening, Diagnostic, and Preventive Services for FAMIS (Well Baby and Well Child)

The Contractor shall cover preventive services and all routine well baby and well child care recommended by the American Academy of Pediatrics Advisory Committee, including routine office visits with screenings; physical, developmental, and behavioral health assessments; physical examinations; routine lab work; and age-appropriate immunizations.

Well child visits are covered at birth and at specified months and years of age, according to the American Academy of Pediatrics recommended periodicity schedule.

The Contractor shall not allow copayments or other member cost sharing for preventive services, well child visits, or immunizations.

w. Tobacco Cessation

Tobacco Cessation Therapy shall be covered for FAMIS in accordance with SUPPORT Act requirements.

x. Vision Services

The member co-payment level for routine eye exams shall be \$2.00 for members with family incomes at or below 150% FPL and \$5.00 for members with family incomes

above 150% FPL. The health plan shall pay the following amounts toward the purchase of frames and lenses:

- Eyeglass frames (one pair) \$25.00
- Eyeglass lenses (one pair) \$25.00
- Single vision \$35.00
- Bifocal \$50.00
- Trifocal \$88.50
- Contacts \$100.00

6. Services Not Covered Under FAMIS

The following services are covered for some members of the Medallion 4.0 program but are not covered for members of the FAMIS program:

- Court-Ordered Services
- Clinical Trials as EPSDT
- EPSDT
- Podiatric Services
- Non-Emergency Medical Transportation
- Services provided in IMDs; psychiatric residential treatment services

7. FAMIS Appeals and Member Requested External Review

FAMIS members are excluded from 42 CFR § 438.400(b)(6) in the definition of an adverse benefit determination pertaining to residents of rural areas with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.

A FAMIS member must exhaust the MCO's member appeals process before the member can request a state fair hearing. FAMIS members may also request an external medical review by submitting a written request to:

KEPRO External Review
2810 N. Parham Road
Suite #305
Henrico, Virginia 23294

8. FAMIS Financial Exceptions

The FAMIS and FAMIS MOMS programs are not subject to:

- Minimum fee schedules described in Section 15.6.A, Increased Payments to Qualifying Physicians.
- The uniform percentage increase described in Section 15.7, Increased Payments to Private Acute Care Hospitals.

Additionally, when FAMIS members are hospitalized under fee-for-service at the time of admission, the Department is responsible for the full DRG, admission to discharge, in

accordance with DMAS established coverage criteria and payment rules. See Section 15.9, Payment Using DRG Methodology.

9. Other Sections Not Applicable to FAMIS

The following sections of this contract are not applicable to FAMIS:

- Drug Rebates in Section 8.7 (k).
- All Payers Claim Database in Section 10.4.
- Intermediate Sanctions for Noncompliance in Section 16.1.A (a).
- Other Categorical Prohibited Affiliations with Entities in Section 16.2.B.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Inpatient Hospital Services	Yes	\$15 per confinement	\$25 per confinement	The Contractor shall cover inpatient stays in general acute care hospitals 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).
Outpatient Hospital Services	Yes	\$2 per visit (waived if admitted)	\$5 per visit (waived if admitted)	The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.
Case Management Services	Yes	N/A	N/A	The Contractor shall cover an alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The Contractor must approve in advance the alternative treatment plan.
Chiropractic Services	Yes	\$2 per visit	\$5 per visit	The Contractor shall provide up to \$500.00 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Clinic Services <i>Well child visits</i> <i>Preventive care</i> <i>Behavioral Health</i> <i>Maternity Services</i>	Yes	\$2 \$0	\$5 \$0	The Contractor shall cover clinic services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician or a dentist. Renal dialysis clinic visits are also covered. There are no copayments for maternity services.
Court Ordered Services	No	N/A	N/A	The Contractor is not required to cover a court-ordered service unless the service is (1) medically necessary and (2) a FAMIS covered service.
Dental Services	Yes, through DBA. Limited coverage provided by Contractor.	For services covered by the Contractor, \$2 per visit Outpatient/ Emergency; \$15 per admission Inpatient	For services covered by the Contractor, \$5 per visit Outpatient/ Emergency; \$25 per admission Inpatient	Pediatric dental services for FAMIS enrollees are covered through the Smiles for Children Program through the Department's Dental Benefit Administrator (DBA). No copayment is due for dental services through the DBA. For more information regarding SFC benefits, call 1-888-912-3456. The Contractor shall cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Early Intervention Services	Yes	\$0	\$0	<p>The Contractor is required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted 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</p> <p>The Contractor shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate. Cost sharing provisions shall not apply to EI services received by FAMIS members enrolled in EI.</p>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	No	N/A	N/A	<p>The Contractor is not required to cover EPSDT for FAMIS. The Contractor is required to cover well-baby and well-child services without cost sharing, including visits, screenings, and laboratory services on a periodicity schedule as recommended by the American Academy of Pediatrics Bright Futures guidelines, as well as immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP).</p>

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Emergency Services using Prudent Layperson Standards for Access <i>Includes physician care</i>	Yes	\$2 per visit	\$5 per visit	The Contractor shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary’s presentation to the emergency room indicate that an emergency may exist. The Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week. The Contractor shall cover all emergency services provided by out-of-network providers. The Contractor may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that a member seeks in an emergency.
Non-emergency use of the Emergency Room	Yes	\$10 per visit	\$25 per visit	Members who present to the emergency room shall pay the Emergency Services co-payment (\$2/\$5). 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 for members with household incomes at or below 150% FPL and \$20 for members with household incomes above 150% FPL. The hospital may not bill for additional charges.
Post Stabilization Care Following Emergency Services	Yes	Covered under Emergency Services copayment	Covered under Emergency Services copayment	The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized. The Contractor must cover post-stabilization services without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor’s network.

SUMMARY OF FAMIS COVERED SERVICES				
SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Experimental and Investigational Procedures	No	N/A	N/A	The Contractor is not required to cover this service.
Family Planning Services	Yes	\$0	\$0	<p>The 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.</p> <p>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.</p> <p><i>Code of Virginia § 54.1-2969 (D)</i>, 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.</p>
Hearing Aids	Yes	\$2	\$5	The Contractor shall cover hearing aids as outlined under Durable Medical Equipment. Hearing aids shall be covered twice every five years.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Home Health Services	Yes	\$2 per visit	\$5 per visit	The 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	The Contractor shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a Provider licensed to do so; furnished and billed by a licensed hospice; and medically necessary. Hospice care services are available if the member is diagnosed with a terminal illness with a life expectancy of six 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 FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Immunizations	Yes	\$0	\$0	<p>The Contractor shall cover immunizations. The Contractor shall ensure that providers render immunizations in accordance with the most current Advisory Committee on Immunization Practices (ACIP) recommendations. The Contractor shall work with the Department to achieve its goals related to increased immunization rates. The Contractor is responsible for educating providers, parents and guardians of members about immunization services, and coordinating information regarding member immunizations.</p> <p>FAMIS eligible members do not qualify for the free Virginia Vaccines for Children (VVFC) program.</p>
Inpatient Mental Health Services	Yes	\$0	\$0	<p>Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS members. Inpatient mental health services are covered for 365 days per confinement. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission. 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. Services rendered in IMDs and psychiatric residential treatment (level C) are not covered services under FAMIS.</p>

SUMMARY OF FAMIS COVERED SERVICES				
SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Inpatient Substance Use Services*	Yes	\$0	\$0	Medically necessary inpatient substance abuse treatment services are covered for 365 days per confinement. This coverage does not include services furnished in a state-operated mental hospital or in an IMD. This coverage does not include residential services or other 24-hour therapeutically planned structural services.
Laboratory and X-ray Services	Yes	\$2, or covered as part of the visit or hospital admission	\$5, or covered as part of the visit or hospital admission	The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician office, hospital, independent and clinical reference labs. No 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	The Contractor shall cover blood lead testing as part of well baby and well child care.
Durable Medical Equipment	Yes	\$2 per item for equipment	\$5 per item for equipment	The Contractor shall cover medically necessary durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). The Contractor shall cover supplies and equipment necessary to administer enteral nutrition.
<i>Disposable Medical Supplies</i>	Yes	\$0 for supplies	\$0 for supplies	The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Medical Transportation	Yes	\$2	\$5	Professional ambulance services when medically necessary are covered when used locally to or from a covered facility or provider office. Ambulance services may be covered when prearranged by the Primary Care Physician and authorized by the Contractor if, because of the member’s medical condition, the member cannot ride safely in a car when going to the provider’s office or to the outpatient department of the hospital. Ambulance services will be covered if the member’s condition suddenly becomes worse and s/he must go to a local hospital’s emergency room, or for transportation between local hospitals when medically necessary. For coverage of ambulance services, the trip to the facility or office must be to the nearest one 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.
Non-Emergency Medical Transportation	No	N/A	N/A	Transportation services are not provided for routine access to and from providers of covered services.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Organ Transplantation	Yes	\$15 per confinement and \$2 per outpatient visit	\$25 per confinement and \$5 per outpatient visit	The Contractor shall cover organ transplantation services as medically necessary and per industry treatment standards for all eligible individuals, including but not limited to transplants of tissues, autologous, allogeneic or syngeneic bone marrow transplants or other forms of stem cell rescue for children with 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. Services to identify donor limited to \$25,000 per member. The Contractor is not required to cover transplant procedures determined to be experimental or investigational.
Outpatient Mental Health and Substance Use Disorder Treatment Services*	Yes	\$0	\$0	The Contractor is responsible for covering medically necessary outpatient individual, family, and group psychotherapy and counseling for treatment of mental health conditions and substance use disorders. Outpatient substance use treatment services for FAMIS members include outpatient, intensive outpatient, partial hospitalization, medication-assisted treatment, case management, and peer support.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Community Mental Health Rehabilitative Services (MHS)	Yes	\$0	\$0	The following behavioral health services known as MHS shall be covered under the Medallion 4.0 Program for FAMIS enrollees: <ul style="list-style-type: none"> ○ Intensive in-home services ○ Therapeutic day treatment ○ Crisis intervention ○ Case management ○ Behavioral therapies ○ Peer support services
Pap Smears	Yes	\$0	\$0	The Contractor shall cover annual pap smears and other preventive services for reproductive health.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	Yes	\$2 per visit	\$5 per visit	The Contractor shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, speech therapy, occupational therapy, inhalation therapy, and intravenous therapy.
Pregnancy-Related Services	Yes	\$0	\$0	The Contractor shall cover services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy related services.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Prescription Drugs <i>Retail up to 34-day supply</i> <i>Retail 35-to-90-day supply</i> <i>Mail service up to 90-day supply</i>	Yes	\$2 per prescription \$4 per prescription \$4 per prescription	\$5 per prescription \$10 per prescription \$10 per prescription	The Contractor shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions. If a generic is available, member pays the copayment plus 100% of the difference between the allowable charge of the generic drug and the brand name drug, except in cases where the prescribing provider requires the brand name drug.
Private Duty Nursing Services	Yes	\$2 per visit	\$5 per visit	The Contractor shall cover medically necessary private duty nursing services for FAMIS children only if the services are provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Private duty nursing services must be pre-authorized. The nurse may not be a relative or member of the member's family.
Prosthetics/Orthotics	Yes	\$2 per item	\$5 per item	The Contractor shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all members. At a minimum, the Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for members when recommended as part of an approved intensive rehabilitation program.
Psychiatric Residential Treatment Services	No	N/A	N/A	This service is non-covered under FAMIS.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Local Education Agency Services	Carved Out	N/A	N/A	The Contractor is not required to cover school-based services provided by a local education agency (LEA). LEA-based services that meet the Department’s criteria will continue to be covered by DMAS on a fee-for-service basis as a carve-out service. However, the Contractor shall not deny medically necessary services or therapies in the outpatient, home, or school setting based on the fact that the child is also receiving LEA-based services pursuant to an IEP.
Second Opinions	Yes	\$2 per visit	\$5 per visit	The Contractor shall provide coverage for second opinions when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for second opinions from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member. The Contractor may require an authorization for the member to receive specialty care from an appropriate provider; however, the Contractor cannot deny a second opinion request as a non-covered service.
Skilled Nursing Facility Care	Yes	\$15 per confinement	\$25 per confinement	The Contractor shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.
Telemedicine Services	Yes	\$2 per visit (Copayment is based upon the service that is being provided via telehealth)	\$5 per visit (Copayment based upon the service that is being provided via telehealth)	The 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.

SUMMARY OF FAMIS COVERED SERVICES				
SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Temporary Detention Orders	No	N/A	N/A	The 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	The 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)	Yes	\$0	\$0	The Contractor shall provide coverage for smoking cessation in accordance with SUPPORT Act requirements.
Well Baby and Well Child Care	Yes	\$0	\$0	The Contractor shall cover all routine well baby and well child care recommended by the American Academy of Pediatrics Advisory Committee and according to AAP's recommended periodicity schedule, including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations. Screenings include, but are not limited to, 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). Hearing Services: All newborn infants will be given a hearing screening before discharge from the hospital after birth.

SUMMARY OF FAMIS COVERED SERVICES

SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Vision Services <i>Routine eye exam</i>	Yes	\$2 Member Payment	\$5 Member Payment	The Contractor shall cover vision services that are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations shall be allowed at least once every two (2) years.
<i>Eyeglass frames (one pair)</i>		\$25 Reimbursed by Plan	\$25 Reimbursed by Plan	
<i>Eyeglass lenses (one pair)</i>		\$25 Reimbursed by Plan	\$25 Reimbursed by Plan	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.
<i>single vision</i>		\$35 Reimbursed by Plan	\$35 Reimbursed by Plan	
<i>bifocal</i>		\$50 Reimbursed by Plan	\$50 Reimbursed by Plan	
<i>trifocal</i>		\$88.50 Reimbursed by Plan	\$88.50 Reimbursed by Plan	
<i>contacts</i>		\$100 Reimbursed by Plan	\$100 Reimbursed by Plan	
Abortions	No	N/A	N/A	The Contractor is not required to cover services for abortions.

SUMMARY OF FAMIS COVERED SERVICES				
SERVICE	FAMIS COVERED	NETWORK COST SHARING & BENEFIT LIMITS		CONTRACT RESPONSIBILITIES, SCOPE OF COVERAGE
		≤150% FPL	>150% FPL	
Cost Sharing:		Annual limit:	Annual limit:	Plan pays 100% of allowable charge once out of pocket limit is met for covered services. In accordance with federal law, no cost sharing will be charged to American Indians and Alaska Natives.
<i>Annual Co-Payment Limit (per family)</i>		2.5% of family income (\$180 cap)	5 percent of family income (\$350 cap)	

*Contractor’s coverage of mental health and substance abuse treatment services shall comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 and the SUPPORT Act Section 5022.

ATTACHMENT XV – GENERAL ASSEMBLY ITEMS

This attachment contains a list of new requirements added to the Code of Virginia during the 2021 General Assembly Session that impact the Medicaid program. This is not intended to be an all inclusive list. Not all of the actions required changes to this contract; however, the Contractor is responsible for understanding the actions and implementing any necessary programmatic or policy changes in order to comply. This list is subject to change based on future General Assembly actions.

Enrolled Bills

Bill Number	Title	Description	DMAS Comment
HB1987/ SB1338	Telemedicine; coverage of telehealth services by an insurer, etc.	Requires the provision for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients, makes clear that nothing shall preclude health insurance carriers from providing coverage for services delivered through real-time audio-only telephone that are not telemedicine, and clarifies rules around prescribing of Schedule II through VI drugs via telemedicine, including establishing a practitioner-patient relationship via telemedicine.	See revised telehealth requirements.
HB2124	COVID-19; DMAS shall deem testing, treatment, and vaccination to be emergency services.	Requires, during the public health emergency related to COVID-19 declared by the United States Secretary of	

		Health and Human Services, to deem testing for, treatment of, and vaccination against COVID-19 to be emergency services for which payment may be made pursuant to federal law for certain aliens not lawfully admitted for permanent residence.	
HB2197/ SB1472	Individuals w/ intellectual & developmental disabilities; DMAS to study use of virtual support, etc.	Creates work group to study options for the permanent use of virtual supports and increasing access to virtual supports and services; individuals with intellectual and developmental disabilities. Report on findings and recommendations to the Governor and the General Assembly by November 1, 2021.	MCO participation may be necessary.
SB1102	Personal care aides; DMAS shall establish an orientation program for certain aides.	Requires the Department of Medical Assistance Services to establish an orientation program for all personal care aides who provide self-directed services through the Medicaid program. The bill lays out the topics to be covered by such orientations, requires orientations to be held in-person or online at least quarterly, and specifies that	

		personal care aides shall be invited and encouraged to attend at least one such orientation per calendar year.	
SB1227	Hormonal contraceptives; payment of medical assistance for 12-month supply.	Directs the Board of Medical Assistance Services to include in the state plan for medical assistance a provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time for Medicaid and Family Access to Medical Insurance Security (FAMIS) enrollees. The bill prohibits the Department of Medical Assistance Services from imposing any utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. The bill provides that the bill shall not be construed to (i) require a provider to prescribe, dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude coverage for	

		hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive purposes.	
SB1307	School-based health services; Bd. of MAS to amend state plan for services to provide for payment.	Department of Medical Assistance Services; school-based health services; telemedicine. Directs the Board of Medical Assistance Services to amend the state plan for medical assistance services to provide for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. The bill specifies that such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment benefit as specified in § 1905(r)	School based services not covered by MCO.

		of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services. The bill also requires the Department of Medical Assistance Services to provide technical assistance to the Department of Education and local school divisions to facilitate their understanding of and compliance with federal ordering, referring, and prescribing provider screening and enrollment requirements.	
HB1831	Home care organizations; personal care services through audio-video telephone communication.	Directs the Board of Health to include in regulations governing home care organizations a provision for supervision of home care attendants providing personal care services by a licensed nurse through use of interactive audio or video technology.	Future regulations
HB1953	Licensed certified midwives; clarifies definition, licensure, etc.	Defines "practice of licensed certified midwifery," directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife, and requires licensed certified midwives to practice in	Defines the practice of certified midwife.

		<p>consultation with a licensed physician in accordance with a practice agreement. The bill also directs the Department of Health Professions to convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals. The bill requires the Department to report its findings and conclusions to the Governor and the General Assembly by November 1, 2021. This bill is identical to SB 1320.</p>	
HB2065	<p>Produce Rx Program; Dept. of Social Services, et al., to develop a plan for a 3-yr. pilot Program.</p>	<p>Directs the Department of Social Services, in cooperation with the Department of Medical Assistance Services, to convene a work group to develop a plan for a three-year pilot Produce Rx program to incentivize consumption of qualifying fruits and vegetables by eligible individuals for whom increased consumption of fruits and vegetables is recommended by a qualified care provider. The bill requires the Department of</p>	<p>Workgroup. MCO participation may be needed.</p>

		Social Services to report on the activities of the work group and the elements of the plan to the Governor and the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by October 1, 2021.	
HB2137	Paid sick leave; employers to provide to certain employees.	Requires employers to provide certain employees paid sick leave.	Sick leave for certain providers.
HB2219	Pharmacies; freedom of choice by covered individual.	Provides that no insurance carrier, corporation providing preferred provider subscription contracts, or health maintenance organization providing health care plans or its pharmacy benefits manager shall prohibit a covered individual from selecting the pharmacy of his choice to furnish specialty pharmaceutical benefits under the covered individual's policy. The bill provides that no pharmacy that meets the terms and conditions of participation shall be precluded from obtaining a direct service agreement or participating provider agreement and that any request for such agreement	

		by a pharmacy shall be acted upon by a carrier, corporation, or organization or its pharmacy benefits manager within 60 days of receiving the request.	
HB2322/ SB1469	Opioid Abatement Authority; established, report.	Establishes the Opioid Abatement Authority. The Authority, with the assistance of the Office of the Attorney General, would administer the Opioid Abatement Fund, which would receive moneys from settlements, judgments, verdicts, and other court orders relating to claims regarding the manufacturing, marketing, distribution, or sale of opioids and any other funds received on the fund's behalf that would be used to provide grants and loans to Virginia agencies and certain localities for the purpose of treating, preventing, or reducing opioid use disorder and the misuse of opioids or otherwise abating or remediating the opioid epidemic in the Commonwealth.	

General Assembly Amendments to Governor's Introduced Budget

Due to the economic uncertainty resulting from the COVID-19 pandemic, the General Assembly has unallotted funding for many of the proposed budget actions. The General Assembly will meet at a yet undetermined date for a Special Session where they will further amend the budget based on a revised economic forecast. The Contract will be responsible for complying with all applicable requirements resulting from the enrolled budget bill and the Special Session.