COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

COMMONWEALTH COORDINATED CARE PLUS MCO CONTRACT
FOR MANAGED LONG TERM SERVICES AND SUPPORTS

January 1, 2018 - December 31, 2018

CCC Plus Contract Table of Contents

SECTION 1.0 SCOPE OF CONTRACT 8

1.1 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS 8

1.2 COMMITMENT TO DEPARTMENT GOALS FOR DELIVERY SYSTEM REFORM AND PAYMENT TRANSFORMATION 9

SECTION 2.0 REQUIREMENTS PRIOR TO OPERATIONS 10

2.1 ORGANIZATIONAL STRUCTURE 10

2.2 READINESS REVIEW 12

2.3 LICENSURE 13

2.4 CERTIFICATION OF QUALITY 13

2.5 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION 13

2.6 DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) 14

2.7 BUSINESS ASSOCIATE AGREEMENT (BAA) 14

2.8 AUTHORIZATION TO CONDUCT BUSINESS IN THE COMMONWEALTH 14

2.9 CONFIDENTIALITY STATUTORY REQUIREMENTS 14

2.10 DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST 15

2.11 PROHIBITED AFFILIATIONS WITH ENTITIES DEBARRED BY FEDERAL AGENCIES 16

2.12 EXCLUDED ENTITIES 17

2.13 CONTRACTOR COMPLIANCE PROGRAM 18

SECTION 3.0 ENROLLMENT AND ASSIGNMENT PROCESS 19

3.1 ELIGIBILITY AND ENROLLMENT RESPONSIBILITIES 19

3.2 CCC PLUS ENROLLMENT PROCESS 22

SECTION 4.0 BENEFITS AND SERVICE REQUIREMENTS 30

4.1 GENERAL BENEFITS PROVISIONS 30

4.2 BEHAVIORAL HEALTH SERVICES 30

4.3 DENTAL AND RELATED SERVICES 42

4.4 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) 43

4.5 EARLY INTERVENTION (EI) 46

4.6 EMERGENCY AND POSTSTABILIZATION SERVICES 47

4.7 LONG TERM SERVICES AND SUPPORTS 48

4.8 PHARMACY SERVICES 72

4.9 TELEMEDICINE SERVICES 79

4.10 TRANSPORTATION SERVICES 80

4.11 CARVED OUT SERVICES 87

4.12 STATE PLAN SUBSTITUTED (IN LIEU OF) SERVICES 88

4.13 ENHANCED BENEFITS 88
4.14 SERVICES RELATED TO FEDERAL MORAL/RELIGIOUS OBJECTIONS 89
4.15 TRANSLATION & INTERPRETER SERVICES 89
4.16 MEDICAID WORKS 90
SECTION 5.0 CCC PLUS MODEL OF CARE 91
5.1 GENERAL REQUIREMENTS AND COVERED POPULATIONS 91
5.2 HEALTH RISK ASSESSMENTS (HRA) 92
5.3 PERSON-CENTERED INDIVIDUALIZED CARE PLAN (ICP) 95
5.4 INTERDISCIPLINARY CARE TEAM (ICT) 98
5.5 REASSESSMENTS 100
5.6 CARE COORDINATION STAFFING 101
5.7 CARE COORDINATION PARTNERSHIPS 103
5.8 CARE COORDINATOR STAFFING RATIOS 103
5.9 CARE COORDINATION REQUIREMENTS 104
5.10 CARE COORDINATION WITH TRANSITIONS OF CARE 106
5.11 VIRGINIA EMERGENCY DEPARTMENT CARE COORDINATION PROGRAM 109
5.12 COORDINATION WITH THE MEMBER'S MEDICARE OR OTHER MCO PLAN 110
5.13 CLINICAL WORKGROUP MEETINGS 112
5.14 CONTINUITY OF CARE 112
5.15 CARE DELIVERY MODEL POLICY AND PROCEDURES 116
SECTION 6.0 UTILIZATION MANAGEMENT REQUIREMENTS 121
6.1 GENERAL UTILIZATION MANAGEMENT REQUIREMENTS 121
6.2 SERVICE AUTHORIZATION 122
6.3 PATIENT UTILIZATION MANAGEMENT & SAFETY (PUMS) PROGRAM 128
6.4 ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM 130
6.5 NOTIFICATION TO THE DEPARTMENT OF SENTINEL EVENTS 130
SECTION 7.0 SUBCONTRACTOR DELEGATION AND MONITORING REQUIREMENTS 131
7.1 GENERAL REQUIREMENTS FOR SUBCONTRACTORS 131
7.2 DELEGATION REQUIREMENTS 132
7.3 MONITORING REQUIREMENTS 133
7.4 DATA SHARING CAPABILITIES 133
7.5 BEHAVIORAL HEALTH SERVICES ADMINISTRATOR 133
7.6 CONSUMER DIRECTION FISCAL/ EMPLOYER AGENT 134
SECTION 8.0 PROVIDER NETWORK MANAGEMENT 136
8.1 GENERAL NETWORK PROVISIONS 136
8.2 SPECIALIZED NETWORK PROVISIONS 137

8.3 CERTIFICATION OF NETWORK ADEQUACY 140
8.4 PROVIDER CREDENTIALING STANDARDS 141
8.5 PROVIDER AGREEMENTS 145
SECTION 9.0 ACCESS TO CARE STANDARDS 150
9.1 GENERAL STANDARDS 150
9.2 CHOICE OF PROVIDER STANDARDS 150
9.3 MEMBER TRAVEL TIME AND DISTANCE STANDARDS 151
9.4 EXCEPTIONS TO ACCESS STANDARDS 152
9.5 TWENTY-FOUR HOUR COVERAGE 152
9.6 URGENT CARE ACCESS 152
9.7 EMERGENCY SERVICES COVERAGE 153
9.8 INPATIENT HOSPITAL ACCESS 153
9.9 MEMBER PRIMARY CARE ACCESS (ADULT AND PEDIATRIC) 153
9.10 TIMELINESS ACCESS STANDARDS 155
9.11 SECOND OPINIONS 156
9.12 OUT-OF-NETWORK SERVICES 156
9.13 OUT-OF-STATE SERVICES 156
9.14 PROVIDER TRAVEL CONSIDERATIONS 157
9.15 POLICY OF NONDISCRIMINATION 157
9.16 ACCOMMODATING PERSONS WITH DISABLITIES 157
9.17 ASSURANCES THAT ACCESS STANDARDS ARE BEING MET 158
9.18 NATIVE AMERICAN HEALTH CARE PROVIDERS 158
SECTION 10.0 QUALITY MANAGEMENT AND IMPROVEMENT 159
10.1 QUALITY DEFINITION AND DOMAINS 159
10.2 CONTINUOUS QUALITY IMPROVEMENT PRINCIPLES AND EXPECTATIONS 159
10.3 QUALITY INFRASTRUCTURE 159
10.4 QI PROGRAM DESCRIPTION, WORK PLAN, AND EVALUATION 161
10.5 QI STAFFING 162
10.6 PERFORMANCE MEASUREMENT 163
10.7 PERFORMANCE IMPROVEMENT PROJECTS (PIPS) 165
10.8 EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES 167
10.9 WAIVER ASSURANCES 168
10.10 QI FOR UTILIZATION MANAGEMENT ACTIVITIES 168
10.11 CLINICAL PRACTICE GUIDELINES 169
10.12 QUALITY COLLABORATIVE AND OTHER WORKGROUPS 169
10.13 QUALITY PERFORMANCE INCENTIVE PROGRAM 170

10.14 BEHAVIORAL HEALTH SERVICES OUTCOMES 171
10.15 ARTS SPECIFIC MEASUREMENT AND REPORTING 171
10.16 QUALITY SYSTEM 173
10.17 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION 173
SECTION 11.0 MEMBER SERVICES AND COMMUNICATIONS 175
11.1 MEMBER CALL CENTERS 175
11.2 MEMBER INQUIRIES 178
11.3 MEMBER RIGHTS AND PROTECTIONS 178
11.4 ADVANCED DIRECTIVES 179
11.5 CULTURAL COMPETENCY 179
11.6 COST-SHARING 179
11.7 PROTECTING MEMBER FROM LIABILITY FOR PAYMENT 179
11.8 MEMBER ADVISORY COMMITTEE 180
11.9 PROTECTION OF CHILDREN AND AGED OR INCAPACITATED ADULTS 181
***11.10** PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS 181*
11.11 MEMBER COMMUNICATIONS AND ENROLLMENT MATERIALS 181
11.12 MARKETING REQUIREMENTS 186
11.13 PROHIBITED MARKETING AND OUTREACH ACTIVITIES 189
SECTION 12.0 PROVIDER SERVICES AND CLAIMS PAYMENT 192
12.1 PROVIDER CALL CENTER 192
12.2 PROVIDER TECHNICAL ASSISTANCE 194
12.3 PROVIDER EDUCATION 194
12.4 PROVIDER PAYMENT SYSTEM 195
12.5 INCREASED PAYMENTS TO ENSURE ACCESS 204
SECTION 13.0 VALUE BASED PAYMENTS 205
13.1 BACKGROUND 205
13.2 CONTRACTOR ANNUAL VBP PLAN 205
13.3 VBP STATUS REPORT 206
13.4 CONTRACTOR HCP-LAN APM DATA COLLECTION SUBMISSION 206
13.5 DMAS APPROVAL OF VBP FOR CERTAIN SERVICES 207
SECTION 14.0 PROGRAM INTEGRITY (PI) AND OVERSIGHT 208
14.1 GENERAL PRINCIPLES 208
14.2 PROGRAM INTEGRITY PLAN, POLICIES, & PROCEDURES 208
14.3 COMPLIANCE OFFICER 213
14.4 PROGRAM INTEGRITY LEAD 213
14.5 TRAINING AND EDUCATION 213

14.6 EFFECTIVE LINES OF COMMUNICATION BETWEEN CONTRACTOR STAFF 213
14.7 ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES....214
14.8 DEVELOPMENT OF CORRECTIVE ACTION INITIATIVES....214
14.9 REPORTING AND INVESTIGATING SUSPECTED FRAUD, AND ABUSE TO THE DEPARTMENT....214
14.10 QUARTERLY FRAUD/WASTE/ABUSE REPORT 215
14.11 COOPERATION WITH STATE AND FEDERAL INVESTIGATIONS....216
14.12 MEDICAID FRAUD CONTROL UNIT (MFCU)....216
14.13 MINIMUM AUDIT REQUIREMENTS....216
14.14 PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES....216
SECTION 15.0 MEMBER AND PROVIDER GRIEVANCES AND APPEALS.... 219
15.1 GENERAL REQUIREMENTS....219
15.2 GRIEVANCES 219
15.3 GENERAL INTERNAL APPEAL REQUIREMENTS....220
15.4 CONTRACTOR INTERNAL APPEALS....222
15.5 STATE FAIR HEARINGS 225
15.6 PROVIDER RECONSIDERATIONS AND APPEALS 227
15.7 EVALUATION OF GRIEVANCES AND APPEALS....231
15.8 GRIEVANCE AND APPEAL REPORTING....231
15.9 RECORDKEEPING AND DOCUMENT PRESERVATION 232
SECTION 16.0 INFORMATION MANAGEMENT SYSTEMS 233
16.1 GENERAL REQUIREMENTS....233
16.2 DESIGN REQUIREMENTS....233
16.3 SYSTEM ACCESS MANAGEMENT AND INFORMATION ACCESSIBILITY REQUIREMENTS 233
16.4 SYSTEM AVAILABILITY AND PERFORMANCE REQUIREMENTS....233
16.5 ELECTRONIC CARE COORDINATION SYSTEM 234
16.6 CENTRAL DATA REPOSITORY 235
16.7 DATA INTERFACES SENT TO AND RECEIVED FROM DMAS 236
16.8 INTERFACE AND CONNECTIVITY TO THE VIRGINIA MEDICAID MANAGEMENT INFORMATION SYSTEM (VAMMIS) AND MEDICAID ENTERPRISE SYSTEM (MES) 236
16.9 DATA QUALITY REQUIREMENTS....237
16.10 DATA SECURITY AND CONFIDENTIALITY OF RECORDS 244
SECTION 17.0 REPORTING REQUIREMENTS.... 251
17.1 GENERAL REQUIREMENTS....251
17.2 ALL PAYERS CLAIM DATABASE....252
17.3 CRITICAL INCIDENT REPORTING AND MANAGEMENT....252
SECTION 18.0 ENFORCEMENT, REMEDIES, AND COMPLIANCE 254

18.1 CCC PLUS PROGRAM EVALUATION ACTIVITIES 254
18.2 COMPLIANCE MONITORING PROCESS (CMP) 254
18.3 OTHER – SPECIFIC PRE-DETERMINED SANCTIONS 257
18.4 REMEDIAL ACTIONS 257
18.5 CORRECTIVE ACTION PLAN 264
18.6 INTERMEDIATE SANCTIONS AND CIVIL MONETARY PENALTIES 264
18.7 NOTICE OF SANCTION AND PRETERMINATION HEARING 265
SECTION 19.0 CONTRACTOR PAYMENT AND FINANCIAL PROVISIONS 267
19.1 FINANCIAL STATEMENTS 267
19.2 REPORTING OF REBATES 268
19.3 FINANCIAL RECORDS 268
19.4 FINANCIAL SOLVENCY 268
19.5 CHANGES IN RISK BASED CAPITAL REQUIREMENTS 268
19.6 HEALTH INSURER FEE 268
19.7 MINIMUM MEDICAL LOSS RATIO (MLR) AND LIMIT ON UNDERWRITING GAIN 269
19.8 REINSURANCE 271
19.9 CAPITATION RATES 274
19.10 CERTIFICATION (NON-ENCOUNTERS) 278
SECTION 20.0 APPEAL RIGHTS OF THE CONTRACTOR 279
20.1 CONTRACTOR RIGHT TO APPEAL 279
20.2 DISPUTES ARISING OUT OF THE CONTRACT 279
20.3 INFORMAL RESOLUTION OF CONTRACT DISPUTES 279
20.4 PRESENTATION OF DOCUMENTED EVIDENCE 279
SECTION 21.0 RENEWAL/TERMINATION OF CONTRACT 280
21.1 CONTRACT RENEWAL 280
21.2 SUSPENSION OF CONTRACTOR OPERATIONS 280
21.3 TERMS OF CONTRACT TERMINATION 280
21.4 TERMINATION PROCEDURES 283
SECTION 22.0 GENERAL TERMS AND CONDITIONS 286
22.1 NOTIFICATION OF ADMINISTRATIVE CHANGES 286
22.2 ASSIGNMENT 286
22.3 INDEPENDENT CONTRACTORS 286
22.4 BUSINESS TRANSACTION REPORTING 286
22.5 LOSS OF LICENSURE 287
22.6 INDEMNIFICATION 287
22.7 CONFLICT OF INTEREST 287

22.8 INSURANCE FOR CONTRACTOR'S EMPLOYEES 288
22.9 IMMIGRATION AND CONTROL ACT OF 1986 288
22.10 SEVERABILITY 288
22.11 ANTI-BOYCOTT COVENANT 288
22.12 RECORD RETENTION, INSPECTION, AND AUDITS 288
22.13 OPERATION OF OTHER CONTRACTS 289
22.14 PREVAILING CONTRACT 289
22.15 NO THIRD-PARTY RIGHTS OR ENFORCEMENT 289
22.16 EFFECT OF INVALIDITY OF CLAUSES 289
22.17 APPLICABLE LAW 289
22.18 SOVEREIGN IMMUNITY 290
22.19 WAIVER OF RIGHTS 290
22.20 INSPECTION 290
22.21 DEBARMENT STATUS 290
22.22 ANTITRUST 290
22.23 DRUG-FREE WORKPLACE 290
SECTION 23.0 DEFINITIONS AND ACRONYMS 291
23.1 DEFINITIONS 291
23.2 ACRONYMS 324
ATTACHMENTS 329
ATTACHMENT 1 - CCC PLUS CONTRACTOR SPECIFIC CONTRACT TERMS 330
ATTACHMENT 2 - BUSINESS ASSOCIATE AGREEMENT 332
ATTACHMENT 3 - BHSA/CCC PLUS MCO COORDINATION AGREEMENT 338
ATTACHMENT 4 - SAMPLE CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION 341
ATTACHMENT 5 - CCC PLUS COVERAGE CHART 342
ATTACHMENT 6 - DMAS DEVELOPMENTAL DISABILITY WAIVER SERVICES 411
ATTACHMENT 7 - CCC PLUS PROGRAM REGIONS AND LOCALITIES 412
ATTACHMENT 8 - COMMON DEFINITIONS FOR MANAGED CARE TERMS 413
ATTACHMENT 9 - CERTIFICATION OF DATA (NON-ENCOUNTER) 416
ATTACHMENT 10 – EI FAMILY DECLINING TO BILL PRIVATE INSURANCE 417
ATTACHMENT 11 - MOC ASSESSMENT (HRA) AND INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS BY POPULATION 418
ATTACHMENT 12 - INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS CHECKLIST (PER CMS FINAL RULE) 419
ATTACHMENT 13 - NOTIFICATION OF PROVIDER INVESTIGATION 420
ATTACHMENT 14 – CCC PLUS WAIVER CHANGE NOTICE FORM 422

SECTION 1.0 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 Medicaid managed long term services and supports to individuals enrolled in the Department's Commonwealth Coordinated Care Plus (CCC Plus) Program. In accordance with MLTSS RFP-2016-01, the initial period of this Contract was from August 1, 2017 through December 31, 2017, and automatically renews annually thereafter on January 1 (per calendar year) for a period of five (5) calendar years with the potential for up to five (5) 12-month extensions. Refer to Section 21.0 *Renewal/Termination of Contract* for terms and conditions. All Contracts and rates will be renewed annually as needed, subject to CMS and Virginia legislative approval.

Under this Contract, the Contractor shall operate in all 6 (six) regions of the Commonwealth and in all localities in each region, except as outlined in Section 2.2 *Readiness Review*. 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.

1.1 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS

The documents listed herein shall constitute the 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
- 1915(b)(c) CCC Plus Waivers
- State Statutes
- State Regulations
- Virginia State Plan
- CCC Plus Contract, including all amendments and attachments including Medicaid memos and relevant manuals, as updated
- CCC Plus Technical Manual including CCC Plus Core Performance Measures List
- CCC Plus Encounter Technical Manual
- ARTS Technical Manual
- CCC Plus Program Operational Memoranda and Guidance Documents
- CCC Plus Model Member Handbook
- DMAS Network Submission Requirements Manual (NSRM)

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 member handbook shall not take precedence over the services required under this Contract or the State Plan for Medical Assistance.

1.1.1 Guidance Documents and Department Forms

The Department may issue guidance documents and program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and clarification of coverage. The Contractor shall comply with all such program memoranda. In addition, DMAS program policy manuals, Medicaid Memos and forms used in the administration of benefits for Medicaid individuals and referenced within this Contract are available on the DMAS web portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

1.2 COMMITMENT TO DEPARTMENT GOALS FOR DELIVERY SYSTEM REFORM AND PAYMENT TRANSFORMATION

The Contractor shall work collaboratively with the Department on Health Information Exchange, Medicaid delivery system reform, payment reform, and other future key initiatives.

SECTION 2.0 REQUIREMENTS PRIOR TO OPERATIONS

2.1 ORGANIZATIONAL STRUCTURE

2.1.1 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.

2.1.2 Dedicated Project Director and Project Manager

The Contractor shall have a dedicated Virginia CCC Plus 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, if desired, may provide oversight for both the Virginia CCC Plus program and the Virginia D-SNP program. The Contractor's Project Director and Project Manager are expected to attend all meetings required by DMAS.

2.1.2.1 Project Director

The Contractor's Project Director shall be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia business. The CCC Plus Project Director shall be solely responsible to the Contractor (not a third party administrator) and comply with all requirements of this Contract in that capacity.

2.1.2.2 Project Manager

The CCC Plus Project Manager shall have the ability to make timely decisions about the CCC Plus program issues and shall represent the Contractor at the Department's meetings. The CCC Plus 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, claim payment, provider relations/contracting, and issues related to the health, safety, and welfare of the Members.

2.1.3 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, Long Term Services and Supports Director, and Care Coordination Manager able to perform comprehensive oversight and comply with all requirements covered under this Contract.

2.1.4 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.

The Contractor shall have dedicated staff available at all times during business hours or providers to call for assistance regarding the CCC Plus program including but not limited to community based providers and nursing facilities. These dedicated provider assistance staff shall be able to guide providers in all areas of the program and in all long term services and supports offered by the program. Refer to *Provider Services and Claims Payment* section of this Contract.

2.1.5 Consumer Direction Services Manager

The Contractor shall have a dedicated project manager for Consumer Directed (CD) services. The complexities of Consumer Direction require that the CD project manager focus on the many areas of consumer direction, patient pay and working with the Fiscal/Employer Agent. The CD project manager shall be the chief liaison with the F/EA, including troubleshooting payment issues, and serving as the Contractor's Subject Matter Expert (SME) for consumer direction. This individual shall not have major responsibility for any other portion of the CCC Plus contract. Refer to the various sections of this Contract referencing Consumer Direction and/or Patient Pay.

2.1.6 First-Tier, Downstream, and Related Entities

The Contractor shall have a detailed plan in place to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the Contractor, including encounter data, enrollment, credentialing and recredentialing policies and procedures. The plan shall be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities.

2.1.7 Care Coordination Staffing

The Contractor's Care Coordination staff must be sufficient for its enrolled population and located within the geographic region where the Contractor operates. Additionally, in each region where the Contractor participates and serves CCC Plus Members, the Contractor shall have at least one (1) dedicated Care Coordinator without a caseload to assist individuals with the goal of transitioning from institutional care to the community. See *CCC Plus Model of Care* section of this Contract for more information.

2.1.8 Key Personnel

The Contractor's Project Director, Project Manager, Chief Medical Officer/Medical Director, Pharmacy Director, Behavioral Health Director, Director of Long Term Services and Support, Chief Financial Officer, Chief Operating Officer or Director of Operations, Quality Director, Senior Manager of Clinical Services, Claims Director, IT Director, Compliance Officer, ADA Compliance Director (can be the same as the Compliance Officer), and/or equivalent position(s) are "key personnel." The Contractor shall submit to the Department the name, resume, and job description for each of the key personnel to the Department within five (5) business days of

executing this Contract. Reference Section 10.5 for additional staffing qualifications for the Quality Director and quality management and improvement related staffing requirements.

2.1.9 Notification of Key Personnel Changes

At any time during the effective dates of this Contract, if the Contractor substitutes another individual in a key staff position or whenever a key staff person vacates the assigned position, the Contractor shall notify the Department within five (5) business days and provide the name(s) and resume(s) of qualified permanent or temporary replacement(s).

2.1.10 Department Concerns Related to Staffing Performance

If the Department is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for in the person's position description, the Contractor will be informed of this concern. The Contractor shall investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify the Department of such actions. If the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by the Department, corrective action provisions may be invoked.

2.2 READINESS REVIEW

The Department and/or its duly authorized representatives shall conduct readiness review(s) which may include desk reviews and site visits. This review(s) shall be conducted prior to enrollment of any Members with the Contractor and/or prior to the renewal of the Contract. The purpose of the review is to provide the Department with assurances that the Contractor 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 Contractor with respect to meeting program standards set forth in the Federal and State regulations and this Contract, as well as any goals established by the Department. The scope of the readiness review(s) shall include, but is not limited to, a review of the following elements:

1) Network Provider composition and access;
2) Staffing, including Key Personnel and functions directly impacting Members (e.g., adequacy of Member Services staffing);
3) Care coordination capabilities;
4) Content of Provider Contracts, including any Provider Performance Incentives;
5) Member Services capability (materials, processes and infrastructure, e.g., call center capabilities);
6) Comprehensiveness of quality management/quality improvement and utilization management strategies;
7) Internal grievance and appeal policies and procedures;
8) Monitoring of all first tier, downstream, and related entities
9) Fraud and abuse and program integrity policies and procedures;
10) Financial solvency;
11) Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, including IT testing and security assurances.

No individual shall be enrolled into the Contractor's health plan prior to the Department making a determination that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

As a result of findings from 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 CCC Plus program if the Contractor fails the Readiness Review within the timeframe specified.

This contract is for all contracted health plans to participate statewide in all regions and localities. However, the Department further reserves the right to deny participation in certain cities/counties where it is found the Contractor has either network or staffing inadequacy. At that time, the Department may utilize one or all of the following: (1) issue a corrective action plan outlining the problematic areas and the timeframe required for compliance; (2) freeze enrollment statewide for any new Members until statewide participation is reached; and/or (3) terminate this contract (refer to Section 21.0 *Renewal/Termination of Contract*).

2.3 LICENSURE

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

2.4 CERTIFICATION OF QUALITY

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 the health care services they deliver. Failure to maintain certification may result in termination of this Contract. A copy of this certification shall be submitted with the signature page at each annual contract renewal.

2.5 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

The Contractor shall obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA). If the Contractor is not accredited at start-up, the Contractor shall adhere to NCQA standards while working toward accreditation based on the most current version of NCQA Health Plan Accreditation Standards. Refer to 10.17 *National Committee for Quality Assurance (NCQA) Accreditation* section for more details regarding requirements, milestones and related timelines.

The Contractor shall advise the Department within ten (10) calendar days if the Contractor has received notification from NCQA of a change in its accreditation status.

2.6 DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

The Contractor shall have an approved Dual Eligible Special Needs Plan (D-SNP) contract in all localities in each region where the health plan provides services under the CCC Plus program Contract or begin operating a D-SNP in all localities in each region where the health plan provides services under this Contract within two (2) years of being awarded a CCC Plus program Contract.

At the Department's discretion, failure to comply with this requirement may deem the Contractor non-compliant and subject to termination of this Contract. Refer to *Renewal/Termination of Contract.*

The Contractor shall respond to requests from the Department for D-SNP operational, benefit, network, performance, financial, and oversight information that directly impacts the continued integration of Medicare and Medicaid benefits in order to maintain a seamless service delivery of Medicare and Medicaid benefits to dual eligible Members. The Contractor also shall notify the Department of significant changes in Medicare information to beneficiaries, benefits, networks, service delivery, oversight results, or policy that are likely to impact the continued integration of Medicare and Medicaid benefits under this Contract.

2.7 BUSINESS ASSOCIATE AGREEMENT (BAA)

The Contractor shall be required to enter into a DMAS-approved *Business Associate Agreement* (BAA) (attached) 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 the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to the Department or CMS.

2.8 AUTHORIZATION TO CONDUCT BUSINESS IN THE COMMONWEALTH

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

2.9 CONFIDENTIALITY STATUTORY REQUIREMENTS

The Contractor understands and agrees that DMAS may require specific written assurances and further agreements regarding the security and privacy of protected health information that are

deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 CFR, parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under the *Code of Virginia* § 32.1-127.1:03. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 USC§ 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

2.9.1 Federal Confidentiality Rules Related To Drug Abuse Diagnosis and Treatment

The Contractor shall comply with Federal confidentiality law and regulations (codified as 42 USC § 290dd-2 and 42 CFR Part 2 ("Part 2")) outlines under what limited circumstances information about the patient's substance use disorder treatment may be disclosed with and without the client's consent. 42 CFR Part 2 applies to any individual or entity that is Federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any Federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser …" (42 CFR § 2.12(a) (1)). With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.
The Contractor will not be held accountable to provide care coordination under Addiction and Recovery Treatment Services (ARTS) if they have not received written disclosure from the Member's provider.

2.10 DISCLOSURE OF 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) or persons or corporations with an ownership or control interest in the Contractor's plan:

- 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 interest in the Contractor's plan 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 on whether a person or corporation with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling;
- Information of any other disclosing entity in which an owner of the Contractor has an ownership or control interest;
- 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 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. The Contractor shall also disclose the information described in this section at least five (5) calendar days prior to any change in ownership, concerning each Person with Ownership or Control Interest. In accordance with Section 1903(m)(4)(B) of the Act, the Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the state, or other agencies available to its Members upon reasonable request.

Additionally, the Contractor shall submit the completed form to the Department within 35 calendar days of the Department's request. 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 the *Enforcement, Remedies and Compliance* section 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 listing 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 the Contractor's 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.

2.11 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.

The Contractor shall report to the Department within five (5) calendar days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor. Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

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 nonprocurement 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:

i. shall notify the Secretary of the noncompliance;
ii. may continue an existing agreement with the Contractor unless the Secretary directs otherwise; and,
iii. 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.

2.12 EXCLUDED 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 who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the DMAS Medicaid or FAMIS programs. The Contractor shall also exclude from participation in the Contractor's plan any provider or administrative entities which have a direct or indirect substantial contractual relationship with such an excluded or debarred individual or entity. 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.
(iv) Entities who are to be excluded per *Code of Virginia* § 32.1- 325.

(v) Prohibited Affiliations with Entities Debarred by Federal Agencies, see §13.3(a).

2.13 CONTRACTOR COMPLIANCE PROGRAM

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

1. Articulate the Contractor's commitment to comply with all applicable Federal and State standards;
2. Describe compliance expectations as embodied in the standards of conduct;
3. Implement the operation of the compliance program;
4. Provide guidance to employees and others on dealing with potential compliance issues;
5. Identify how to communicate compliance issues to appropriate compliance personnel;
6. Describe how potential compliance issues are investigated and resolved by the Contractor; and,
7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

SECTION 3.0 ENROLLMENT AND ASSIGNMENT PROCESS

3.1 ELIGIBILITY AND ENROLLMENT RESPONSIBILITIES

The Department shall have sole responsibility for determining the eligibility of an individual for Medicaid funded services. The Department shall also have sole responsibility for determining enrollment with the Contractor and such determinations shall be final and are not subject to review or appeal by the Contractor.

3.1.1 Eligible Populations

The Contractor shall enroll and provide coverage for Members as determined by the Department. The following populations shall be included in the CCC Plus program:

1) Dual eligible individuals with full Medicaid and any Medicare A and/or B coverage.

2) Non-dual eligible individuals who receive LTSS, either through:
   a) An institution; or,
   b) These HCBS 1915(c) waivers:
      i. Building Independence (BI);
      ii. Commonwealth Coordinated Care (CCC) Plus;
      iii. Community Living (CL); and,
      iii. Family and Individual Supports (FIS).

   This includes individuals who transition from Medallion 3.0.

3) Individuals enrolled in the Commonwealth Coordinated Care (CCC) program will transition to the CCC Plus program on January 2018, which is after the CCC program ends.

4) Remaining ABD population (non-duals and those who do not receive LTSS). The majority of this population will transition from the Department's Medallion 3.0 program to the CCC Plus program on January 1, 2018.

5) The CCC Plus program populations listed above may include individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance, individuals with Alzheimer's disease and persons with dementia, and individuals approved by DMAS as inpatients in long-stay hospitals (the Department recognizes two facilities: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]).

6) In addition, individuals enrolled in the Building Independence, Community Living, and Family and Individual Supports Waivers will be enrolled in CCC Plus program for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services).

7) The Department reserves the right to transition additional populations and services into the CCC Plus program in the future.

   a) The AAL Waiver will discontinue on June 30, 2018. At that time, individuals who were enrolled in the AAL Waiver may become enrolled in the CCC Plus program if they meet

the eligibility requirements of the program. The Department will provide communication and/or require workgroups with the Contractor to transition these individuals from an assisted living facility to the CCC Plus program.

3.1.2 Exclusions From CCC Plus Program Participation

Individuals enrolled in CCC Plus program who subsequently meet one or more of the criteria outlined below shall be excluded as appropriate by DMAS. The Department shall also have sole responsibility for determining the program exclusion for these individuals. Individuals excluded from CCC Plus program enrollment shall receive Medicaid services under the current FFS system unless eligible for one of DMAS' other managed care programs. When individuals no longer meet the criteria for CCC Plus program exclusion, they shall be required to re-enroll in the CCC Plus program. DMAS shall exclude individuals who meet at least one of the exclusion criteria listed below:

1) Individuals enrolled in the Commonwealth's Medallion 3.0 and Title XXI CHIP programs (FAMIS, FAMIS MOMS).
2) Individuals enrolled in a PACE program.
3) Individuals enrolled in the Alzheimer's Assisted Living Waiver. However, individuals with Alzheimer's disease and persons with dementia will be included if they meet other eligibility requirements and are not enrolled in the Alzheimer's Assisted Living Waiver. Refer to Model of Care Section 5.1.1.1 for more information. Also, refer to 3.1.1, 7.a.
4) Newborns whose mothers are CCC Plus Members on their date of birth. However, the Contractor must adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form per http://www.dmas.virginia.gov/Content_atchs/mch/dmas-213mco.docx.
5) Dual eligible individuals *without full Medicaid* benefits, such as:
    i. Qualified Medicare Beneficiaries (QMBs);
    ii. Special Low-Income Medicare Beneficiaries (SLMBs);
    iii. Qualified Disabled Working Individuals (QDWIs); or,
    iv. Qualifying Individuals (QIs).-Medicaid pays Part B premium.
6) Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
7) Individuals with temporary coverage or who are in limited coverage groups, including:
    a. Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention).
    b. Individuals enrolled in the Governor's Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories.
8) Individuals enrolled in a Medicaid-approved hospice program will not be auto-enrolled. However, if an individual enters a hospice program while enrolled in the CCC Plus program, the Member will remain enrolled in CCC Plus for those services.
9) Individuals who live on Tangier Island.
10) Individuals under age 21 who are approved for DMAS psychiatric residential treatment facility (formerly Level C) (PRTC) programs as defined in 12VAC 30-130-860.
11) Individuals with end stage renal disease (ESRD) and in fee-for-service at the time of enrollment will be auto-enrolled into the CCC Plus program but may request to be disenrolled and remain in fee-for-service. DMAS will manually exclude these individuals

if requested by Member within the first ninety (90) days of CCC Plus enrollment. However, an individual who does not request exclusion within the first ninety (90) days of CCC Plus enrollment or who develops ESRD while enrolled in the CCC Plus program will remain in CCC Plus.

12) Individuals who are institutionalized in state or private ICF/ID and state ICF/MH facilities. A State acute care facility **is not** excluded.
13) Individuals who reside at Piedmont, Catawba, Hiram Davis, and Hancock State facilities operated by DBHDS.
14) Individuals who reside in nursing facilities operated by the Veterans Administration, or individuals who elect to receive nursing facility services in The Virginia Home Nursing Facility or in local government-owned nursing homes. These include the following nursing facilities:

CCC Plus Excluded Nursing Facilities	NPI
Bedford County Nursing Home	1669440715
Birmingham Green	1477586550
Dogwood Village of Orange County Health	1932216546
Lake Taylor Transitional Care Hospital *(Different from Lake Taylor Long-Stay Hospital)*	1336101039
Lucy Corr Nursing Home	1992713812
The Virginia Home Nursing Facility	1669432951
Virginia Veterans Care Center	1730187048
Sitter & Barfoot Veterans Care Center	1619184645

15) Individuals enrolled in the Department's Money Follows the Person (MFP) Demonstration project.
16) Individuals participating in the CMS Independence at Home (IAH) demonstration (DMAS will manually exclude these individuals). However, IAH individuals may enroll in the CCC Plus program if they choose to disenroll from IAH.
17) Certain individuals receiving treatment in facilities located outside of Virginia as authorized by DMAS.
18) Individuals who are incarcerated. (Individuals on house arrest are not considered incarcerated.)
19) Individuals who reside in the Virginia Home Nursing Facility will be temporarily excluded from CCC Plus. DMAS will transition the enrollment for Virginia Home residents to CCC Plus during a later implementation phase and through a transition plan that addresses the unique needs of the Virginia Home population and its system of care. DMAS will develop the transition plan in collaboration with the Virginia Home and the CCC Plus health plans.
20) Pregnant individuals who are within their first ninety (90) days of initial managed care enrollment, in their 3rd trimester of pregnancy, and their provider (including midwife) is not participating with the Contractor, upon request of the Member.
21) Individuals enrolled in the Birth Injury Fund (refer to Section 23.1).

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

3.2 CCC PLUS ENROLLMENT PROCESS

Enrollment in the CCC Plus program is mandatory for eligible individuals as described in Section 3.1 above. All eligible Members, except those meeting one of the exclusions outlined in Section 3.1.2 above, shall be enrolled in CCC Plus program.

The Contractor may receive enrollment on an individual who lives in a locality (i.e., Richmond) outside of the enrollment region (i.e., Norfolk). Unless these individuals meet a specific requirement for exclusion, these individuals shall remain enrolled with the Contractor for all contractually required and medically necessary services under this Contract. The Contractor shall coordinate care and work with providers in the locality where the Member is receiving services.

3.2.1 Monthly Assignment Process

The CCC Plus program enrollment process will run monthly on the night of the 18th and will determine the Member's initial health plan default assignment. The Member health plan default assignment is based upon the plans that have been approved by DMAS for participation in the Member's locality of residence and the Department's intelligent assignment rules. There shall be no retroactive enrollment in the CCC Plus program.

3.2.2 Intelligent Assignment

DMAS will use the following intelligent assignment methodology to determine the Member's default health plan assignment, in the following order of priority:

1) If known, most recent previous Medicare (excluding Part D only plans) managed care enrollment within the past two (2) months;
2) Most recent previous Medicaid managed care enrollment (i.e., Medallion 3.0, CCC, CCC Plus) within the past two (2) months;
3) Individuals in a Nursing Facility will be assigned to a Contractor that includes the individual's Nursing Facility in its network, based upon the Contractor's successful submission of the provider record on the PSF106 file. If the Nursing Facility is in more than one Contractor's network, the assignment will be random between the Contractors with the Nursing Facilities in the network;
4) Individuals in the CCC Plus Waiver who receive adult day health care (ADHC) services will be assigned to a Contractor that includes the individual's ADHC provider in its network, based upon the Contractor's successful submission of the provider record on the PSF106 file. If more than one Contractor's network includes the individual's ADHC provider in its network, the assignment will be random between the Contractors;
5) Individuals in the CCC Plus program receiving technology assistance under the CCC Plus HCBS waiver will be assigned to a Contractor that includes the individual's private duty nursing provider, based upon the Contractor's successful submission of the provider record on the PSF106 file. If more than one Contractor's network includes the individual's private duty nursing provider in its network, the assignment will be random between the Contractors; and,
6) If none of the above applies to the individual, the Member will be randomly assigned to a Contractor in the individual's locality (in approximately equal numbers by Contractor). A limit of 70% of enrolled lives within an operational region **may** be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an

operational region exceed 70%, the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at 70% or below. However, the enrollment cap may be exceeded due to Member-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary.

The Department reserves the right to revise the intelligent assignment methodology, as needed based upon DMAS' sole discretion.

3.2.2.1 Aged, Blind, and Disabled Transition from Medallion

The aged, blind and disabled (ABD) population transitioning from Medallion to the CCC Plus program shall use a one-time, minimum threshold assignment process. The minimum threshold shall equal 12,000 Member lives. Individuals will be assigned during the November 2017 assignment cycle for an effective date of January 1, 2018, and as follows:

1) Based upon the actual enrollment count as of November 3, 2017, any health plan that has less than 12,000 assigned lives will receive priority assignment up to the minimum threshold.
2) After any necessary priority assignments are made to reach the said threshold across all six (6) CCC Plus health plans, the remaining individuals will be assigned equitably across plans. Assignment for remaining participants will consider previous managed care history up to the equitable amount. All remaining assignments will be randomly assigned.
3) Members will have approximately forty (40) days in which to change their assigned health plan prior to the CCC Plus enrollment effective date. Members will also be permitted to change without cause during the initial ninety (90) days of enrollment.

3.2.3 Enrollment Process for Individuals Hospitalized at Time of Enrollment

Members who are hospitalized at the time of enrollment (other than those listed in the *Exclusions from CCC Plus Program Participation* section of this Contract) will be enrolled through the CCC Plus enrollment process described above. The Contractor shall be responsible for the Member's care and treatment on the Member's effective date of enrollment with the Contractor regardless of the hospital admission date. The Contractor shall make every effort to reach out to these individuals immediately upon learning of their enrollment/ hospitalization to assure care coordination services and discharge planning are handled appropriately. Refer to Section 12.4.9 for payment of services for individuals hospitalized at time of enrollment.

3.2.4 Enrollment Process for Pregnant Individuals

Members who are pregnant, other than those listed in the *Exclusions from CCC Plus Program Participation* section of this Contract, will be enrolled following the described CCC Plus enrollment process. The Contractor shall reach out to these individuals immediately upon learning of the pregnancy to assure continuity of care and care coordination services are handled appropriately.

3.2.5 Enrollment Process for Newborns

When a CCC Plus Member is enrolled with the Contractor and gives birth during this enrollment, the newborn's related birth and subsequent charges are not the responsibility of the Contractor. The Contractor shall inform mother/parent/guardian that in order for the newborn to be covered,

the mother/parent/guardian must report the birth of the child by either calling the Cover Virginia Call Center at (855) 242-8282 or by contacting the Member's local Department of Social Services. The Contractor must also adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form available at: http://www.dmas.virginia.gov/Content_atchs/mch/dmas-213mco.docx. Once Medicaid enrolled, the newborn is the responsibility of FFS Medicaid until such time as the newborn is enrolled in one of the Department's Medicaid managed care programs.

3.2.6 Enrollment Process for Foster Care and Adoption Assistance Children

The Contractor shall cover services for CCC Plus program enrolled foster care & adoption assistance children (designation codes 076 and 072, respectively). Foster Care and Adoption Assistance children shall be considered one of the CCC Plus vulnerable sub-populations. Refer the attached *MOC Assessment (HRA) and Individualized Care Plan (ICP) Requirements by Population* for guidance on assessment, reassessment, and ICP development timelines. The Contractor shall work collaboratively with DMAS and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care. The Contractor shall comply with the following rules:

1) For decisions regarding the foster care child's medical care, the Contractor shall work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child's medical care, the Contractor shall work directly with the adoptive parent.
2) The social worker will be responsible for all changes to MCO enrollment for foster care children. The adoptive parent will be responsible for all changes to MCO enrollment for adoption assistance children. An enrollment change can be requested at any time that the child is placed in an area not serviced by the MCO where the child is enrolled.
3) 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.
4) If the Contractor has found that the foster care child has been placed in an area other than the one where the Contractor participates, the Contractor may contact the social worker to request a change of health plan be initiated.
5) The Contractor shall work with DSS in all areas of care coordination.
6) Foster care children are not restricted to their health plan selection following the initial ninety (90) day enrollment period.
7) The Contractor shall provide coverage for all contractual covered services until DMAS disenrolls the child from the Contractor's plan. This includes circumstances where a child moves out of the Contractor's service area.

The Contractor shall report monthly to the Department any barriers identified in contacting and/or providing care to foster care children (Aid Category 076). The Barrier Report will provide DMAS with needed information to assist the Contractor in resolving the barriers reported. Refer to the CCC Plus Technical Manual for Barrier Report specifications.

For individuals enrolled with the Contractor who are former foster care children (Aid Category 070), the Contractor shall communicate with the Member directly for any care coordination, service and/or program related issues. These individuals have the same restrictions on health

plan enrollment changes as any other CCC Plus program enrolled Member except foster care and adoption assistance individuals (See *Health Plan Enrollment Changes* in Section 3.2.14.)

3.2.7 Enrollment Process for Medallion 3.0 Health and Acute Program (HAP) and Commonwealth Coordinated Care Dual Demonstration Program Members

For the initial enrollment into the CCC Plus program, whenever possible, the initial assignment for individuals that are enrolled in HAP and the CCC programs will maintain the Member's existing managed care relationship. (e.g., if the Member's CCC Contractor is also a CCC Plus Contractor, that Member will be enrolled with that Contractor). If the HAP or CCC individual's Contractor does not participate in CCC Plus program, the Member will be assigned based on the intelligent assignment rules. The Member can elect to choose a different CCC Plus Contractor.

3.2.8 Alignment with D-SNP

Dual eligible Members will have the option of having their CCC Plus program and Medicare services coordinated by the same Contractor. Therefore, the Contractor shall educate the Member on benefits of alignment and encourage dual Members that are enrolled with them for the CCC Plus program to also enroll in their companion D-SNP for the Medicare portion of their benefits. However, these Members will continue to have the option of receiving their Medicare benefits from fee-for-service Medicare or through another Medicare Advantage/D-SNP Plan.

3.2.9 Contractor Responsibilities Related to Enrollment

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.

In accordance with 42 CFR § 438.56, the Contractor shall not request that the Department disenroll a Member for any reason, including but not limited to: because of an adverse change in the enrollee's health status, the Member's utilization of medical services; a Member's diminished mental capacity; or, a Member's uncooperative or disruptive behavior resulting from his or her special needs.

The Contractor shall refer Members and Potential Members who inquire about CCC Plus 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 is without regard to health status, physical or mental condition or disability, age, sex, national origin, race, or creed.

The Contractor shall notify the Department within two (2) business days upon learning that a Member meets one or more of the CCC Plus 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. (See CCC Plus Technical Manual for reporting requirements.)

The Contractor shall be responsible for keeping its network providers informed of the enrollment status of each Member. The Contractor shall 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 *Member Communications and Enrollment Materials.*

3.2.10 Initial Enrollment Notice

The Department shall send Members an initial assignment notice approximately one (1) week after initial MCO assignment. This initial notification letter is mailed to the Member and includes the Member's default MCO assignment and the CCC Plus MCO comparison chart for the Member's region. Initial notices also specify a "call by" date on or before the 18th of the month prior to the MCO effective date for the Member to confirm their default MCO assignment or to choose a different MCO. The Member's initial notice also explains if the Member does not call by the "call by date" they will be enrolled with the default MCO, and provides the default MCO enrollment effective date.

3.2.11 Enrollment Confirmation Notice

The Department shall send Members a confirmation notice confirming MCO final assignment and the Member's right to change from one MCO to another during their initial ninety (90) calendar days of CCC Plus program enrollment. The confirmation notice is generated approximately a week prior to the effective date of MCO enrollment. Changes made on or before the 18th will be effective the following month (March 1st, if made in February) and will trigger a confirmation letter in the current month (February). Changes made after the 18th will be effective 2 months in the future (April 1st, if made in February) and will trigger a confirmation letter the following mid-month (March).

3.2.12 Enrollment Effective Time

All enrollments are effective 12:00 a.m. on the first day of the first month in which they appear on the enrollment report. The Contractor shall not be liable for the cost of any covered services prior to the effective date of enrollment/eligibility but shall be responsible for the costs of covered services obtained on or after 12:00 a.m. on the effective date of enrollment/eligibility.

3.2.13 Automatic Re-enrollment

CCC Plus program individuals who have been previously enrolled with the Contractor and who regain eligibility for the CCC Plus program within sixty (60) calendar days of the effective date of exclusion or disenrollment will be reassigned to the Contractor without going through the selection or assignment process. The Department will send Members a notice informing them of their re-enrollment with the Contractor.

3.2.14 Health Plan Enrollment Changes

Individuals will be permitted to change from one Contractor to another for cause at any time and without cause as follows:

1) For the initial ninety (90) calendar days (3 calendar months) following the effective date of CCC Plus program enrollment with a health plan, the individual will be permitted to change

from one Contractor to another without cause. This ninety (90) day time frame applies only to the individual's initial program start date of enrollment. It does not reset or apply to any subsequent enrollment periods with a different Contractor. After the initial ninety (90) day period following the initial enrollment date, he or she may not disenroll without cause until the next open enrollment period.

2) In accordance with §438.56(c)(2)(iv), when the Department imposes the intermediate sanction specified in 42 CFR §438.702(a)(4).

3) Following their initial 90-day enrollment period, individuals (other than Foster Care and Adoption Assistance children) shall be restricted to their Contractor selection until the open enrollment period, unless disenrolled under one of the conditions described and pursuant to Section 1932 (a)(4)(A) of Title XIX. The individual may disenroll from any contracted Contractor to another at any time, for cause, as defined by the *Cause for Enrollment Changes* section of this Contract.

4) DMAS will notify individuals of their ability to change Contractors during an annual open enrollment period at least ninety (90) calendar days before the end of their enrollment period.

3.2.15 Cause for Enrollment Changes

Consistent with § 1932(a)(4) of the Social Security Act, as amended (42 USC § 1396u-2), the Department must permit a Member to disenroll from one health plan to another at any time for cause. In accordance with 42 CFR §438.56, a Member may disenroll from his/her current plan to another plan for the following reasons:

1) The Member moves out of the Contractor's service area;
2) The Contractor does not, because of moral or religious objections, cover the service the Member seeks;
3) The Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk;
4) The Member who receives LTSS would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment; and,
5) Other reasons as determined by the Department, including poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the Member's care needs.

The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR § 438.56(d)(2). The Department will respond to "cause" requests, in writing, within fifteen (15) business days of the Department's receipt of the request. In accordance with 42 CFR § 438.56(e)(2), 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.

If Member is dissatisfied with the good cause for disenrollment from one plan to another determination made by the Department the Member may appeal through the *State Fair Hearing Process* per Section 15.5 of this Contract.

3.2.16 Disenrollment Effective Time

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

3.2.17 Loss of CCC Plus Enrollment

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

- Death of the Member;
- Cessation of Medicaid eligibility;
- Member meets at least one of the exclusion criteria listed in the *Exclusions from CCC Plus Program Participation* section of this Contract (the Department shall determine if the Member meets the criteria for exclusion);
- Transfer to a Medicaid eligibility category not included in this Contract; or,
- Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

In certain instances, a Member may be excluded from participation effective with retroactive dates of coverage. Reference *Benefits and Service Requirements.*

3.2.18 Informing of Potential Ineligibility

At least monthly, the Department or its enrollment broker will share with the Contractor data regarding reasons for enrollment and disenrollment (via the MCO Change Report). When a Member for whom services have been authorized but not provided as of the effective date of exclusion or disenrollment, the Contractor shall provide to the Department and the relevant provider the history for that Member upon request. The Contractor shall provide this service authorization history to the Department using the Medical Transition Reporting process described in the CCC Plus Technical Manual.

3.2.19 Monthly and Weekly 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 CCC Plus MCO program disenrollments. The monthly 834 file will contain information about the Contractor's CCC Plus 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. The 834 includes all related CCC Plus Members' Level of Care

(LOC) benefit information, including retro changes, based upon the transaction date. For example, the 834:

1) Includes current and future-dated assignments (1 or 2 months in future - includes March and April for February run);
2) Includes both future-ended and open-ended Members;
3) Reflects Members cancelled as of current month-end as dropped;
4) Includes retro enrollments for level of care (LOC);
5) Files on the 6th and 13th will only include audit (changes)/adds/drops since last 834 was created;
6) Files on the 6th and 13th are also triggered by a Member's health plan change, benefit plan, or exception indicator (anything that is included on the 834);
7) Reflects if Member is added and then dropped within a couple of days (within same report period and same health plan) as both an ADD and a DROP;
8) Reflects moving from the Contractor's plan to a new plan as a DROP and moving from another plan to the Contractor's Plan as an ADD.
9) Reflects changes to the LOC or other information as an AUDIT (CHANGE), not both a DROP and ADD.

3.2.20 Medical Transition Report (MTR) File

The Department will send a Medical Transition Report (MTR) File to the Contractor (with the 834) on the 6th, 13th, 19th, and at the end of each month (EOM). The Contractor will receive one full MTR with the earliest 834 run that reflects a Member's enrollment with the Contractor. The full MTR includes claims and encounter history for the past two (2) years and any active Service Authorization (SA) history for the previous six months.

The Contractor will also receive interim MTRs (which will include SA information only) on the 6th, 13th, 19th, and EOM. An interim MTR is only sent for Members who have experienced SA changes since the prior full/interim MTR. Therefore, if a Member has not had any changes since the last report, the Member will not appear on the Contractor's interim MTR. The MTR and 834 may not match for the same reporting period. The Contractor shall have established procedures in which this critical service information is reviewed, incorporated into the Contractor's system(s) as needed, SAs are honored, and care coordination is initiated for these Members.

When the Contractor is notified by the Department that a Member has disenrolled from its plan, the Contractor shall send MTR files for the Member's active service authorizations (SA only) to DMAS. The files shall be sent to the Department within three (3) business days of notification on the 834 that shows that the Member is being disenrolled. The Contractor shall send MTR files on the 9th, 16th, 22nd, and the 3rd. The Contractor shall also send an interim MTR one day prior to the last day of the month, for a total of five (5) MTR reports during a month. Only changes from the prior MTR are to be reported. MCO MTR information shall be sent using the established MTR format reflected in the CCC Plus Technical Manual. In circumstances where a Member changes from one MCO to another, DMAS will share the prior MCO's MTR information with the new MCO for care coordination, utilization management and other related activities.

SECTION 4.0 BENEFITS AND SERVICE REQUIREMENTS

4.1 GENERAL BENEFITS PROVISIONS

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase or otherwise make available the full continuum of services required under this Contract to all of its Members, including: acute and primary, institutional and community-based LTSS, behavioral health, and special Medicaid services outlined in this section. As provided in 42 CFR § 438.210 (a)(5)(i), the Contractor's medical necessity criteria shall not be more restrictive than the Department's criteria. The Contractor's coverage rules for contract covered services shall also ensure compliance with Federal EPSDT coverage requirements for Members under the age of 21. The Contractor shall provide services *at least* in equal amount, duration, and scope as available under Medicaid fee-for-service program and as described in the Attached *CCC Plus Coverage Chart*.

The Contractor shall assume responsibility for all covered medical conditions of each Member as of the effective date of coverage under the CCC Plus program, regardless of the date on which the condition was first diagnosed. The Contractor shall cover all pre-existing conditions.

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

4.1.1 Laboratories

In accordance with 42 CFR§§ 493.1 and 493.3, all laboratory testing sites providing services under this Contract are required to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

4.2 BEHAVIORAL HEALTH SERVICES

4.2.1 Inpatient and Outpatient Services

The Contractor shall provide coverage for Medicaid covered inpatient and outpatient behavioral health treatment services to its CCC Plus Members within the amount, duration, and scope described in the attached *CCC Plus Coverage Chart*. The Contractor's medical necessity criteria shall be consistent with Federal, State, and the Department's guidelines. The Contractor's coverage rules and authorization practices shall at all times comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). Reference *State Plan Substituted Services (In Lieu of Services).*

4.2.2 Community Mental Health Rehabilitation Services (CMHRS)

Effective with dates of service on or after January 1, 2018, the Contractor shall provide coverage for the subset of behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS). CMHRS are listed in the table below and are explained in detail in the attached *CCC Plus Coverage Chart*. CMHRS have been covered for CCC Plus Members

through the Department's Behavioral Health Services Administrator (BHSA) through December 31, 2017.

Community Mental Health Rehabilitation Services	Procedure Code
Mental Health Case Management	H0023
Therapeutic Day Treatment (TDT) for Children / Assessment	H0035 HA, UG, U7 / H0032 U7
Day Treatment/ Partial Hospitalization for Adults / Assessment	H0035 HB / H0032 U7
Crisis Intervention	H0036
Intensive Community Treatment / Assessment	H0039 / H0032 U9
Mental Health Skill-building Services (MHSS) / Assessment	H0046 / H0032 U8
Intensive In-Home / Assessment	H2012 / H0031
Psychosocial Rehab / Assessment	H2017 / H0032 U6
Crisis Stabilization	H2019
Behavioral Therapy / Assessment	H2033 / H0032 UA
Mental Health Peer Support Services or Family Support Partners – Individual	H0025
Mental Health Peer Support Services or Family Support Partners – Group	H0024

Effective January 1, 2018, the Contractor shall be fully responsible for meeting the CMHRS network adequacy standards. To meet these standards, the Contractor may (1) subcontract with the Department's BHSA (Magellan of Virginia); (2) contract with a different BHSA; or (3) provide the full scope of required services through the Contractor's own network of behavioral health providers. The Department will review and approve the Contractor's complete behavioral health provider network and transition plan. Also refer to *Specialized Network Provisions* and *Behavioral Health Services Administrator*.

The Contractor shall work with the Department to implement the CMHRS benefit and facilitate care coordination between CMHRS and other healthcare providers to improve integrated care based delivery systems for individuals with mental health disorders.

The Contractor's CMHRS criteria shall be consistent with the Department's criteria for the Community Mental Health Rehabilitation Services (CMHRS) 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. Providers are required to perform a service specific provider intake prior to submitting a request for CMHRS. Behavioral Therapy services shall be consistent with the Department's criteria as defined in the EPSDT Behavioral Therapy Manual Supplement. All CMHRS Services will require a service authorization or registration to qualify for reimbursement. CMHRS service authorization and registration requirements are described in Section 6.2.5.2.

The Contractor shall implement all CMHRS requirements, provider training goals and targeted programmatic improvements as directed by the Department. The Contractor shall work with the Department and the CMHRS Transition Implementation Workgroup to ensure that the Contractor's CMHRS system of care is able to meet its Members' needs.

4.2.2.1 CMHRS Standards of Care

The Contractor shall use the DMAS defined medical necessity criteria for coverage of CMHRS. In order to receive CMHRS services, the Member must be enrolled in the CCC Plus program and must meet the service specific medical necessity criteria as defined in the CMHRS Provider Manual and the EPSDT Behavioral Therapy Manual Supplement. The Contractor shall review the requests on an individual basis and determine the length of treatment and service limits are based on the individual's most current clinical presentation.

4.2.2.2 CMHRS Network Development Plan

The Contractor's CMHRS 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. Reference *Specialized Network Provisions.*

4.2.2.3 CMHRS Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-60-143 and 12VAC30-60-61, and the EPSDT Behavioral Therapy Manual Supplement. The Contractor shall implement the registration requirements for peers and qualified mental health professionals with the department of health professions as directed by the Department and in accordance with all applicable regulations.

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

Community Mental Health Rehabilitation Services	Billing Method	Urban Rate Per Unit	Rural Rate Per Unit
Mental Health Case Management	CMS-1500	N/A	N/A
Therapeutic Day Treatment (TDT) for Children	CMS-1500 or UB	N/A	N/A
Day Treatment/ Partial Hospitalization for Adults	CMS-1500 or UB	N/A	N/A
Crisis Intervention	CMS-1500	$30.79	$18.61
Intensive Community Treatment	CMS-1500	$153.00	$139.00
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
EPSDT Behavioral Therapy (ABA)	CMS-1500	N/A	N/A
Mental Health Peer Support Services – Individual	CMS-1500	N/A	N/A
Mental Health Peer Support Services – Group	CMS-1500	N/A	N/A
Peer Supports	CMS-1500	N/A	N/A

4.2.3 Residential Treatment Services

Residential Treatment services include Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) for the Department's CCC Plus program individuals and are administered through the Department's BHSA (Magellan of Virginia). Any person or child admitted to a Psychiatric Residential Treatment Facility will be temporarily excluded from the CCC Plus program until they are discharged. Any person or child admitted to a Therapeutic Group Home will not be excluded from the CCC Plus Program; however, the TGH per diem service is carved out of the CCC Plus contract and will be administered through Magellan of Virginia. Any professional medical services rendered to individuals in the TGH will be administered by the CCC Plus health plans.

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 collaborate with the BHSA to ensure physician engagement occurs on behalf of the Member during the independent certification of need process as required prior to any residential treatment service authorization.

The Contractor shall collaborate with the BHSA to facilitate Independent Assessment Certification and Coordination Team (IACCT) activities on behalf of the Member. 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, TGH carved out services.

Members enrolled with the Contractor and who are admitted to a Residential Treatment Center for Substance Use Disorder are **not** excluded and shall remain enrolled with the Contractor. Transitioning PRTF and TGH services including the Independent Assessment Certification and Coordination Team (IACCT) functions to the CCC Plus program may occur at a later date.

4.2.4 Addiction and Recovery Treatment Services (ARTS)

The Contractor shall work with the Department to improve the ARTS benefit and delivery systems for individuals with a substance use disorder (SUD). The Department's system goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a SUD.

The Contractor's ARTS criteria shall be consistent with the American Society for Addiction Medicine (ASAM) criteria as well as the Department's criteria for the Addiction and Recovery Treatment Services (ARTS) benefit as defined in 12 VAC 30-130-5000 et al.

The Contractor shall implement all ARTS requirements and improvements as directed by the Department. The Contractor shall work with the Department and the ARTS Stakeholder Implementation Workgroup to ensure that the Contractor's ARTS system of care is able to meet its Members' needs.

4.2.4.1 Critical Elements of the Contractor's ARTS System of Care

4.2.4.1.1 Comprehensive Evidence-Based Benefit Design

The Contractor's ARTS system of care shall include recognized best practices in the Addiction Disease Management field, including a robust array of services and treatment methods to address the immediate and long-term physical, mental and SUD care needs of the individual. The Contractor's system of care shall include recognized best practices in the Addiction Disease Management field such as the American Society of Addiction Medicine (ASAM) criteria and the Centers for Disease Control Opioid Prescribing Guidelines.

The Contractor shall provide coverage for services at the most appropriate American Society of Addiction Medicine (ASAM) level of care based on the most current version of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, which includes inpatient detoxification services provided in an acute care hospital settings licensed by the Virginia Department of Health (VDH); residential treatment services provided in a facility licensed by DBHDS; and SUD outpatient services by licensed or credentialed staff through the Department of Health Professions (DHP). DMAS is pursuing delivery opportunities for short-term acute and residential SUD treatment in a facility that meet CMS' definition of an institution for mental disease (IMD), as defined in 42 CFR § 435.1010, for adults age 21-64. As directed by DMAS, the Contractor shall provide coverage in IMD settings as appropriate based on the ASAM Criteria for adults who are 21 through 64 years of age.

4.2.4.1.2 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 CCC Plus 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 21);

2) Must meet the severity and intensity of treatment requirements for each service level defined by the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*. Medical necessity for all ASAM levels of care is based on the individual's assessed biopsychosocial severity and is defined by the extent and severity of the individual's problems as defined by a licensed clinician based on the individuals documented severity of need in all six (6) ASAM multidimensional assessment areas; and,

3) If applicable, must meet the ASAM adolescent treatment criteria. For individuals under the age of twenty-one (21) who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review will be administered to ensure the individual's treatment needs are assessed and medically necessary services will be coordinated to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-130-5020 and in Section 4.2.4.1.4 of this contract. The Contractor shall use *The ASAM Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* to review and coordinate service needs by applying the ASAM treatment criteria when administering ARTS benefits and determining medical necessity for ARTS services in accord with 12VAC30-130-5100. The Contractor's ARTS Care Coordinator, or a licensed physician or Medical Director employed by the Contractor, will perform an independent assessment of requests for all ARTS intensive outpatient (ASAM Level 2.1), partial hospitalization (ASAM Level 2.5), residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0) using Member information transmitted by providers via the *ARTS Service Authorization Review Forms*. The *ARTS Service Authorization Review Forms are available at: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx*. The Contractor shall review the requests on an individual basis and determine the length of treatment and service limits are based on the individual's most current multidimensional risk profile and apply the ASAM Treatment Criteria in accord with 12VAC30-130-5100.

4.2.4.1.3 Strong Network Development Plan

The Contractor's ARTS network shall ensure Member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care. Reference *Specialized Network Provisions.*

4.2.4.1.4 ARTS Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals including: addiction credentialed physicians; buprenorphine waivered practitioners licensed under Virginia law and registered with the Drug Enforcement Administration (DEA) to prescribe schedule III, IV, or V medications for treatment of pain; credentialed addiction treatment professionals as defined in 12VAC30-130-5020; and certified peer recovery specialists as defined in 12VAC30-130-5160. In situations where a certified addiction physician is not available, the Contractor shall recognize physicians who are not addiction credentialed but have some specialty training or experience in treating addiction or experience in addiction medicine or addiction psychiatry. The Contractor shall credential ASAM Level 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4.0 and Opioid Treatment Programs using the *ARTS ASAM Level 2.1 to 4.0 Uniform Credentialing Form* and *ARTS Staff Roster* available: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx.

The Contractor shall credential the Office Based Opioid Treatment (OBOT) providers approved by the Department and the CMO and Pharmacy Director Workgroup using the criteria as set forth by the Department in 12 VAC 30-50-5160. Approval will be based on the CMO and Pharmacy Workgroup's review of the *ARTS OBOT Attestation Application* available online at: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx. The Contractor shall provide the Department a report on a monthly basis of the OBOT credentialed organizations in the Contractor's network as defined in the ARTS *Management and Improvement* section of this Contract.

4.2.4.1.5 ARTS Benefit Management

The Contractor shall provide coverage for ARTS benefits within the amount, duration, and scope of coverage requirements described in the *CCC Plus Coverage Chart* of this Contract, in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and as defined in 12 VAC 30-130-5100.

To the greatest extent possible, the Contractor will aim to maintain compliance with length of stay limits, e.g., 30-day average length of stay for residential services. Should length of stay limits be exceeded, the Contractor shall provide evidence to DMAS that such limits were exceeded due to the lack of provider availability (e.g., provider shortage area) in a lower ASAM Level of Care as defined in this Contract.

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

ASAM Level	Billing Method
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB
2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Residential	UB
3.5 Inpatient	UB
3.7 Residential	UB
3.7 Inpatient	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Office Based Opioid Treatment	CMS-1500
Substance Abuse Case Management	CMS-1500
Substance Abuse Care Coordination	CMS-1500
Peer Supports	CMS-1500

The Contractor shall not require service authorizations for Screening, Brief Intervention and Referral to Treatment (ASAM Level 0.5), Outpatient Services (ASAM Level 1.0), or services provided by a Contractor credentialed OTP or OBOT organization. The following ARTS Services will require a service authorization to qualify for reimbursement:

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

Authorizations may be approved retroactively based on established provider enrollment contractual requirements after a provider has engaged a Member in treatment to promote immediate entry into withdrawal management processes and addiction treatment. The Contractor shall respond to the provider's service authorization submission via the ARTS uniform service authorization request form with the results of the Contractor's independent assessment within 3 calendar days for requests for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1, 2.5) and Group Home (ASAM Level 3.1). The Contractor must respond to the provider's service authorization submission via the *ARTS Service*

Authorization Request Forms within one (1) calendar day for requests for placement in Residential Treatment Services (ASAM levels 3.3, 3.5, and 3.7) and Inpatient Hospitals (ASAM Level 4.0).

The Contractor shall employ an ARTS Care Coordinator who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner or registered nurse with clinical experience in treatment of substance use disorder. The ARTS Care Coordinator shall perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0). The ARTS Care Coordinator shall also provide clinical care coordination as defined in section 4.2.4.1.9 of this Contract.

4.2.4.1.6 Pharmacy

The Contractor shall be responsible for covering all 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 Contract shall assure that coverage is no more restrictive than the applicable DMAS PDL requirements and that no additional service authorization criteria, quantity limits or clinical edits are applied.

The Contractor shall utilize the Department's approved service authorization criteria and quantity limits for methadone, short-acting opioids, long-acting opioids and buprenorphine containing products when evaluating benefit coverage. DMAS approved service authorization forms can be accessed at https://www.virginiamedicaidpharmacyservices.com/asp/authorizations.asp. The Contractor shall not place additional service authorization criteria, quantity limits or other clinical edits on these drugs.

The Contractor shall be responsible for complying with the DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria can be found in the DMAS Provider Memo dated December 1, 2016 titled "Implementation of CDC Guideline for Prescribing Opioids for Chronic Pain – Coverage of Non-Opioid Pain Relievers and Uniform, Streamlined Prior Authorization for New Opioid Prescriptions Effective December 1, 2016".

The Contractor shall cover buprenorphine containing drugs, naltrexone and methadone when provided as part of Medication Assisted Therapy (MAT) program which includes psychosocial therapy at rates no less than the Medicaid Fee-for-Service fee schedule in place at the time of service.

The Contractor shall allow prescriptions for buprenorphine containing drugs written by providers of organizations that are credentialed by the Contractor as an Office Based Opioid Treatment (OBOT) provider to by-pass all service authorization requirements.

The Contractor shall allow prescriptions for methadone and buprenorphine containing drugs written by providers of organizations that are credentialed by the Contractor as an Opioid Treatment Program to by-pass all service authorization requirements.

The Contractor shall ensure all orders, prescriptions or referrals for items, or services for Members originate from appropriately licensed practitioners. The Contractor must credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to CCC Plus program Members. All claims for payment for ordered or referred drugs, items or services must include the NPI of the ordering or referring physician or other professional. If the NPI is not provided on the claim for payment of the ordering or referring provider is not credentialed by the Contractor, the Contractor may deny the claim.

4.2.4.1.7 Patient Utilization Management & Safety (PUMS) Program

The Contractor must have a Patient Utilization Management & Safety 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.

4.2.4.1.8 Integration of Physical Health, Behavioral 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 to implement a fully integrated care model.

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

4.2.4.1.9 ARTS Clinical Care Coordination and 24/7 Toll-Free Access

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 the ARTS benefit, transitions between all ASAM 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 BHSA. 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. Reference *Member Clinical Triage Line.*

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 will 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 Behavioral Health Services Administrator (BHSA) for mental health services not included in the contract. 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. Reference *Federal Confidentiality Rules Related To Drug Abuse Diagnosis and Treatment.*

4.2.4.1.10 Program Integrity Safeguards

The Contractor shall perform an annual review on all providers to assure that the health care professionals under contract with the provider are qualified to provide ARTS and that services are being provided in accordance with contract, the ASAM criteria, and CCC Plus program requirements. Reference *Provider Credentialing Standards.*

4.2.4.1.11 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.

DMAS will work with the External Quality Review Organization (EQRO) to collect Member experiences, e.g., surveys and complaint/grievance processes. The Department will review and analyze results on a continuous basis as a measure of Member satisfaction. Low or inadequate scores will be analyzed, and the Contractor shall report to the Department on opportunities the Contractor has identified for improvement and interventions such as changes in workflows and/or processes being implemented to improve Member satisfaction.

Peer support services will be made available to CCC Plus Members receiving ARTS services at all levels of care. Peer support resources will be an integral component of community integration. The Contractor shall work with DMAS to implement the Peer support services benefit for Members with SUD. Program specifications for peer support services will be developed and shared with the Contractor.

4.2.4.1.12 Services for Adolescents and Youth with SUD

The Contractor shall ensure timely access to the full scope of coverage available to children under age 21, pursuant to the EPSDT benefits. The Contractor shall ensure that providers working with children under age 12 have the experience in addiction treatment with children and adolescents.

4.2.4.1.13 ARTS Reimbursement

The Contractor must reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule. Reference *Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, and Early Intervention.*

4.2.4.1.14 Quality Measurement and Improvement

The Contractor shall comply with the detailed requirements and expectations outlined in this Contract. The ARTS specific quality measures and reporting and monthly ARTS dashboards are described in the *Quality Management and Improvement* section of this Contract.

The Contractor shall submit any ad hoc reporting requirements specific to ARTS according the specifications given by the Department at any time for the purposes of Federal and State ARTS reporting, ARTS ongoing monitoring and compliance, ARTS evaluation, etc.

4.2.4.1.15 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.

4.2.4.1.16 Data Reporting

The Department will track ARTS health metrics for the Medicaid populations across fee-for-service and managed care programs. These tools will help the Department as well as the contracted evaluator for the ARTS benefit evaluate how well the ARTS program is serving individuals, while identifying best practices and opportunities for improvement. This comprehensive data mining approach will enable the Department to project risk, enhance care coordination, mitigate service gaps, and promote efficiencies. In addition to the data reporting requirements described in the CCC Plus Technical Manual, the Contractor shall report data specific to the ARTS benefits as detailed in the ARTS section of the CCC Plus Technical Manual. Reference *Central Data Repository*.

4.2.4.1.17 Implementing Innovative Payment Models

The Contractor shall work with ARTS providers to develop and implement ARTS value-based payments and alternative payment methodologies that drive high-quality care and improve Member outcomes.

4.2.4.1.18 Collaboration with DMAS, DBHDS, and Interested Stakeholders

The Contractor shall work collaboratively with DMAS, DBHDS, DHP, VDH, providers, DMAS contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support successful ARTS benefit and to ensure that the Contractor's ARTS benefit is fully operational by the effective date of this Contract.

4.2.5 Court-Ordered Services

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

4.2.6 Temporary Detention Orders and Emergency Custody Orders (TDO)

A TDO is an order issued by a magistrate for a person who has been determined to be in imminent danger to themselves or others as a result of behavioral illness or is so seriously behaviorally ill and is unable to care for self and is incapable or unwilling to consent to treatment. The Contractor shall provide coverage for TDOs and ECOs per 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 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 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 Code of Virginia, as follows:

- For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the Code of Virginia, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the 96-hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services.

- For Adults age 18 and over – Pursuant to § 37.2-809.H of the *Code of Virginia*, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.

4.3 DENTAL AND RELATED SERVICES

The Department's contracted dental benefits administrator (DBA) under the Smiles for Children program will continue to cover diagnostic, preventive, restorative/surgical procedures, for CCC Plus program children and pregnant women as well as orthodontia services for CCC Plus program children. The DBA also will provide coverage for limited medically necessary oral surgery services for adults (age 21 and older).

The Contractor shall be responsible for transportation and medication related to all 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:

1) CPT codes billed for dental services performed as a result of an accident.
2) Medically necessary procedures, including but not limited to, preparation of the mouth for radiation therapy; maxillary or mandibular frenectomy when not related to a dental procedure; orthognathic surgery to attain functional capacity; and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.
3) Coverage for anesthesia and hospitalization for medically necessary dental services.

4) In accordance with § 38.2-3418.12 of the *Code of Virginia*, the Contractor shall cover anesthesia and hospitalization services when deemed medically necessary to effectively and safely provide dental care. The Contractor shall work with the Department's DBA to coordinate coverage for these services.
5) Coverage is required for children under the age of 5, persons who are severely disabled, and persons who have a medical condition that requires admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the Member's treating physician that such services are required to effectively and safely provide dental care. The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the Department's DBA.

At their option, the Contractor may cover routine and preventive dental services for adults as an enhanced benefit.

4.3.1 Coordination with Dental Benefits Administrator (DBA)

The Contractor shall assure efforts to coordinate outreach with the DBA to improve utilization.

The Contractor shall designate a liaison (by name, phone number, and email address) and a back-up to work collaboratively with the Department's DBA and to assure that the required authorizations are handled timely and in accordance with the provisions described below. Authorizations for these services shall be handled as follows:

- The dental service provider must submit the request for authorization directly to the DBA;
- If the DBA reviews the request for dental related hospitalization and/or anesthesia based upon medical necessity;
- If the DBA approves the request, the DBA coordinates anesthesia and hospitalization authorization for Dental Services with the Contractor and within the Contractor's provider network.
- The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA. The Contractor shall respond in writing via facsimile (262) 834-3575 to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request.

If the Contractor disagrees with the DBA's decision for medical necessity, the Contractor may appeal within two (2) business days of notification by the DBA of the authorization. The appeal must be made directly with the Department's Dental Benefit Manager. The Department's decision shall be final and shall not be subject to further appeal by the Contractor. The Department's decision, however, does not override any decisions made as part of the Member's State Fair Hearing Process.

4.4 EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

The Contractor is responsible for all EPSDT services for their Members under age twenty-one (21). The Contractor shall comply with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status. Refer to the *CCC Plus Coverage Chart* attached to this Contract for more information.

4.4.1 Enhanced Scope of Coverage

The Contractor shall provide coverage through EPSDT for medically necessary benefits for children outside the basic Medicaid benefit package including, but not limited to, extended behavioral health benefits, nursing care (including private duty), personal care, pharmacy services, treatment of obesity, neurobehavioral treatment, durable medical equipment, nutritional supplements, and other individualized treatments specific to developmental issues where it is determined that otherwise excluded services/benefits for a child is a medically necessary service that will correct, improve, or is needed to maintain (ameliorate) the child's medical condition. The Contractor shall cover medical services (even if experimental or investigational) for children per EPSDT guidelines if it is determined that the treatment or item would be effective to address the child's condition. The determination whether a service is experimental must be reasonable and based on the latest scientific information available.

4.4.2 Contractor's EPSDT Review Process

The Contractor's EPSDT review process for medical necessity shall consider the EPSDT correct, maintain or ameliorate criteria. The determination of whether a service is medically necessary for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child. The Contractor shall consider the child's long-term needs, not just what is required to address the immediate presenting problem. The Contractor shall consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders. Services for Medicaid children that do not meet the plan's general coverage criteria shall receive an individualized review by a physician with experience in treating the Member's condition or disease and that ensures that the EPSDT provision has been considered. The Contractor shall not use a definition of medical necessity that is more restrictive than the state's definition. The Contractor shall not issue a denial for children services until an individualized medical necessity review has been completed.

The policies and procedures must allow providers to contact Care Coordinators to explore alternative services, therapies, and resources for Members when necessary. No service provided to a child under EPSDT can be denied as "out-of-network" and/or "experimental" or "non-covered," unless specifically noted as non-covered or carved out of this Contract.

4.4.3 Department Approval of Contractor's EPSDT Review Process

The Department must review and approve the policies and procedures for the Contractor's EPSDT review process prior to implementation, at revision or upon request.

4.4.4 Contractor EPSDT Outreach and Education Responsibilities

The Contractor shall inform Members about EPSDT services and how to access care. The Contractor shall assure that a participating child is periodically screened following the American Academy of Pediatrics (AAP) and Bright Future recommendations, and treated in conformity with the AAP 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.

The Contractor must educate and inform Members identified as not complying with the EPSDT periodicity and immunization schedules, as appropriate. The Contractor shall provide copies of

any such notices to the Department and provide documentation as to the frequency and timing of these notices, as well as further outreach if notices are not successful.

4.4.5 Documentation of Screenings

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 AAP and Bright Futures periodicity schedule and all EPSDT related services whether provided by the PCP or another provider; and, (2) Documentation of a comprehensive screening shall, at a minimum, contain a description of the components utilized.

4.4.6 EPSDT Quality Improvement Activities

The Contractor shall incorporate EPSDT requirements such as lead testing and developmental screenings, according to AAP and Bright Futures, in its quality assurance activities. The Contractor must implement interventions/strategies to meet the following criteria: (1) Childhood Immunization rates; (2) Well-child rates in all age groups; (3) Lead testing rates; (4) Increase percentage of lead testing of 1-5 year olds each contract year; and, (5) Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).

The Contractor will follow a long-term improvement plan to increase EPSDT levels that will not exceed five (5) years.

4.4.7 Treatment and Referrals

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.

4.4.8 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 EPSDT screening and that Members are not inappropriately referred to other providers for immunizations. The Contractor shall work with its network providers to adhere to the ACIP recommendations.

The Contractor is responsible for educating providers about reimbursement of immunizations, educating Members about immunization services, and coordinating information regarding Member immunization. The Contractor shall encourage all PCPs who administer childhood immunizations to enroll in the Virginia Vaccines for Children program (VVFC), administered by the Virginia Department of Health and shall include enrollment instructions and a "Vaccines for Children" application (or, if electronic, a hyperlink to the application) in its provider network manual and trainings.

The capitation rate paid to the Contractor does include the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The Contractor shall not allow primary care providers to routinely refer 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.

4.4.9 Private Duty Nursing (PDN) Services for Children

The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria 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) I. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing which provides for short-term, intermittent care where the emphasis is on Member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring, and skilled interventions.

4.5 EARLY INTERVENTION (EI)

Early Intervention (EI) services, authorized 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), are covered under this Contract. Children from birth to age three who have (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are eligible for EI services. EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social or emotional, or adaptive).

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.

EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP), developed by the multidisciplinary team, including the MCO Care Coordinator and EI service team. The Contractor's Care Coordinator may collaborate with the EI Service Coordinator if unable to attend the IFSP meeting. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. EI services are performed by EI certified providers in the child's natural environment, to the maximum extent appropriate.

Natural environments can include the child's home or a community based setting in which children without disabilities also participate.

In accordance with Chapter 53 of Title 2.2 of the *Code of Virginia*, the Contractor shall provide coverage for EI services as described in the Member's IFSP developed by the local lead agency. The Contractor shall work collaboratively as part of the Member's multidisciplinary team 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. 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.

The IFSP shall be approved by the child's primary care provider. The Member's physician signature on the IFSP or a letter accompanying the IFSP or an IFSP Summary letter within 30 days of the first visit for the IFSP service is required for reimbursement of those IFSP services. If physician certification is delayed, services are reimbursed beginning the date of the physician signature. The Contractor shall ensure that its EI policies and procedures, including credentialing, follow Federal and State EI regulations and coverage and reimbursement rules in the DMAS Early Intervention Services Manual and the DBHDS Practice Manual.

The Contractor shall ensure that Members have access to EI providers who are certified by the Department of Behavioral Health and Developmental Services (DBHDS). 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. EI providers shall be contracted with or have a memorandum of agreement (MOA) in place with the local lead agency for the catchment area in which the Member resides.

Refer to *Comprehensive Health Coverage* section of this Contract for information on the handling of TPL for EI services, the Attached *CCC Plus Coverage Chart* (Section 3B) for covered services and billing codes, and *Provider Payment* for special EI claim processing requirements.

4.6 EMERGENCY AND POSTSTABILIZATION SERVICES

The Contractor shall provide coverage and payment of emergency services and post-emergency care services in accordance with 42 CFR§438.114 without service authorization and regardless of whether the provider that furnishes the services has a contract with the Contractor. The Contractor shall also cover services needed to ascertain whether an emergency exists. The Contractor shall base coverage decisions for emergency services on the acuity of the presenting symptoms at the time emergency services are sought. The prudent layperson standard of an emergency service definition shall not serve as the sole reason for denial of payment.

The Contractor shall not deny payment for treatment obtained by a Member who had an emergency medical condition, including in which a representative of the Contractor instructs the Member to seek emergency services or in cases where the absence of immediate medical attention would not have resulted in a serious health condition as provided in the definition of emergency medical condition.

The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Contractor, Member's primary care provider, or applicable State entity of the Member's screening and treatment within ten (10) calendar days of presentation for emergency services. The Contractor shall ensure that the Member who has an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member's condition.

The Contractor shall ensure that the Member's attending emergency physician, or the provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.

The Contractor shall provide coverage and payment for poststabilization care services in accordance with provisions set forth at 42 CFR §422.113(c) that a treating physician views as medically necessary until AFTER an emergency condition has been stabilized. In applying those provisions, the Contractor shall comply with all provisions in the same manner as required for "MA organization" and "financially responsible" entity.

In accordance with 42 CFR §438.114(e), the Contractor is required to cover post-stabilization care services administered to maintain, improve, or resolve the Member's stabilized condition without preauthorization, and regardless of whether the Member obtains the services within the Contractor's network when the Contractor's representative and the treating physician could not reach agreement concerning the Member's care, and the Contractor's physician was not available for consultation.

4.7 LONG TERM SERVICES AND SUPPORTS

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

LTSS may be provided through a 1915(c) Home and Community Based Services (HCBS) waiver. Individuals enrolled in the Commonwealth Coordinated Care Plus waiver shall receive waiver services furnished by the Contractor as well as medically necessary non-waiver services. Individuals enrolled in the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers, known collectively as the DD waivers, are covered under this Contract only for their medically necessary non-waiver services. The Contractor shall be responsible for knowledge of the services within the DD waivers to ensure the overall health and well-being of all CCC Plus program Members. Individuals enrolled in the Alzheimer's Assisted Living (AAL) HCBS Waiver are excluded from the CCC Plus program.

The Contractor shall comply with regulations and policy governing the CCC Plus Waiver. Refer to the *CCC Plus Coverage Chart* attached to this Contract for more information on LTSS services, billing codes, and links to DMAS regulatory and policy guidelines.

Refer to the attached *MOC Assessment (HRA) and Individualized Care Plan (ICP) Requirements by Population* chart for guidance on timelines for individuals receiving Long Term Care Services.

4.7.1 Screening Requirements

In accordance with the §32.1-330 of the *Code of Virginia*, all individuals requesting community based or nursing facility LTSS, must receive a screening to determine if they meet the level of care needed for NF services. DMAS contracts with the Virginia Department of Health (VDH), Department of Aging and Rehabilitation Services (DARS), and hospitals to conduct screenings for individuals. In the community, screeners are members of the local health departments (LHD) that may include physicians and nurses along with social workers and family services specialists within the local departments of social services (LDSS) for adults (over the age of 18 years). Community screenings for children (up to the age of 18) are contracted to a DMAS designee, currently VDH through the local health departments in the jurisdiction where the child resides. Acute care hospitals utilize discharge planners to complete the screening. Details about the screening process and the criteria for meeting the level of care required for functional eligibility for LTSS can be found in the Department's *Screening Provider Manual* (previously referred to as the Preadmission Screening Manual) on the Virginia Medicaid Provider Portal.

The screening process is automated through the DMAS Electronic Screening (ePAS) system. The ePAS system is a paperless, automated reimbursement and tracking system for all entities contracted by DMAS to perform screenings. DMAS requires all LTSS screenings to be entered by the appropriate screening team into the ePAS automated system. Timeframes for the validity of the screenings are outlined in the *Screening Provider Manual*. Time frames for completing the screenings can be found at http://townhall.virginia.gov/L/ViewStage.cfm?stageid=7370.

The PAS team conducts the screening using the screening form, the Uniform Assessment Instrument (UAI) and other required forms and enters the Member's screening into ePAS. The ePAS system informs the screener if the individual meets the NF level of care.

As part of the screening, individuals that are technology dependent also receive an age appropriate DMAS Technology Adult Referral form (DMAS 108) or Technology Pediatric Referral form (DMAS 109). The CCC Plus Waiver shall be offered to individuals who meet criteria described in 12VAC30-60-303 and 12VAC30-60-307. Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website http://townhall.virginia.gov/L/ViewStage.cfm?stageid=7370. Appropriate community based services shall be offered prior to consideration of nursing facility placement; community based services include the CCC Plus Waiver, Alzheimer's Assisted Living Waiver (AAL)(excluded population until waiver discontinuance on June 30, 2018) and Program of all Inclusive Care for the Elderly (PACE) (excluded population).

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

1. Uniform Assessment Instrument (UAI)
2. DMAS 95 MI/DD/RC (Supplemental Assessment Process Form Level 1) for individuals who select nursing facility placement
3. DMAS-96 (Medicaid Funded Long-Term Care Service Authorization Form)

4. DMAS-97 (Individual Choice - Institutional Care or Waiver Services Form)
5. DMAS 108 (Adults) or DMAS 109 (Children) for individuals who are technology dependent.

For Members that have screening determinations completed after enrolling in the CCC Plus program, the screening information shall be submitted to the Contractor by the screening team. Refer to the DMAS Medicaid Memo posted August 17, 2017 for details of the screening and referral process.

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

Individuals should not be approved to receive Medicaid funded LTSS without having a screening on file that confirms the individual meets NF level of care. Exceptions to this process are outlined in the Department's *Screening Manual*, Chapter IV. The Contractor shall work closely with DMAS and stakeholders to develop and implement a process that ensures the appropriate level of care documentation is on file for its Members prior to the Contractor's payment of nursing facility or community based LTSS claims. The term LTSS in this Section refers specifically to nursing facilities, the CCC Plus Waiver and the Alzheimer's Assisted Living Waiver. Once the process is developed and implemented, DMAS intends to include a contractual requirement predicating payment upon the approved process; until that point, the Contractor shall accept the MDS for NF admissions where the UAI is not available. Reference Sections 4.7.2.3 (CCC Plus Waiver) and 4.7.3.3 (Nursing Facility) for Contractor responsibilities related to level of care admissions and discharges.

4.7.2 Commonwealth Coordinated Care Plus Waiver

On July 1, 2017, Virginia received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, which combines the Department's prior Elderly or Disabled with Consumer Direction (EDCD) Waiver with the Technology Assisted (Tech) Waiver. The CCC Plus Home and Community Based Waiver includes all of the services that were available in both the EDCD and Tech Waivers. These services described in Section 4.7.2.2 and in Attachment 5 of this Contract.

4.7.2.1 Populations

The CCC Plus Waiver covers a range of community support services to individuals who are aged, who have a disability, or individuals who are technology dependent and rely on a device for medical or nutritional support (e.g. ventilators, feeding tube, or tracheostomy). The CCC Plus Waiver has two benefit plans: the standard benefit plan (similar to the EDCD benefit) and the tech assisted benefit plan (similar to the Technology Assisted benefit). Individuals who are enrolled in the tech assisted benefit plan receive all of the services in the Standard benefit as well as private duty nursing services. Individuals receiving the tech assisted benefit are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care.

In accordance with 12 VAC 30-120-920, CCC Plus Waiver services shall not be offered or provided to any individual who resides in a NF, an ICF/IID, a hospital, an assisted living facility licensed by VDSS that serves five or more individuals, or a group home licensed by DBHDS. Transition coordination and transition services may be available to individuals residing in some settings through the Contractor's transition services or through the DMAS Money Follows the Person demonstration program. Additionally, certain CCC Plus Waiver services shall not be available to individuals residing in an assisted living facility licensed by VDSS that serves four or fewer individuals. These services are: respite, PERS, ADHC, environmental modifications, assistive technology and transition services. Personal care services shall be covered for individuals living in these facilities but shall be limited to personal care not to exceed five hours per day. Personal care services shall be authorized based on the individual's documented need for care over and above that provided by the facility. Services shall also be provided in settings that meet the *CMS Home and Community Based Settings Final Rule*; see Attachment 12 of this Contract for additional details.

4.7.2.2 Services

For Members enrolled in the CCC Plus Waiver, the Contractor shall cover all services which provide Members an alternative to institutional placement. This includes the following *qualifying* CCC Plus Waiver Services: adult day health care, personal care (agency-directed and/or consumer-directed), skilled private duty nursing, respite care (agency-directed and/or consumer-directed) or skilled private duty respite care (agency directed) as well as the following services that can be covered for individuals who receive at least one *qualifying* waiver service: personal emergency response systems and medication monitoring, assistive technology, and environmental modifications. Transition services shall be covered for those Members meeting criteria who are transitioning back to the community from a Nursing Facility or long stay hospital. For children under age 21, most of these services will be covered through EPSDT. The CCC Plus Waiver would be used for any services not covered under EPSDT, such as respite services. Refer to Section 4.4 for details regarding EPSDT. Also see *Care Coordination with Transitions of Care* in Section 5.10 and *Attachment 5 - CCC Plus Coverage Chart.*

4.7.2.3 Level of Care

In order to be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a Nursing Facility, specialized Nursing Facility, or long stay hospital. Enrollment into the CCC Plus Waiver requires a screening, performed by a hospital or community team as described in Section 4.7.1 *Screening Requirements*.

The Contractor shall be responsible for ensuring that the CCC Plus Waiver level of care is correct for its membership. It is important that the level of care be information be revised timely so that the member has access to the appropriate services and also to enable DMAS to pay the Contractor at the correct capitation rate. See Section 19.9.8 *Recoupment/Reconciliation*. The Contractor shall follow the process described in Section 4.7.9 for level of care entries and notifications to DMAS regarding certain level of care admissions, discharges, and changes.

4.7.2.3.1 Level of Care (LOC)Reviews

Level of Care (LOC) reviews shall be completed at least annually. The annual LOC review may be completed up to sixty (60) calendar days prior to the annual due date for the Member. These reviews ensure that Members enrolled in the CCC Plus Waiver continue to meet the functional and medical criteria for enrollment in the waiver (CFR 42 §441.302 (c) (2)). The Contractor

shall submit to the Department for approval at implementation, upon revision, or upon request, the policies and procedures for its Level of Care (LOC) Reviews.

In addition to the annual LOC review, the Contractor shall initiate a LOC review at any time the Contractor's (Care Coordinator) assessment indicates that the Member may not meet the CCC Plus Waiver criteria.

LOC Reviews shall be conducted using the *Level of Care Review Instrument* (LOCERI) also known as the DMAS 99 Series Form. The Contractor shall enter all required information for the LOCERI electronically using the Virginia Medicaid Web Portal; LOC review tab. The *Level of Care User Guide and Tutorial*, is available on the Virginia Medicaid Web Portal, Provider Resources tab, at: https://www.virginiamedicaid.dmas.virginia.gov.

All LOC reviews for Members in CCC Plus Waiver must: 1) be conducted face-to-face; 2) be performed by individuals that meet the review requirements as outlined in this Contract; 3) be conducted timely (minimum within 365 calendar days of the last annual LOC review); 4) be conducted when a Member experiences a change in status that could impact waiver functional eligibility; and, 5) include all the elements on the DMAS 99 Series Form (Level of Care Review Instrument). For Members who are receiving private duty nursing services, the LOC annual review shall also include all of the elements on the DMAS 109 (Technology Assisted Pediatric Referral Form) or the DMAS 108 (Technology Assisted Adult Referral Form).

The Contractor shall provide the Department any LOC review data and results for CCC Plus Waiver participants via the Virginia Medicaid Provider Portal within two (2) business days of the LOC review. See the CCC Plus Technical Manual for more detail.

For individuals that do not meet criteria, DMAS will conduct a second level review. During this review, DMAS may contact the Contractor and/or the Member for additional information. If DMAS' second level review confirms that the Member does not meet criteria, DMAS will notify the Member and the Contractor in writing of the termination of the waiver (with appeal rights) within no more than thirty (30) days.

Any resulting Member appeal will be led by DMAS. The Contractor shall work collaboratively with DMAS on all appeal related activities. The Contractor shall continue services in accordance with the appeals criteria described in Section 15 of this Contract.

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

4.7.2.4 Health Risk Assessment (HRA) Elements

The Contractor shall use Care Coordinators who shall complete an initial face to face Health Risk Assessment (HRA) for newly enrolled Members as expeditiously as the Member's condition requires and according to the guidelines set forth in the *Health Risk Assessment (HRA)* section of this Contract.

4.7.2.5 CCC Plus Waiver Services Scope of Coverage

The Contractor shall provide CCC Plus Waiver services *at least* in equal amount, duration, and scope as available under Medicaid fee-for-service as described 12VAC30-120-924 and Attachment 5 of this Contract. Waiver services may be agency-directed (AD) or consumer-directed (CD). CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

4.7.2.6 Consumer Directed or Agency Directed Services

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

For both AD and CD care, the Member must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the Member, etc.) in case the personal care aide or CD attendant or nurse is unable to work as expected or terminates employment without prior notice. The identification of a back-up plan is the responsibility of the Member and family and must be identified and documented on the person-centered Individualized Care Plan. Members who do not have viable back-up plans are not eligible for services until viable back-up plans have been developed. For AD care, the provider must make a reasonable attempt to send a substitute personal care aide but, if this is not possible, the Member must have someone available to perform the services needed.

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

For more information on CCC Plus Waiver services, refer to the *CCC Plus Coverage Chart* attached to this Contract.

4.7.2.7 Adult Day Health Care (ADHC)

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

4.7.2.8 Personal Care Services

Assistance with Activities of Daily Living (ADL): eating, bathing, dressing, transferring, and toileting, including medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-19-

240 through 18VAC90-19-280. When specified in the individual service plan, personal care services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves. Supervision, as an allowable personal care service, shall be provided pursuant to 12VAC-30-120-924 D.2.c. and d. and 12VAC-30-120-924 G.2.b. CD skilled services shall be provided pursuant to the *Code of Virginia* § 54.1-3001(12).

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

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For CD services, The *Code of Virginia* § 54.1-3001(12) states "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements. Reference Chapter IV of the DMAS Elderly or Disabled with Consumer Direction Waiver Services Provider Manual for additional details.

In accordance with 12VAC30-120-924.B, the Contractor shall develop policies and procedures for Department approval prior to implementation, and at revision, and upon request that include the ability to determine the capacity of Members to self-direct services, the criteria for determining when a person receiving services is no longer able to self-direct services received, and regularly verifying that appropriate services are provided. The Contractor has the option to use the DMAS-95 Addendum to determine the Member's capacity to self-direct services.

There are no maximum limitations to the number of personal care hours that an individual may receive. Personal care hours are limited by medical necessity. Under the fee-for-service program, personal care hours are limited to 56 hours per week, 52 weeks per year, for a maximum total of 2,920 hours per year, where the Department provides exceptions based on medical necessity using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided. The Contractor shall manage exception requests for its membership in accordance criteria is listed in 12VAC30-120–927 and contract standards. Refer to Section 6.0 *Utilization Management Requirements.*

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

4.7.2.9 Respite Care Services

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

Individuals may choose to use agency directed (AD), consumer directed (CD), or a combination of these models of service delivery. CD respite is only available to Members requiring unskilled respite care services. Unskilled respite is not available to individuals who have 24 hours skilled nursing needs.

Respite care services are limited to 480 hours per individual per state fiscal year (July 1st through June 30th).

4.7.2.10 Services Facilitation (SF)

SF is a function that assists the Member (or the Member's family or representative, as appropriate) when consumer directed services are chosen. The SF provider serves as the agent of the individual or family and the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the Member/family to be the employer. Practical skills training is offered to enable families and Members to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem-solving. The services include providing information to ensure that Members understand the responsibilities involved with directing their services.

4.7.2.11 Environmental Modifications (EM)

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

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

4.7.2.12 Assistive Technology (AT)

Assistive Technology provided outside of the Medicaid State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver for Members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the Member's residence to specifically increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live.

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

AT must be provided in conjunction with at least one other qualifying CCC Plus Waiver service. All AT requires an independent evaluation by a qualified professional who is knowledgeable of the recommended item prior to authorization of the device. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

4.7.2.13 Personal Electronic Response System (PERS)

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

4.7.2.14 Skilled Private Duty Nursing (PDN)

Skilled PDN are nursing services ordered by a physician in the Plan of Care and provided by a licensed Registered Nurse (RN) or by a Licensed Practical Nurse (LPN). This service is provided to individuals in the technology dependent subgroup who have serious medical conditions and complex health care needs. Skilled PDN is used as hands-on Member care, training, consultation and oversight of direct care staff, as appropriate. Examples of Members that may qualify for Skilled PDN coverage include, but are not limited to, those with health conditions requiring: mechanical ventilation, tracheostomies, prolonged intravenous administration of nutritional substances (TPN/IL) or drugs, peritoneal dialysis, continuous oxygen support, and/or continuous tube feedings.

PDN hours are determined by the scores on the appropriate objective assessment based on the Member’s age. The pediatric assessment (DMAS-109) is utilized for a Member less than 21 years of age. PDN hours for adult Members are determined by medical necessity on the DMAS-108 form.

4.7.2.15 Transition Services

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

of a birth certificate or an identification card or driver's license; and other reasonable one-time expenses incurred as part of a transition.

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

4.7.2.16 Service Authorizations

Initial Service Authorizations (SA) as well as SA renewals shall comply with requirements in the *Service Authorization* section of this Contract. Refer to the *Model of Care, Health Risk Assessments and Person-centered Individualized Care Plans* section of the Contract for more information.

4.7.2.17 Documentation Requirements

The following is the minimum documentation to be retained in the Member's Record by the Contractor's Care Coordinator. The Department reserves the right to adjust the chart as regulations and/or policy manuals are changed. DMAS forms may be found on the DMAS web portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch .

Documentation	Frequency
RN Supervisory Visit	Monthly for technology dependent Members; Quarterly for all others
Plan of Care (CMS-485)	Every 60 calendar days
Plan of Care (DMAS 97 A/B)	Every 12 months or more frequently as needs change
Telephone Communications with individuals/caregivers, providers, physicians, etc.	Daily or as needed
Initial Screening (UAI, DMAS-95 [as applicable], DMAS-96, DMAS-97, 99-LOC, DMAS 108/109 as appropriate, MD order for Tech subgroup admission, etc. as applicable)	On admission
Updated Screening	Lapse of LTSS services >30 calendar days
Hospital summaries, discharge orders, additional medical record information (i.e. tests, procedures, etc.)	Hospital admissions, change in health status
Service Authorization Documentation	Yearly, Change in hours or provider
Correspondence with Individual/Caregiver (letters)	Enrollment, Disenrollment, Change in provider, Change in hours
Medicaid LTC Communication Form (DMAS 225)	Enrollment, Disenrollment
Health Risk Assessment	Refer to the *Model of Care Assessment and Individualized Care Plan Expectations* table

Individualized Care Plan	Refer to the *Model of Care Assessment and Individualized Care Plan Expectations* table
Interdisciplinary Care Team Report	As needed

4.7.3 Nursing Facility and Long Stay Hospital Services

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

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

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

4.7.3.1 Specialized Care Nursing Facility Units and Long Stay Hospitals

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

This population has medical/nursing needs to exceed the needs of a typical nursing facility resident which is why DMAS developed the program to account for the medical/nursing needs for these individuals.

The two long stay hospitals (one located in Washington, DC and one located in Norfolk, VA) serve primarily pediatric individuals with complex medical/nursing needs. The Contractor shall work closely with these two facilities to ensure Members receive the full scope of services needed and as covered under this Contract.

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

The Contractor should incorporate all activities associated with traditional nursing facility individuals when working with individuals receiving services through either specialized care or long stay hospitals. The individuals have to meet the underlying criteria for nursing facility placement.

Currently DMAS has a limited number of nursing facilities who have an add-on agreement to provide services under the specialized care program. The Contractor may contract with other Nursing Facilities to provide specialized care services, however, the facilities must meet the minimum requirements as outlined for fee for service specialized care providers. The Contractor shall work with DMAS regarding the addition of new specialized care providers.

The Contractor shall not seek to add any additional long stay hospitals to the program. DMAS limits long stay hospital participation to the two currently enrolled providers.

4.7.3.2 Out of State or Out of Area Placements

4.7.3.2.1 Out of State

The Contractor shall ensure that the needs cannot be met within the Commonwealth before considering out of state placement. When considering an out of state facility, the facility must meet all the standard licensing and certification requirements within that state and have an active license to operate within that state. The Contractor shall coordinate with the Department regarding any out of state placement requests for Members who may not be able to be served in the Commonwealth.

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

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

4.7.3.2.2 Out of Area

The Contractor shall consider the needs of the Member when the Member cannot be adequately served in a facility located within the Member's permanent area of residence. Relocation to a facility in another region is allowable when the Member and/or the Member's representative agree that it is in the Member's best interest.

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

4.7.3.3 Nursing Facility Admissions and Discharges

In order to receive Nursing Facility services, an individual must meet the level of care (LOC) required for a Nursing Facility, specialized Nursing Facility for technologically dependent individuals or long stay hospital. Enrollment into the Nursing Facility level of care requires a screening performed by a hospital or community team as described in Section 4.7.1 of this Contract.

The Contractor shall enter Nursing Facility admissions and discharges into the Virginia Medicaid Web Portal (LTC Tab). The Contractor shall also enter changes to the NF level of care into the Virginia Medicaid Web Portal when a Member transitions between a skilled Medicare stay and a custodial Medicaid stay. Such admission/discharge and change transactions shall be entered by the Contractor no later than two (2) business days of the admission/discharge or level of care change. Also refer to *Screening Requirements* in Section 4.7.1. Also reference Section 4.7.9 for additional information on the level of care entry process.

The Contractor shall submit the DMAS 225 to LDSS for all nursing facility admissions or discharges within five (5) business days receipt of notice of the start of care..

4.7.3.4 Contractor Attendance at Annual Care Plan Meetings

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

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

4.7.3.5 Extraordinary Care Management During Involuntary Relocation

The Contractor shall be prepared to assist in the event that a Nursing Facility's provider agreement with Medicare and/or Medicaid is terminated due to failure to meet licensure and certification requirements. The Contractor shall be involved in any decisions regarding the relocation of Members under their care.

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

The Contractor shall work with the Nursing Facility and the identified relocation team which may include a combination of individuals from DMAS, the Department of Aging and Rehab Services, the local Departments of Social Services, and the Long Term Care Ombudsman (either at the state or local level).

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

4.7.3.6 Annual Review of Section Q of Minimum Data Set (MDS)

The Contractor shall ensure that Section Q of the MDS is completed and must participate in any discussions with the Nursing Facility and any Members expressing an interest in returning home. The Contractor shall be prepared to offer services in the home if discharge to home is appropriate and consistent with the Member's choice. The Contractor shall support the Member's right to choose the setting in which he/she receives care and shall work to ensure that the care received is in the least restrictive setting to ensure the Member's health, safety and welfare.

The Contractor shall review with the Nursing Facility on at least a quarterly basis (or at such time as the interest is expressed by the Member) and whenever the Member expresses an interest in being discharged, any and all options for discharge from the Nursing Facility.

4.7.3.7 Nursing Facility Reassessments

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

4.7.4 Developmental Disability (DD) Waivers

The Department of Medical Assistance Services (DMAS) and Department of Behavioral Health Developmental Services (DBHDS) have worked diligently for three years, engaging the expertise of consultants as well as stakeholders across the Commonwealth, to redesign Virginia's Home and Community Based Services waivers (HCBS) for individuals with developmental disabilities including intellectual disabilities. This redesign combines the target population of individuals with both intellectual disability and other developmental disabilities and offers services that promote community integration and engagement. Additional information about the waiver redesign may be found at http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/my-life-my-community.

Individuals enrolled in one of the Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers) will be enrolled in the CCC Plus program for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). DD Waiver services (including when covered under EPSDT), targeted case management and transportation to the waiver services, will be paid through Medicaid fee-for-service as "carved-out" services. See *CCC Plus Coverage Chart - Part 4C*.

All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are

included in a person-centered ICP. Individuals receiving home and community based services through one of these waivers have a variety of choices of both types of services and providers.

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

The Contractor shall have policies and procedures in place to manage Members that are enrolled in the BI, CL or FIS waivers, in addition to all individuals with a diagnosis of a developmental disability as identified in the Vulnerable Subpopulations criteria. The Contractor shall work with the Member's DD waiver support coordinator/case manager and service provider to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services, as applicable, to support the individual's health and well-being. The Contractor shall be able to identify and access the appropriate community-based resources for these Members.

4.7.5 Patient Pay for Long Term Services and Supports

Patient Pay refers to the Member's obligation to pay towards the cost of long-term services and supports, if the Member's income exceeds certain thresholds. Patient Pay is required to be calculated for every individual receiving NF or waiver services, although not every eligible individual will end up having to pay each month. When a Member's income exceeds an allowable amount, he/she must contribute toward the cost of his/her LTSS. This contribution is known as the Patient Pay amount.

DMAS will provide information to the Contractor that identifies Members who are required to pay a Patient Pay amount and the amount of the obligation as part of the monthly transition report. DMAS Capitation Payments to Contractors for Members who are required to pay a Patient Pay Amount will be net of the monthly Patient Pay Amount. The Contractor shall establish a process to ensure collection of the Patient Pay Amounts and coordinate with LTSS providers. The Contractor shall develop policies and procedures regarding the collection of the Patient Pay obligation. The Contractor may collect it directly from the Member or assign this responsibility to LTSS providers. If assigned to the LTSS providers, the Contractor shall explain this process in its LTSS provider contracts and shall reduce reimbursements to LTSS providers equal to the Patient Pay amounts each month.

4.7.5.1 Patient Pay for Members Who Transition Between a Nursing Facility and the CCC Plus Waiver

Unless the Contractor collects the patient pay from the Member directly, the Contractor shall ensure that the following process is implemented no later than July 1, 2018. For Members who transition to or from a nursing facility during the month, the Contractor shall collect the patient pay amount from the nursing facility claim (i.e., for the transition month) instead of from the CCC Plus Waiver provider(s). This process applies regardless of the order in which the Contractor receives the claims.

4.7.5.2 Patient Pay for Members with Medicare

There are circumstances where individuals with Medicare may also have a patient pay responsibility towards skilled nursing facility care. For example, a Member who falls into a low RUGS category, and who has a coinsurance responsibility through Medicare Part A, could have a cost share responsibility if the Medicare payment is lower than the Medicaid allowable amount for the same service. In this circumstance the Member is responsible for the difference in the Medicare payment and Medicaid allowable charges, up to the Member's DSS-calculated patient pay amount.

4.7.5.3 Patient Pay Form - DMAS-225 Form

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

When a Member enrolled with the Contractor is determined to be newly eligible for LTSS, the Contractor shall submit a DMAS-225 form to the LDSS eligibility worker, in order for the eligibility worker to determine the Patient Pay amount. The Contractor is required to adhere to the regulations regarding the collection of Patient Pay from enrolled Members.

Immediately upon initiation of long term care services, and within no more than five (5) business days receipt of notice of initiation of long term care services, the Contractor shall send a DMAS-225 to the eligibility unit of the appropriate local Department of Social Services (LDSS) indicating the Contractor's first date of long term care service delivery. The LDSS eligibility worker will complete a Patient Pay determination. A copy of the completed DMAS-225 must be kept by the Contractor in the Member's file.

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

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

The Contract must send the DMAS-225 on a timely basis so that the LDSS can update Patient Pay in the VACMS/MMIS.

4.7.6 Consumer Direction and Contract with the Department's Fiscal/Employer Agent (F/EA)

The Department offers home and community-based support services, approved by the Centers for Medicare and Medicaid Services pursuant to §1915(c) of the Social Security Act, for Medicaid individuals who would otherwise require a level of care provided in institutional settings the opportunity to remain in their homes and communities. Eligible CCC Plus Waiver Members may choose the Consumer-Directed model of service delivery for their personal care and respite services in which the Member, or someone designated by the Member, employs

attendants and directs their care. The Member will receive financial management support in their role as employer by the Department's contracted Fiscal/Employer Agent (F/EA).

Financial Management Services, provided by the F/EA for CCC Plus Waiver Members include:

- Pre-employment services, including enrolling Medicaid Individuals (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; and,
- Providing training on F/EA enrollment and payroll processing procedures to Medicaid Members and Service Facilitators or the Designated Entity responsible for supporting the Medicaid Member in managing his or her Personal Care Assistants.

The Contractor shall maintain a Business Associate Agreement (BAA) with the Department's designated 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 processing all required IT and data exchange processes.

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 policies and procedures shall reflect the timeframes for data exchange as well as the internal process controls and implementation plan for all required IT and data exchange necessary for the Consumer Directed services with the F/EA. The Contractor shall have a dedicated project manager for Consumer Directed services and shall report updates on the status of each task, subtask, and deliverable on a weekly frequency. Refer to the CCC Plus Technical Manual for the required format.

The Contractor shall comply with program requirements as documented in the F/EA Business Rules Document.

4.7.6.1 Background Checks

State and Federal laws and regulations 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 18; the Federal list of Excluded Individuals and Entities (LEIE) database checks; and, employment eligibility checks. Also see Section 8.4.8 of this Contract.

The F/EA shall be obligated to perform reference checks. CCC Plus Waiver Members shall not be charged for the cost of background checks. The Contractor shall reimburse exact fees paid by the F/EA to the Virginia State Police for criminal record checks and to the Virginia Department of Social Services for Child Abuse and Neglect Central Registry checks.

4.7.6.2 Contractor Database and Automated Systems

The Contractor shall have an automated system that has the capacity to exchange files with the Department's F/EA to verify Service Authorizations, Patient Pay, Medicaid eligibility, Program eligibility, pay rates, and other necessary data to ensure accurate payroll.

4.7.6.3 Service Authorizations

The Contractor shall electronically submit Service Authorizations (SAs) that are associated with new or updated SAs for Consumer-Directed Services. These SAs are the authorizations to the F/EA that either services have been approved for the CCC Plus Waiver Member to receive CD Services, or existing services have been changed, canceled or ended based on SA activity. The Contractor shall bear all financial risks associated with improper payment when the Contractor does not update a SA when a Member is no longer eligible. This includes brief periods of ineligibility for temporary in-patient stays. The F/EA shall not be held responsible for these payments.

4.7.6.4 Patient Pay Through the F/EA

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

The F/EA shall accurately deduct Patient Pay amounts from employee's paychecks in the pay period that includes the first day of each month. The total Patient Pay amount shall be deducted from the employee's pay before funds are used to pay for services.

The Contractor shall have an automated system and internal controls that have the capacity to electronically exchange files with the F/EA. The Contractor shall send a monthly file to the F/EA that includes Patient Pay amounts to be withheld for CCC Plus Waiver Members. Refer to *Patient Pay for Long Term Services and Supports* above for more information.

4.7.6.5 EDI File Exchanges

The Contractor must establish and maintain the ability to exchange EDI transactions with the Department's F/EA. These transactions may include, but are not limited to, the 834, 837P, 835, and 270/271 batch processing formats. There is no requirement for the Contractor to exchange file transactions using a clearing house sub-contractor. All EDI transactions must comply with current DMAS and industry standards and, where applicable, are required to meet the HIPAA Security standards for electronic PHI.

The Contractor shall be able to submit and accept eligibility requests and responses (batch 270 and 271) that are needed to verify the CCC Plus Waiver Member's eligibility for Medicaid and waiver service before submitting claims data associated to timesheet payments for employees. It will be the responsibility of the Contractor to verify the validity of the claims data prior to submitting claims to the F/EA. Reference the *Business Rules Document for Consumer Direction* for additional details.

4.7.6.6 Pay Rates

The Contractor's reimbursement for consumer directed personal care and respite 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 .

4.7.6.7 Withholdings, End of Year Tax Processes, and Reconciliation

The Contractor shall provide quarterly reviews and analysis of F/EA payroll registers and supporting documents including withholdings, tax filings, and payments of State and Federal income and employment taxes; withholding of patient-payments, garnishments, and liens; and, the Contractor's payments made to the F/EA compared to actual payroll expenses for CCC Plus Waiver Members participating in Consumer-Directed Services. The F/EA is contractually required to ensure the accuracy and timeliness of all enrollment, tax obligations, and payroll invoices submitted to the Contractor. Refer to *Reports and Refunds* table *in* Section 4.7.6.9 of this Contract.

Personal Care Attendants working for CCC Plus program Members in multiple MCOs will receive multiple paychecks as opposed to one combined paycheck. The F/EA reports and documents, listed below, shall be reviewed each quarter by the Contractor. Timing and other activities shall be considered when reconciling payroll costs between the Contractors financial system and the F/EA's payroll and financial systems including prior period adjustments, adjustments to the general ledger, and availability of payroll information from information technology systems.

- *IRS Form 941 Employers Quarterly Federal Tax Return*
  The Contractor shall review an electronic copy, provided by the F/EA, of the CCC Plus Waiver Member's quarterly federal tax return, including proof of funds received, by the Internal Revenue Service and any amended returns.

- *VEC-FC-21/20*
  The Contractor shall review an electronic copy, provided by the F/EA, of the CCC Plus Waiver Member's quarterly tax report, including proof of funds received, by the Virginia Employment Commission. The data is broken down by employer of record and wages filed by the employer of record and employee.

- *Form VA-5 Employer Return of Virginia Income Tax Withheld*
  The Contractor shall review an electronic copy, provided by the F/EA, of form VA-5 employer return of Virginia income tax withheld, with proof of funds received by the Virginia Department of Taxation.

- *Quarterly Payroll Register*

The Department's F/EA shall bill the Contractor using a billing rate that equals the hourly pay rate plus estimated taxes. At the end of each quarter, the Contractor shall review the F/EAs payroll register report and related schedules that provide reconciliation of estimated with actual payroll expenses for the quarter. The payroll register shall be submitted by the F/EA in electronic file submission, with no formatting of totals, subtotals, etc. and include the following data fields:

- Check Number
- Check Date
- Employee Name
- Employee ID #
- Member Name
- Member Medicaid ID #
- Total Hours Worked
- Gross Pay
- Federal Withholding Tax
- Medicare Tax (Employee and Employer)
- Social Security Tax (Employee and Employer)
- Federal Unemployment Tax
- State Withholding Tax
- State Unemployment Tax
- Patient Pay
- Garnishments *
- Other Categories Assigned
- Net Pay
- Published Agency Pay Rate
- Billable Rates (Approved by DMAS)

*Garnishments may be provided in a separate quarterly schedule that corresponds with the quarterly payroll register.

- *Schedule of Penalties and Interest Incurred*
  The Contractor shall review a schedule, provided by the F/EA, 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 schedule shall include an explanation of each charge and its disposition.

  The Contractor shall review a schedule of all penalties, interest incurred, and bank charges for stop payments, overdrafts, and other banking related fees assessed on the established payroll account.

- *Report of Uncashed or Cancelled Payroll Checks*
  The Contractor shall review a quarterly report of uncashed or cancelled (voided) payroll checks beyond a period of 180 calendar days from the issuance date including the amount refunded to the Contractor.

- *Payroll Bank Account, Statements and Bank Reconciliations*

The Contractor shall establish a non-interest bearing bank account with the F/EA separate and apart from any other Contractor account. Funds in the established account shall only be used for payroll and federal and state taxes for employees of CCC Plus Waiver Members, EORs, and shall not be pledged by the Contractor or used to secure a loan, guaranty, debt, or other obligation of the Contractor or any other person. The Contractor will not be liable for over-draft charges or any other banking related charges assessed on the established payroll payment accounts.

The Contractor shall review copies of the established bank account statements (PDF File), bank reconciliations, and check register for the quarter provided in electronic format with no formatting of totals, subtotals, etc.

- *Payroll Tax Accrual Reconciliation Report*
  The Contractor shall review the F/EAs Quarterly Payroll Tax Accrual Reconciliation Report which reconciles taxes billed (gross wages x estimated billable tax rate) with actual State and Federal taxes.

4.7.6.8 Payments to the F/EA

The Contractor shall submit weekly payroll payments to the F/EA and a weekly reconciliation of actual paid hours and overtime (if applicable) at the billable rate for the same schedule payrolls (e.g. Payroll A to Payroll A). Weekly invoices from the F/EA include the following detail:

- Pay Schedule
- Batch Date
- Pay Period
- Amount of Payroll
- Tax Liabilities
- Services Type

The net amount from the weekly service advance and weekly reconciliation shall be deposited into the established F/EA payroll bank account the day before the F/EA issues paychecks to personal care attendants.

Weekly payroll projections shall be derived by a forecast model determined by the Contractor and approved by the Department. The net amount from the weekly payroll projection and weekly reconciliation shall be deposited into the established F/EA payroll bank account the day before the F/EA issues paychecks to Personal Care Assistants. Projections are reviewed and modified by the Department on at least a quarterly basis to ensure sufficient funds to cover 100% of the weekly payroll.

4.7.6.9 Administrative Services Organization (ASO) Payments for F/EA Services

The F/EA shall be compensated, by the Department, for ASO responsibilities based on a fixed Per Member Per Month (PMPM) fee in accordance with the established rate set forth in the F/EA contract. DMAS will not pay a maintenance fee for non-active CCC Plus Waiver Members.

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 Quarterly Payroll Tax Reconciliation Summary IRS Form 941 VA-5 VEC-FC-21/20	Mar 31 Jun 30 Sep 30 Dec 31	May 20 Aug 20 Nov 20 Feb 20
Monthly Bank Statements for the Quarter Monthly Bank Reconciliations for the Quarter Quarterly Check Register Monthly Cleared Checks Reports for the Quarter Listing of Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue Date Employer Tax Filing Penalties & Interest Incurred Report & refund	Mar 31 Jun 30 Sep 30 Dec 31	May 20 Aug 20 Nov 20 Feb 20
Amounts due to (from) Contractor's Payroll Tax Reconciliation Report Refund due to Contractor for Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue Report and refund to Contractor or proof of credit to the CD-Services Payroll Payment Account for bank penalties and interest incurred	Mar 31 Jun 30 Sep 30 Dec 31	May 20 Aug 20 Nov 20 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

4.7.7 Hospice

CCC Plus program enrolled Members who elect hospice will remain enrolled in the CCC Plus program. A Member may be in a waiver and also receive hospice services. The Contractor shall cover all services associated with the provision of hospice services for its enrolled Members. The Contractor shall ensure that children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. Refer to the *CCC Plus Coverage Chart* in Attachment 5 coverage details regarding hospice services, including when provided in the Member's home, an inpatient facility, or a nursing facility.

In order to receive hospice services, an individual must be enrolled in the hospice level of care (LOC). The Contractor shall enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of the admission/discharge.

4.7.8 Special Rules Related to Financial Eligibility for Long Term Care

In rare circumstances, individuals who are Medicaid eligible for most services may be determined by DSS to not be eligible for long-term care services. For example, a Medicaid applicant (or spouse) who transfers ownership of his/her property within the "look back period" without receiving adequate compensation may be ineligible for Medicaid to pay for long-term care during a penalty period. There is no transfer penalty imposed on Medicaid eligibility for care other than long-term care. In this scenario, the long term care service is considered non-covered. The LTSS provider is allowed to bill the Member for these as non-covered services if the provider has informed the Member prior to LTSS admission that If the Member is found by DSS to not be financially eligible for Medicaid funded long term services, the Member will be held financially liable for the costs of long term services. Reference the Medical Assistance For Aged, Blind or Disabled Individuals Handbook, pages 4-6, available at: http://www.dmas.virginia.gov/Content_atchs/atchs/Medical%20Assistance%20Handbook_2014%20(Aged%20Blind%20%20Disabled)%20-%20%20final.pdf. The information is also detailed in the Virginia Department of Social Services Medicaid Eligibility Manual, Chapter M1450.000, available on the DMAS website at: http://dmasva.dmas.virginia.gov/Content_pgs/pg-home.aspx.

4.7.9 LTC Portal Entry Process

4.7.9.1 Entry into the Virginia Medicaid Web Portal

The Contractor shall enter hospice, nursing facility (including long-stay hospital) admissions, discharges, and changes; and CCC Plus Waiver admissions directly into the Virginia Medicaid Web Portal (LTC Tab). The Contractor shall not enter LOC benefit information until the applicable services (NF, CCC Plus Waiver, Hospice) have started.

If the Contractor is unable to enter this information in the Portal because the individual does not have a UAI screening record, the Contractor shall submit the DMAS MCO 80 LTC Status Form, via FAX to DMAS within two (2) business days.

4.7.9.1.1 Hospice

The Contractor shall enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of the admission/discharge. A screening is not required for hospice services.

4.7.9.1.2 Nursing Facility

The Contractor shall enter Nursing Facility admissions and discharges into the Virginia Medicaid Web Portal (LTC Tab). The Contractor shall also enter changes to the NF level of care into the Virginia Medicaid Web Portal when a Member transitions between a skilled Medicare stay and a custodial Medicaid stay. Such admission/discharge and change transactions shall be entered by the Contractor no later than two (2) business days. Also refer to *Screening Requirements* in Section 4.7.1.

4.7.9.1.3 CCC Plus Waiver

The Contractor shall enter CCC Plus Waiver enrollments directly into the Virginia Medicaid Web Portal (on the LTC Tab). Such admission/discharge and change transactions shall be entered by the Contractor no later than two (2) business days. Also refer to Screening Requirements in Section 4.7.1.

The Contractor shall contact the DMAS Care Management Unit by email or phone for clarification in any instance where the Contractor is unsure of or requires guidance or clarification on the CCC Plus Waiver eligibility criteria prior to making any enrollment entries.

4.7.9.1.4 DD Waiver Level of Care Entries

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

4.7.10 CCC Plus Waiver Change Notice Form

The Contractor shall provide the CCC Plus Waiver Change Notice Form to DMAS for all CCC Plus Technology Assisted benefit plan (benefit plan A) admissions or discharges, including when the CCC Plus Waiver Member transitions to the tech assisted benefit plan from the standard benefit (i.e., benefit plan 9 to A). The Contractor shall submit the CCC Plus Change Notice Form, with all supporting documentation to DMAS via email at CCCPlusCareCoordination@dmas.virginia.gov or by FAX to 804-452-5442. To ensure timely processing, all email or FAX subject lines should be marked: *CCC Plus Waiver Change Notice Form*. A copy of the form and instructions is provided in Attachment 14 of this Contract for informational purposes. DMAS reserves the right to revise the form and instructions as needed.

DMAS will review the form and documentation submitted to ensure that the Contractor is applying the Department's technology assisted benefit plan criteria correctly. DMAS will provide follow-up technical assistance to the Contractor as appropriate within no more than five (5) business days receipt of the Form. This review is an interim process for DMAS to provide technical assistance to the Contractor. This review process shall continue for up to six (6) months to ensure that the Contractor is applying technology assisted benefit plan criteria correctly. DMAS reserves the right to require the Contractor to continue the review process beyond six (6) months based upon the Contractor's demonstration of its ability to correctly apply the technology assisted benefit plan criteria. After the initial six (6) month review, DMAS will continue to monitor the Contractor's performance in this area on-going as part of the Department's compliance audits.

The Contractor shall also submit the form to DMAS for individuals who meet criteria for CCC Plus Waiver Services and have refused services as well as for individuals who have not received CCC Plus Waiver services for more than thirty (30) consecutive days. DMAS will review the form and documentation submitted and provide follow-up instruction to the Contractor regarding the Member's CCC Plus Waiver status within no more than five (5) business days after receiving the form.

If at any time the Contractor determines that the Member does not meet CCC Plus Waiver criteria, the Contractor shall initiate a LOC review prior to making any CCC Plus Waiver disenrollment entries. Additional details about LOC reviews is available in Section 4.7.2.3.1.

4.8 PHARMACY SERVICES

4.8.1 General Coverage Provisions

The Contractor shall be responsible for covering all medically necessary 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 may not impose co-payments on any medications.

4.8.1.1 Prescription Drug 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) available at https://www.virginiamedicaidpharmacyservices.com.

The Contractor shall include the DMAS Preferred Drug List (PDL) as a "common core" formulary for all Members enrolled in the CCC Plus program who have a pharmacy benefit covered by the Contractor's Medicaid plan. The DMAS PDL is not an all-inclusive list of drugs for Medicaid Members.

The "common core" formulary will not apply to dual eligible Members who have a pharmacy benefit covered by a Medicare Part D plan.

The Contractor's formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit their formulary to DMAS annually after review by its P&T Committee and inform DMAS of changes to their formulary by their P&T Committee. The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including prior authorizations and quantity limits. The Contractor shall submit changes for review and approval 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.

4.8.1.1.1 Formulary Closed Classes (DMAS Defined)

The Department will define a Supplemental Preferred Drug List (PDL) (also known as "closed classes") with a select number of classes from the overall PDL. The Contractor shall not add or remove drugs including alternative dosage forms to drug classes on the DMAS Supplemental PDL. The Contractor shall not solicit additional rebates or discounts for drugs included on the DMAS Supplemental PDL. Supplemental PDL will apply only to non-dual Members.

4.8.1.1.2 Formulary Non-Closed Classes

The Contractor may add drugs to their formulary in drug classes **not** included on the DMAS Supplemental PDL. For drug classes not included on the DMAS Supplemental PDL, the Contractor retains the ability to negotiate rebates or discounts. All drug rebates and discounts must be reported to DMAS as defined in the *Reporting of Rebates* section of this contract.

4.8.1.2 Program Preferred Drug Access Requirements

The "preferred drugs" included on the DMAS PDL and the DMAS Supplemental PDL 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.

4.8.1.3 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.

4.8.2 Shared Preferred Drug List (PDL) Workgroup

The Contractor shall include the DMAS PDL as a "common core" Preferred Drug List for all Members enrolled in the CCC Plus program. The Department will provide the Contractor with the opportunity to provide input into the PDL through the pharmacy implementation work group, including the P&T meetings, or meetings specifically established for the purpose of discussing/implementing the "common core" Preferred Drug List.

4.8.3 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.

4.8.4 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.

4.8.5 Utilization Management For Pharmacy Services

4.8.5.1 Transition of Care

The Contractor shall have in place policies and procedures to ensure the continuity of care for Members with established pharmacological treatment regimens. The Contractor shall also ensure that it is able to process pharmacy claims using either the Medicaid ID or the MCO ID number. Refer to *Continuity of Care* section of this Contract for more information.

4.8.5.2 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) of the Social Security Act. The Contractor shall incorporate the requirements into its pharmacy provider contracts.

The Contractor must accept telephonic, facsimile, or electronic submissions of service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug programs' SCRIPT standards for service authorization requests.

Pharmacy services for children must be reviewed in accordance with EPSDT requirements to cover medically necessary 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.

4.8.5.3 Denial of Services

If the Contractor denies a request for service authorization, the Contractor must issue a Notice of Action within 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 *Member and Provider Grievances and Appeals* section of this Contract.

4.8.5.4 Emergency Supply

If needed, a 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, believes that the Member's health would be compromised without the benefit of the drug. For unit-of-use drugs (i.e., inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the 72-hour supply.

4.8.5.5 Notification Requirement

The Contractor must have policies and procedures for general notifications to participating providers and Members of revisions to the formulary and service authorization requirements. Written notification for changes to the formulary and service authorization requirements and revisions must be provided to all affected participating providers and Members at least 30 calendar days prior to the effective date of the change.

4.8.6 Pharmacy and Therapeutics (P&T) Committee

The Contractor shall have a P&T Committee that will ensure safe, appropriate, and cost effective use of pharmaceuticals for the Virginia Medicaid enrollees of this Contract. The P&T Committee shall serve in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of this Contract and the appropriate use of medications.

The Contractor's P&T Committee shall be comprised of physicians, pharmacists or nurse practitioners holding valid professional licenses. The Committee must include at least one practitioner in each of the following specialties: pediatrics, gerontology/geriatrics, and psychiatry. The Contractor's P&T Committee shall meet at least biannually.

The Contractor shall require all individuals participating in the P&T Committee to complete a financial disclosure form annually which is reviewable by the Department upon request.

4.8.7 Drug Utilization Review (DUR) Programs

In accordance with 42 CFR§ 438.3, the Contractor shall develop and maintain a DUR program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR§ 456, subpart K including prospective DUR, retrospective DUR and the DUR Board. The Contractor's DUR program at a minimum shall include all the DUR activities conducted by the Department.

The Contractor's DUR Board will meet at least biannually. The DUR Board must include a voting representative from the Department. The Contractor must provide the Department with

the minutes from each DUR Board meeting within thirty (30) calendar days of the date of the meeting.

The Contractor 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 CRF § 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 must provide the Department with a detailed description of its DUR program activities which will be used to complete the CMS Drug Utilization Review Annual Report. The Contractor must submit the CMS DUR Annual Report to the Department at least forty five (45) days prior to the due date established by CMS. The Department will share with the Contractor all reporting requirements including the weblink for the submission of the DUR Report.

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.

4.8.8 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 that the State shall collect such rebates from pharmaceutical manufacturers.

Drug utilization data must include all drugs dispensed at point-of-sale (POS) and those administered in a provider's office or other outpatient setting. Pursuant to Section 2501(c)(1)(C)(III) of the Social Security Act, the Department will require encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS physician administered code. 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 physician administered code must be submitted with a valid NDC on each claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a claim line using the same HCPCS physician administered code. For the purpose of this contract the term "dispense" is defined to include the terms "provide" and "administer." 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.

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 DMAS and the Contractor, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing. (See CCC Plus Technical Manual for reporting requirements.). If a

Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the Contractor shall ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This shall include the use of a unique BIN/PCN combination to distinguish Medicaid managed care claims from commercial or other lines of business. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered as part of the DMAS pharmacy benefit.

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

Refer to the *Capitation Payment to the Contractor* section of this Contract for more information.

4.8.9 Long Acting Reversible Contraception (LARC) Utilization and Reimbursement

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

Consistent with 42 CFR § 441.20, the Contractor shall provide coverage for its enrolled Members for all methods of family planning including but not limited to barrier methods, oral contraceptives, vaginal rings, contraceptive patches and long acting reversible contraceptives (LARCs). As required by section 1902(a)(23)(B) of the Act, the Contractor cannot require the Member to obtain a referral prior to choosing a provider for family planning services. The Member must be allowed to select any qualified family planning provider from in- network or out-of-network without referral. In addition to a Member's free choice of family planning provider, Members are free to choose the method of family planning as provided in 42 CFR § 441.20.

4.8.9.1 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 insertion of LARC device immediately post-delivery insertion of a LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.

4.8.9.2 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.

4.8.10 Prescription Monitoring Program (PMP)

The Department of Health Professions established, maintains, and administers an electronic system to monitor the dispensing of Schedule II, III, and IV controlled substance prescription drugs pursuant to § 54.1-2520 and § 54.1-3400 et. seq of the *Code of Virginia*, known as the Prescription Monitoring Program (PMP).

Under § 54.1-2523 of the *Code of Virginia*, the Contractor may obtain information from the PMP about specific Members in order to determine eligibility and to manage the care of the specific Member participating in the PUMS or a similar program (Refer to the *Patient Utilization Management & Safety (PUMS) Program* section of this Contract for more information.) Information may only be obtained by a current employee of the Contractor who is also a physician or pharmacist licensed in the Commonwealth.

Notice shall be given to Members that information may be requested from the Prescription Monitoring Program by a licensed physician or pharmacist employed by the Contractor. The Contractor must notify its Members of the possibility that the Member's information may be accessed using the PMP, such as via the Member Handbook, postcard mailings, PUMS letters, etc. Note that all data related to the PMP are exempt from FOIA requests and considered confidential information.

4.8.10.1 Process for Contractor Access to the PMP

The Contractor shall provide to DMAS, in the format specified by the Department of Health Professions, an actively maintained list of up to four (4) Commonwealth-licensed pharmacists/physicians employed by the Contractor who will be utilizing the PMP. PMP access login credentials will be provided by the Department of Health Professions and shall not be delegated to or used by other staff. The Contractor, and its employees accessing the PMP, shall only use the PMP in accordance with all applicable State laws, including but not limited to § 54.1-2520, § 54.1-2523, and § 54.1-3400 et. seq of the *Code of Virginia*, and will be required to attest to such usage as a conditional term of access. The Contractor shall notify the Department of Health Professions immediately (within 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.

4.8.11 Reporting Requirements for HB 1500 Item 306 #3c for Contractor's Pharmacy Benefit Manager

The Contractor shall report as follows for all pharmacy claims:

1) The actual amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. Reporting requirements are defined in the State Companion Guides and the CCC Plus Technical Manual.

2) In the event the Department identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy

benefit manager the Contractor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The Contractor shall submit such reports by the 15th of each month or the next business day. Additional reporting requirements are defined in the CCC Plus Technical Manual.

3) For dual eligible enrollees, the Contractor shall report on pharmacy claims paid through Medicaid.

4.9 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. Telemedicine may also include 'store and forward' technology, where digital information (such as an X-ray) is forwarded to a professional for interpretation and diagnosis.

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 as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions.

The Contractor also shall encourage the use of telemedicine to promote community living and improve access to health services.

The Contractor may use the following types of providers for Medicaid-covered telemedicine services: physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family counselors, licensed substance abuse practitioners, and credentialed addiction treatment providers. The Contractor may propose additional provider types for the Department to approve for use.

The decision to participate in a telemedicine encounter will be at the discretion of the Member and/or their authorized representative(s), for which informed consent must be provided, and all telehealth activities shall be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department's program requirements. Covered services include:

1. Store and Forward Applications: The Contractor shall 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.
2. The ability to cover remote patient monitoring, especially for Members with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases or the need for anticoagulation. Examples of remote patient monitoring activities include transferring vital signs such as weight, blood pressure, blood sugar, and heart rate.

3. The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the Member's primary care physician.

All telemedicine services shall be provided in a manner that meets the needs of vulnerable and emerging high risk populations and consistent with integrated care delivery. Telemedicine services can be provided in the home or another location if agreeable with the Member.

4.10 TRANSPORTATION SERVICES

The Contractor shall cover emergency, urgent, and non-emergency transportation services to ensure that Members have necessary access to and from providers of covered medical, behavioral health, dental, and LTSS services, per 42 CFR § 440.170(a) and 12 VAC 30-50-530 in a manner that seeks to ensure the Member's health, safety, and welfare. The Contractor shall not be responsible for transportation to DD waiver services for Members enrolled in the Building Independence, Community Living, and the Family and Individual Supports Waivers. Transportation DD waiver services for these Members will be paid through Medicaid fee-for-service as "carved out" services.

Transportation for medical, behavioral health (including ARTS and CMHRS), CCC Plus Waiver services (formerly known as EDCD & Tech), dental, LTSS, and all services covered under the CCC Plus contract other than to/from DD Waiver services or DD Waiver services when covered through EPSDT shall be the responsibility of the Contractor. The Contractor shall provide the transportation benefit to all carved out services, except for DD Waiver services which are the responsibility of the Department's fee-for-service transportation broker.

The Contractor shall cover 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 taxies and commercial carriers as well as public agencies, non-profit and for-profit private agencies, and public carriers.

At 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.

The Contractor shall participate in a transportation workgroup that will include representatives from DMAS, the MCOs, and stakeholders to review transportation issues, including level of

assistance guidelines, capacity by level of assistance, data transfer, and other facets of transportation services. Recommendations from this workgroup will result in a collaborative and strategic approach that addresses member access to transportation services.

4.10.1 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.

4.10.2 Transportation Expenses

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

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

4.10.3 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.

4.10.4 Transportation Provider Network

The Contractor or its broker shall establish a network of qualified transportation providers to provide covered transportation services to meet the transportation needs of its members. The Contractor or its transportation broker shall have a sufficient network of transportation providers (numbers and types of vehicles and drivers), to provide services in accordance with the amount, duration, and scope, requirements described in this Contract. The Contractor or its broker shall also 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 9.3 of this Contract. The Contractor's transportation network shall include a 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.

4.10.5 Alternate Transportation

Alternate transportation includes fixed-route public transportation, volunteer drivers, vouchers and gas and/or mileage reimbursement.

4.10.6 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.

4.10.7 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.

4.10.8 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, especially those residing in nursing facilities, dialysis or attending Day Support programs or Adult Day Health Care programs, may require door-to-door or hand-to-hand transportation assistance.

4.10.8.1 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.

4.10.9 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.

4.10.10 Driver Training

The Contractor is required to train all taxi company or independent (i.e., Uber, Lyft) drivers. The Contractor shall ensure drivers who perform transports for CCC Plus Waiver 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. Driver training shall encompass, the following areas:

- Customer service;
- Passenger assistance;
- Sensitivity training;
- 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);
- HIPAA privacy requirements;
- ADA requirements (Americans with Disabilities Act of 1990);
- Wheelchair securement/safety;
- Seat belt usage and child restraints;
- Handling and reporting accidents and incidents;
- Emergency evacuation;
- Daily vehicle inspection;
- Defensive driving;
- Risk management;
- Communications;
- Infection control;

- Annual road tests; and
- Reporting enrollee and provider fraud and abuse.

4.10.11 Attendants

The use of an attendant must be prior approved by the Contractor. The transportation attendant can be an employee of a transportation provider, and or Member's attendant, approved and reimbursed by the Contractor, 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 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.

4.10.12 Transportation Services for Minors

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.

4.10.13 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. 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:

https://law.lis.virginia.gov/vacode/title46.2/chapter20/section46.2-2000.1/
https://law.lis.virginia.gov/vacode/title46.2/chapter20/section46.2-2001.2/

4.10.14 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.

4.10.15 Transportation 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.

4.10.16 Reporting Missed Trips

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

4.10.17 Department of Justice (DOJ) Settlement

In August 2008, DOJ initiated an investigation of Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling. The Olmstead decision requires that individuals be served in the most integrated settings appropriate to meet their needs consistent with their choice. In February 2011, DOJ submitted a findings letter to Virginia, concluding that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs.

In March 2011, upon advice and counsel from the Office of the Attorney General, Virginia entered into negotiations with DOJ in an effort to reach a settlement without subjecting the Commonwealth to an extremely costly and lengthy court battle with the federal government. On January 26, 2012, Virginia and DOJ reached a settlement agreement. The agreement resolves DOJ's investigation of Virginia's training centers and community programs and the Commonwealth's compliance with the ADA and Olmstead with respect to individuals with intellectual and developmental disabilities.

The Department's compliance with the settlement agreement includes compliance with recommendations of an Independent Reviewer. One of the areas under review includes transportation services for DD Waiver individuals, where the goal is to ensure that transportation services are of "good quality, appropriate, available and accessible to the DD population."

The Contractor provides transportation services for DD Waiver individuals to and from non-DD waiver services. In accordance with the agreement, the Contractor shall report on the quality of transportation provided to DD waiver individuals. In following with these requirements, the Contractor shall:

1. Separate out individuals with ID/DD waivers;

2. Complete an analysis related to the delivery of transportation services for DD members: and
3. Evaluate the quality of the transportation services provided to DD waiver members by the Contractor.

In addition, the Contractor shall at a minimum collect and provide the following data to the Department specifically for individuals enrolled in one of the three DD waivers, and receiving transportation through the Contractor for non-wavier services:

1. Collect and report the accident/injury reports for ID/D population; list each accident and/or injury of each ID/D waivered member,
2. Collect and report all transportation related complaints received from DD Waiver individuals.
3. Conduct a satisfaction survey of a sample of the DD waiver individuals receiving transportation services through the Contractor and provide a summary to the Department in accordance with the requirements outlined in the CCC Plus technical manual.
4. Provide an analysis of the activities that the Contractor has in place that support the goal of ensuring that DD Waiver members have access to transportation services that are of "good quality, appropriate, available and accessible to the DD population."
5. Reports shall be submitted quarterly, on the following schedule: >
   4th Quarter – for October, November, December - by January 15th
   1st Quarter – for January, February, March - by April 15th
   2nd Quarter – for April, May, June - by July 15th
   3rd Quarter - for July, August, September - by October 15th

The data requirements and reporting specs are provided in the CCC Plus Technical Guide. DMAS reserves the right to revise the reporting requirements at the recommendations of the Independent Reviewer or as negotiated for the settlement. Additional information is available at: http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/doj-settlement-agreement.

4.10.17.1 Transportation Services Consultation and Support

The Contractor shall work collaboratively to support the Department in responding to the Department of Justice (DOJ), the Joint Legislative Audit and Review Commission (JLARC), the Virginia General Assembly, individuals, organizations, agencies, facilities and medical service providers that deliver services to Virginia Medicaid DD Waiver members, in accordance with the DOJ agreement and any and all subsequent recommendations of the Independent Reviewer.

4.11 CARVED OUT SERVICES

The Contractor shall have Care Coordinators and staff familiar with all carved out services. Carved out services include: Dental, School Health Services, DD Waiver Services, DD case management services, and transportation services to and from DD Waiver Services. DD Waivers include: Community Living, Family and Individual Supports, and Building Independence Waiver services. The Contractor shall have the ability to refer and communicate with the Department, DBHDS, LTSS provider staff, and other formal and informal supports to ensure coordination of care. The Contractor must ensure that the carved out services are included in the person-centered Individualized Care Plan (ICP) in order to most effectively coordinate

services for the Member. Refer to the *CCC Plus Coverage Chart* attached to this Contract for more information on each of these Waivers and carved out services.

4.12 STATE PLAN SUBSTITUTED (IN LIEU OF) SERVICES

The Contractor may provide alternative services or services in a setting that is not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services that are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). Such services shall comply with Federal requirements described in 42 CFR § 438.3(e)(2). The Contractor shall not require a Member to use a state plan substituted service "in lieu of" arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner.

For individuals aged 21 through 64, and in accordance with 42 CFR §438.6(e), 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 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; and,
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; reference *Addiction And Recovery Treatment Services (ARTS).*

4.13 ENHANCED BENEFITS

Enhanced benefits are services offered by the Contractor to Members in excess of the CCC Plus program's covered services. No increased reimbursement shall be made for enhanced benefits provided by the Contractor. When being developed, the Contractor shall consider the population to whom they are being offered, and should address the Members' needs. At least thirty (30) calendar days prior to implementation, and prior to each annual open enrollment period, the Contractor shall provide to the Department for approval the list of enhanced benefits it would like to offer and to whom the benefits would be available, the benefit limits, and criteria for each enhanced benefit. 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 CCC Plus program comparison chart).

Enhanced benefits offered by Contractors will be listed in the Department's CCC Plus 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 shall be made only at open enrollment. However, the Contractor may revise to add additional enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts.

The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of and expenditures for enhanced benefits provided to Members during the Contract. The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services which have been added by the Contractor and approved by the Department.

The Department strongly encourages Contractors to work with Department of Aging & Rehabilitative Services (DARS) to cover innovative services like the Chronic Disease Self-Management Program (CDSMP), as it aligns with the Department's priorities to empower individuals to take steps to improve their overall health and maintain an active and fulfilling lifestyle.

Examples of potential enhanced benefits for the CCC Plus program population may include, but are not limited to, social determinants of health, routine and preventive dental coverage for adults, chiropractic care, environmental modifications and assistive technology, vision, hearing, and personal care services for individuals who do not meet waiver criteria. If consumer directed personal care services will be offered as an enhanced benefit, the Contractor shall contract with and reimburse the F/EA for all of the administrative costs associated with the F/EA functions for this benefit.

4.14 SERVICES RELATED TO FEDERAL MORAL/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:

The Contractor shall furnish information about the services it does not cover based upon this rule:

1. To the Department with the initiation of the Contract, whenever changes are made, and upon request, and upon adoption of such policy in the event that the Contractor adopts the policy during the term of the Contract.
2. To potential Members before and during enrollment and to Members within thirty (30) calendar days before the effective date of change.

4.15 TRANSLATION & INTERPRETER SERVICES

Translation services (including oral interpreter services and sign language interpreter services) shall be available to ensure effective communication regarding treatment, consent to treatment, medical history, or health education. [42 CFR § 438.10(c)(4)] Trained professionals, including qualified sign language interpreters, shall be used when needed where technical, medical, or treatment information is to be discussed with the Member, a family Member or a friend.

The Contractor shall institute a mechanism for all Members who do not speak English to communicate effectively with their PCPs and with Contractor staff and subcontractors.
If five hundred (500) or more of its Members are non-English speaking and speak a common language, the Contractor shall include, if feasible, in its network at least two (2) medically trained professionals who speak that language.

In addition, the Contractor shall provide TTY/TDD services for the hearing impaired.

4.16 MEDICAID WORKS

Medicaid Works is a work incentive opportunity offered by the Virginia Medicaid program for individuals with disabilities who are employed or who want to work. To qualify for Medicaid Works, applicants must be determined to meet the income, asset and eligibility requirements for the Aged, Blind and Disabled (80% of the Federal Poverty Level) Medicaid covered group by their local Department of Social Services. Medicaid Works individuals are at least 16 years of age and less than 65 years of age. Additional background information about Medicaid Works is available at: http://www.dmas.virginia.gov/Content_pgs/rcp-mbi.aspx.

Medicaid Works individuals shall receive the same amount, duration and scope of services as other CCC Plus Program Members, with two (2) additional benefits.

1) Dietary Counseling Services are covered when medically necessary, for example for Medicaid Works enrolled individuals who have hyperlipidemia (high cholesterol) and/or other known risk factors for cardiovascular and diet-related chronic disease (for example, heart disease, diabetes, kidney disease, obesity).
2) Medicaid Works individuals are also eligible to receive personal care attendant services, including consumer directed care, without enrolling in a HCBS waiver. Medicaid Works individuals are not required to have a preadmission screening. Individuals who receive personal care services through Medicaid Works do not have a patient pay responsibility for the personal care services. The coverage criteria for personal care services for Medicaid Works enrolled Members shall be the same as the personal care coverage criteria described under the CCC Plus HCBS waiver. Criteria information regarding personal care can be found in the EDCD Waiver Provider Manual, Chapter IV, and the CCC Plus Coverage Chart, Attachment 5 to this Contract.

SECTION 5.0 CCC PLUS MODEL OF CARE

5.1 GENERAL REQUIREMENTS AND COVERED POPULATIONS

The Contractor's model of care shall align with the Department's CCC Plus program goals to provide comprehensive care coordination that integrates the medical and social models of care through a person centered approach; that promotes Member choice and rights; and, engages the Member and family members throughout the process. In addition, the Contractor's model of care shall also include processes that prioritize continuity of care, and seamless transitions for Members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits. Reference the attached *Model of Care*.

The Contractor's model of care shall include all of the required elements:

1) Provide the full scope of care coordination and related services for the CCC Plus populations (listed below) as required in this Contract.
2) Operate using person-centered care coordination for all Members
3) Include methods to identify, assess, and stratify vulnerable CCC Plus Populations and populations with emerging high risks.
4) Include comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement,
5) Integrate primary, acute, behavioral health, and LTSS,
6) Be responsive to the Member's needs and preferences, and shall take into account the health, safety, and welfare of its Members.
7) Include staff and provider training on the CCC Plus model of care to ensure Members receive person-centered, culturally competent care through trained Care Coordinators and through a network of high-quality, credentialed providers who have attested to or demonstrated the required competencies required by the Contractor.
8) Include processes and systems of care that engage Members and family members in person centered, culturally competent care and ensures seamless transitions between levels of care and care settings.

5.1.1 CCC Plus Vulnerable and Emerging High Risk Populations

The Contractor's model of care design shall have the capacity to effectively manage the following complex populations that will participate in CCC Plus. Reference Section 5.8 for classification of populations by risk level and related Care Coordinator ratios. Reference Attachment 11 for HRA and ICP deliverable requirements by population.

a. Members enrolled the CCC Plus HCBS waiver (refer to Section 4.7.2)
b. Members residing in nursing facilities
c. Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling)
d. Members enrolled in the DD HCBS Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers)
e. Members with intellectual/developmental disabilities (I/DD)
f. Members with cognitive or memory problems (e.g., dementia)
g. Members with brain injuries
h. Members with physical or sensory disabilities

i. Members with substance use disorders
j. Members with end stage renal disease
k. Members receiving hospice benefits
l. Children in foster care or adoption assistance
m. Women with a high risk pregnancy
n. Members with other complex or multiple chronic conditions
o. Members who have limited or no current medical, behavioral health, or LTSS needs but may have needs in the future.

5.2 HEALTH RISK ASSESSMENTS (HRA)

The Contractor shall use a Health Risk Assessment (HRA) as a tool to develop the Member's person-centered Individualized Care Plan (ICP) (see section *Person Centered Individualized Care Plan and Reassessments* for more information). The Department reserves the right, providing the Contractor with at least sixty (60) calendar days advance notice, to require the Contractor to add additional elements to its HRA. The Contractor shall participate in an HRA workgroup in the Summer of 2018 that includes representation from all plans, DMAS, and relevant stakeholders. The goal of the HRA workgroup is to create a universal HRA that is portable and that can follow the Member from one MCO to another.

5.2.1 HRA Tool Required Elements

5.2.1.1 Global HRA Tool Elements

At a Minimum, the Contractor's HRA shall effectively identify the Member's unmet needs, and shall encompass social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, the Member's strengths and goals, the need for any specialists, community resources used or available for the Member, the Member's desires related to their health care needs (as appropriate), and the person-centered ICP maintenance. The Contractor should use appropriate documentation (e.g., MTR data, early intervention individualized family service plan, MDS, UAI when current/relevant) to complete HRA elements in order to avoid unnecessary burden to the Member, caregiver or provider.

The Contractor's HRA shall also:

1) Document that during the initial health risk assessment, the Member was informed of the program name, covered benefits, and the role of the Care Coordinator.
2) Document the source of information for the HRA i.e. the Member, providers, facility staff, family/caregivers, etc. to include name and title) and location of completion (face to face or telephone and physical location).

5.2.1.2 HRA Tool Elements for CCC Plus Waiver Members

For CCC Plus Waiver Members, in addition to the required elements above, the Contractor's assessment shall also include the following elements:

1) Pertinent information from the Uniform Assessment Instrument (UAI), when available.
2) Discussion with Member/caregiver regarding satisfaction with services received;
3) Evaluate the environment for appropriateness, safety, and Member comfort;
4) Confirmation of the Member's needs;
5) Clarification with Member/caregiver program services, limits, and rights and responsibilities of everyone involved in providing care;

6) Confirmation that the waiver provider(s) is working to meet Member's care plan as written; and,
7) Confirmation that all appropriate documentation is available in the home (i.e. Plan of Care).

5.2.1.3 HRA Tool Elements for Technology Dependent Members

For CCC Plus Waiver Members who are technology dependent, in addition to the required elements above, the Contractor's assessment shall also include the following elements:

1) Determination that appropriate medical equipment is available;
2) Confirmation that medical needs are as described on the DMAS 108/109;
3) Confirmation that the Private Duty Nursing provider is working to meet Member's care plan as written; and,
4) Confirmation that all appropriate documentation is available in the home (i.e. physicians' orders, Home Health Certification and Plan of Care (CMS-485), nursing care and medication administration documentation, etc.).

5.2.1.4 HRA Tool Elements for Nursing Facility Members

For CCC Plus Members who reside in a nursing facility, in addition to the required elements above, the Contractor's assessment shall also include the following elements:

1) All pertinent information from the Minimum Data Set (MDS);
2) Information from the MDS Section Q, in addition to separate documentation of the Member's interest and desire for transition to the community and available resources and barriers to doing so;
3) The transition process including any identified health, safety or welfare needs which may result in the Member's inability to transition by to the community; and,
4) Pertinent information from the Uniform Assessment Instrument (UAI), when available.

5.2.2 HRA Staff Qualifications

The Contractor's staff performing Member HRAs shall meet the minimum qualifications of a Care Coordinator as specified in *Care Coordination Staffing*.

5.2.3 HRA Requirements

1) The Contractor shall ensure that its HRAs conducted by telephone interview, if recorded, shall have the Member's consent to be audio recorded. The Contractor shall provide the audio recording including the Member's consent to DMAS upon request.

2) The Contractor shall conduct HRAs for Members in the CCC Plus Waiver, for Members residing in nursing facilities, and for Members with serious mental illness, via face-to-face communication. DMAS may recognize HRAs conducted via telehealth as an accepted means of face to face communications. The Contractor shall ensure that any telehealth communication processes are an effective and appropriate option based upon the Member's condition, communication abilities, and preferences. The Contractor shall submit any telehealth HRA protocols to DMAS for approval prior to implementation.

3) The Contractor's Care Coordinators 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 assessment process.

4) The Contractor's Care Coordinators shall document efforts made to outreach and conduct HRAs for Members the Contractor has difficulty locating.

5) The Contractor shall conduct HRAs in a location that meets the needs of the Member.

6) The Contractor's Care Coordinator shall have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.

7) Relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) shall be used by the Contractor. Results of the HRA shall be used to confirm the appropriate stratification level for the Member and as the basis for developing the ICP.

8) The Contractor shall ensure that each element of the HRA, including a description of the CCC Plus Waiver and other covered services to be provided until the next person-centered ICP review, is reflected in the ICP. In addition, the Contractor shall ensure that its ICT process ensures that all relevant aspects of the Member's care is addressed in a fully integrated manner on an ongoing basis.

9) During assessments and reassessments, the Contractor's Care Coordinator shall gather advance directive information. This includes educating the Member about advance directives, obtaining any advance directives documentation, and complying with all Federal and State requirements for advance directives, including maintaining a copy of all related documents in the Member's file.

10) The Contractor shall report specific data elements from the HRAs in a format and frequency as specified by DMAS in the CCC Plus Technical Manual.

5.2.4 HRA Completion Timeframes

Care Coordinators shall complete an initial face to face Health Risk Assessment (HRA) for newly enrolled Members as expeditiously as the Member's condition requires and within the timeframes set forth below.

5.2.4.1 CCC Plus Waivers and EPSDT Populations

1) For CCC Plus Members who receive Private Duty Nursing Services, the Contractor shall ensure that HRAs are completed face to face within fourteen (14) calendar days of plan enrollment,
2) For CCC Plus Waiver Members who do not receive Private Duty Nursing Services, the Contractor shall ensure that HRAs are completed face to face within thirty (30) calendar days of plan enrollment.

5.2.4.2 Nursing Facility CCC Plus Populations

For CCC Plus Members who reside in a nursing facility, the Contractor shall ensure that HRAs are completed face to face within one-hundred twenty (120) calendar days of plan enrollment.

The Contractor shall contact the nursing facility and Member within thirty (30) calendar days of enrollment, and provide the contact name and number of the Care Coordinator.

5.2.4.3 Other High-Risk Populations

The Contractor shall ensure that HRAs are completed for remaining *CCC Plus High-Risk Subpopulations*, within sixty (60) calendar days of plan enrollment. Populations include: individuals with serious mental illness, and individuals (duals and non-duals) with complex or multiple conditions who are identified by the plan or self-identified as having conditions that are not well managed, e.g. multiple ED visits, multiple inpatient admits, or have a lack of medication adherence, etc. The Contractor shall conduct HRAs for SMI populations face-to-face, as described in Section 5.2.3. Otherwise, the Contractor is not required to conduct HRAS face to face except in circumstances where appropriate based upon the Member's needs and preferences. The Contractor shall use risk stratification and predictive modeling protocols to identify and prioritize completion of assessments for its CCC subpopulations in an efficient manner that considers the acuity of need for its Members.

5.2.4.4 CCC Plus Populations with Emerging High Risks

The Contractor shall complete HRAs for emerging high risk subpopulations within one-hundred twenty (120) calendar days of enrollment. The completion timeframe for this population is extended to within one-hundred eighty (180) days during Medallion ABD Transition. The Contractor shall contact the Member within thirty (30) calendar days of enrollment, and provide the contact name and number of the Care Coordinator. DMAS reserves the right to revise this completion standard in future Contracts. Assessments are not required to be conducted face-to-face except in circumstances where appropriate based upon the Member's needs and preferences. *Refer to Model of Care (MOC), Assessment (HRA) And Individualized Care Plan (ICP) Requirements,* Attachment 11 of this Contract.

5.2.4.5 HRA for Members Who Transition To or From the Contractor

For Members who have transitioned from the Contractor's health plan to a different MCO, the Contractor shall share the most recent HRA data with the Department upon request. DMAS will share the Contractor's prior HRA information with the new MCO via secure email. If the Contractor is the "newly receiving MCO," the Contractor should request the prior MCO's HRA data through DMAS, by email to CCCPlusCareCoordination@dmas.virginia.gov. The Contractor is not required to conduct a new HRA unless the Member has experienced a triggering event or a new HRA is due per the requirements in Section 5.5 of this Contract. This also applies in the event that a Member is disenrolled and re-enrolled with the Contractor. A new HRA is required when the Member has experienced a triggering event or by the due date of the next HRA, based upon the timeframes listed in Section 5.5 of this Contract. This is an interim process for sharing HRA until a more efficient method for sharing the information is available.

5.3 PERSON-CENTERED INDIVIDUALIZED CARE PLAN (ICP)

The Contractor shall develop a person-centered, culturally competent ICP for each of its enrolled Members. The person-centered ICP shall be tailored to the Member's needs and preferences and completed in the timeframes specified in this Contract and based on the results of the Contractor's risk stratification analysis.

5.3.1 General Requirements

The Contractor's Care Coordinator shall:

1) Engage each Member in the ICP process;
2) Ensure that the Member receives any necessary assistance and accommodations to prepare for and fully participates in the care planning process that includes ICT participation and person-centered ICP development;
3) Develop and maintain the ICP and make the ICP or information related to the ICP accessible to providers and Members as needed and upon request;
4) Revise the ICP based on triggering events, such as hospitalizations or a decline or improvement in health or functional status;
5) Ensure information is secured for privacy and confidentiality in accordance with all applicable State and Federal requirements;
6) Obtain Member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is conducted telephonically, if the audio is recorded, the Contractor shall have the Member's consent for the audio recording. Also document all efforts when Members or their representatives refuse to sign, including a clear explanation of the reason for the Member's refusal;
7) Communicate any ICP revisions to the Member, ICT, and other pertinent providers;
8) Develop and implement the ICP no later than the end date of any existing SA. Services must be continued until the HRA has been completed and the ICP has been developed.

5.3.2 ICP Required Elements

The following elements shall be included in the Contractor's ICP. Other elements may also be necessary depending upon the Member's circumstances. Required elements include but are not limited to:

1) ICP Completion date; ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measures based assessments;
2) Strategies and actions, including interventions and specific services to be implemented to meet the Member's needs and preferences (including community-based resources, service provider information, quantity, frequency, and duration of the services or the person(s) responsible for the specific interventions/services (including peer supports);
3) Documentation within the ICP regarding progress towards goal completion noting success; rationale for extending target end goal dates; updating of ICP with new goals; any barriers or obstacles;
4) Identification of the Member's primary care provider and specialists, including plans for follow-up care;
5) Member's informal support network and services;
6) Addressing all needs of the Member (functional, medical, behavioral, cognitive, social, LTSS, wellness and preventive) as well as any preferences as identified by the Individualized Care Team (ICT) and agreed upon by the Member. Social needs include but are not limited to: housing, food, security, economic security, community and informational supports, and personal goals (e.g. go to school, have a job, be at granddaughter's wedding);
7) Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the Member;

8) Advance directive information; including education needs of the Member about advance directives, and obtaining any advance directive documentation and filing them in the Member's file. The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and shall be included in the ICP. Also included is documentation of information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives may not have been obtained;
9) Plans for transition coordination and services for Members in nursing facilities who wish to move to the community;
10) Addressing health, safety (including minimizing risk), and welfare of the Member.
11) Back up plans as appropriate for CCC Plus Waiver Members in the event that the primary caregiver is unable to provide care. If applicable, the use of skilled respite nursing, trained backup caregivers, and facility admission may be required. All technology dependent Members must have a trained primary caregiver who accepts responsibility for providing care whenever nursing is not in the home and, if applicable, Members must have a back-up plan if personal care services cannot be rendered as planned;
12) Crisis plans for Members with behavioral health needs. For crisis plans, describe how the Contractor will assist the Member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer supports) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
13) Plan to access needed and desired community resources and non-covered services;
14) Member's choice of services (including model of service delivery for personal care and respite –consumer-directed vs. agency-directed when appropriate for CCC Plus Waiver Members); and,
15) Elements included in the Provider Plan of Care (DMAS-97AB) for CCC Plus Waiver Members receiving personal care services and the DMAS-301 for Members receiving ADHC; and,
16) Elements included in the Home Health Plan of Care (CMS-485) for Members receiving Private Duty Nursing.
17) Elements included in the IFSP for Members receiving early intervention.

The Contractor's ICP shall comply with requirements reflected in the attached *Individualized Care Plan (ICP) Requirements Checklist per the CMS Home and Community Based Settings Final Rule.*

The Contractor shall fully comply with 42 CFR §441.301(c)(1) and (2) and to the CMS guidance documents located at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html.

5.3.3 ICP Completion Timeframes

Following completion of the HRA, the Contractor's Care Coordinator shall develop an initial ICP prior to the ICT meeting. The Member must agree to and sign revisions/updates to the ICP following the ICT as indicated above for initial ICP. The ICP is considered complete upon Member signature. The Care Coordinator can develop the initial ICP during the HRA process and obtain the Member's signature at that time. The Care Coordinator is not required to wait

until after the ICT meeting to complete the ICP. Electronic signatures are acceptable within federal requirements and when developed with the Member's agreement, when obtained over the phone (for non-LTSS Members).

5.3.3.1 CCC Plus Waivers and EPSDT Private Duty Nursing

1) For CCC Plus Members Receiving Private Duty Nursing, the Contractor shall complete the ICP within thirty (30) calendar days of plan enrollment.
2) For other CCC Plus Waiver Enrollees, the Contractor shall complete the ICP within thirty (30) calendar days of plan enrollment.

5.3.3.2 Nursing Facility

For CCC Plus Members residing in a nursing facility, the Contractor shall complete the ICP within sixty (60) calendar days of initial enrollment

5.3.3.3 Vulnerable Subpopulation

For CCC Plus Members in a vulnerable subpopulation not listed above, the Contractor shall complete the ICP within sixty (60) calendar days of plan enrollment

5.3.3.4 Emerging High Risk Subpopulation

For CCC Plus Members who do not meet one of the vulnerable subpopulation groups, the Contractor shall complete the ICP within ninety (90) calendar days of enrollment

5.3.3.5 Special Rules During Program Launch

For CCC Plus Members and EPSDT Members not receiving Private Duty Nursing services; Nursing Facility and Vulnerable Subpopulations described above, the timeframe for completion of ICP is within ninety (90) calendar days of enrollment for new Members at program launch. Refer to the attached *MOC Assessment (HRA) And Individualized Care Plan (ICP) Requirements By Population*. At program launch" means the first month that a CCC Plus region is implemented. The "clock" begins on the Member's enrollment effective date with the Contractor.

5.4 INTERDISCIPLINARY CARE TEAM (ICT)

The Contractor shall arrange for each Member, in a manner that respects the needs and preferences of the Member, the formation and operation of an interdisciplinary care team (ICT). The Contractor shall ensure that each Member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention and social needs) is integrated and coordinated within the framework of an ICT and that each ICT member has a defined role appropriate to his/her licensure and relationship with the Member. The Member shall be encouraged to identify individuals that he/she would like to participate on the ICT. The ICT shall be person-centered, built on the Member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The Care Coordinator shall lead the ICT.

5.4.1 ICT Meeting Timeframes

The Contractor shall conduct initial ICT meetings within timeframes that are consistent with the Member's needs and ensure completion of the ICPs within the Department's contractual standards. At a minimum, the Contractor shall conduct initial ICT meetings within the timeframes listed.

1) Nursing Facility Members shall be completed within sixty (60) calendar days of initial enrollment with the Contractor, or no later than the next scheduled ICT in conjunction with the service provider, whichever is later. If a triggering event occurs before the nursing facility scheduled ICT, the Care Coordinator must schedule an ICT prior to the NF ICT.
2) Adult Day Health Care participants shall be completed within thirty (30) calendar days or no later than the next scheduled ICT in conjunction with the service provider, whichever is later. If a triggering event occurs before the ADHC-scheduled ICT, the Care Coordinator must schedule an ICT prior to the ADHC-ICT.
3) CCC Plus Waivers and Members receiving EPSDT Private Duty Nursing shall be completed within thirty (30) calendar days of initial enrollment with the Contractor.
4) Vulnerable Subpopulation Members (excluding CCC Plus Waiver and Nursing Facility) shall be completed within sixty (60) calendar days of enrollment with the Contractor.
5) Emerging High Risk Subpopulation Members shall be completed within ninety (90) calendar days of enrollment with the Contractor.

5.4.2 Required ICT Members

The Contractor shall ensure that the ICT includes the Member and/or their authorized representative(s) and at least the staff listed below. The Contractor shall ensure that advance notice is provided to the Member and other required attendees in order to maximize participation for planned ICT meetings, such advance notice shall be provided at least one (1) week in advance. The Contractor shall ensure that input is requested for inclusion in the ICT discussion from ICT members who are unable to attend the ICT in-person or telephonically. At a minimum, the following staff shall be invited to participate in the ICT:

1) Care Coordinator
2) PCP
3) Behavioral health clinician, if indicated
4) LTSS provider(s) when the Member is receiving LTSS
5) Targeted case manager, if applicable (if the Member is receiving TCM services, the Contractor shall include the targeted case manager on the Member's ICT.) TCM includes ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high risk prenatal and infant case management services.
6) Pharmacist, if indicated

As appropriate and at the discretion of the Member, the ICT also may include any or all of the following participants:

1) A representative from the Medicare plan, if applicable
2) Registered nurse
3) Specialist clinician
4) Other professional and support disciplines, including social workers, community health workers, and qualified peers
5) Family members
6) Other informal caregivers or supports
7) Advocates
8) State agency or other case managers

5.4.3 ICT Documentation Requirements

The Contractor shall ensure that there is documented evidence in the Member record to support all of the following:

1) The names, titles, and roles of each ICT participant in attendance
2) The names, titles, and roles of invitees but not in attendance
3) Solicited input from required participants who are unable to participate in the ICT meeting and information provided through alternate means
4) Informing of the ICT participants (present or not) of information discussed; outcomes of the ICT meeting and any additional information obtained through alternate means.
5) When applicable, the Member's active refusal to participate in the ICT. The Member or his/her authorized representative must be included in the ICT; alternate forms of soliciting input from the Member are not acceptable unless there is clear documentation of the Member's refusal to participate with the stated reason
6) Review and discussion of the initial ICP developed by the Care Coordinator with the Member. The ICP shall be revised/updated as deemed necessary based on the needs and goals developed through the ICT process.

5.5 REASSESSMENTS

The Contractor shall conduct reassessments to identify any changes in the specialized needs of its Members as outlined in the attached *Model of Care Assessment and Individualized Care Plan (ICP) Expectations* table. The Contractor shall ensure that reassessments comply with the following requirements described below.

5.5.1 Routine Re-Assessment Completion Timeframes

The Care Coordinator shall perform a comprehensive re-assessment utilizing the approved HRA tool for all routine re-assessments.

1) For Members residing in a NF, reassessments shall be completed quarterly, consistent with MDS guidelines;
2) For CCC Plus Waiver participants and Members receiving EPSDT Private Duty Nursing services reassessments shall be completed at least every six (6) months; and.
3) For all other Members, reassessments shall be completed by the HRA anniversary, not to exceed 365 calendar days.

5.5.2 Reassessments Upon Triggering Events

The Care Coordinator shall conduct a comprehensive re-assessment for all Members:

1) When the Member experiences a trigger event such as a hospitalization or significant change in health or functional status; and,
2) To determine changes in the Member's status and needs, utilizing a standardized re-assessment tool. The re-assessment tool must be approved by DMAS prior to Program implementation.

5.5.3 Annual LOC Review

The Contractor shall conduct an annual LOC review for Members enrolled in the CCC Plus Waiver within 365 of the last annual LOC review.

5.5.4 ICT Related to Reassessments

The ICT shall be convened subsequent to all routine re-assessments, within thirty (30) calendar days and in the following circumstances:

1) Subsequent to triggering events requiring significant changes to the Member's ICP (e.g. initiation of LTSS, BH crisis services, etc.);
2) Upon readmissions to acute or psychiatric hospitals or Nursing Facility within 30 calendar days of discharge; and,
3) Upon Member request.

5.6 CARE COORDINATION STAFFING

Care Coordination and Care Coordinators are considered fundamental foundations of the CCC Plus program. As such, the Contractor shall communicate the benefits of care coordination and the role of the Care Coordinator when working with Members, providers, or other individuals inquiring and learning about the program. The Contractor shall use the title "Care Coordinator" for individuals assigned to be the Members' Care Coordinator, regardless of the primary diagnosis or condition of the Member.

The Contractor shall submit to the Department for approval prior to implementation, upon revision, or upon request, the care coordination staffing structure, including staff positions that will be involved in care coordination operations for the CCC Plus program, including but not limited to, Care Coordinator supervisors, Care Coordinators, care coordination support staff, and administrative staff support. The Contractor shall also identify the role/function(s) of each care coordination staff as well as the required educational requirements, clinical licensure standards certification, and relevant experience with care coordination standards and/or activities. DMAS reserves the right to train to the Contractor's care coordination staff in relation to the CCC Program requirements.

The Contractor shall also include a description of its assignment process for Care Coordinators to CCC Plus Members, which must take into consideration the Care Coordinator's experience working with populations with physical disabilities, developmental disabilities, serious mental illness, traumatic brain injury, the elderly, etc. The Contractor's care coordination staffing plan and staff credentials shall be in accordance with the contractual standards described below.

5.6.1 Care Coordinator Qualifications

At a minimum, the Contractor's Care Coordinators assigned to CCC Plus 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 CCC Plus 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.*

Assignment of the Care Coordinator shall be based on the assessment of the Member's needs and condition, as well as the qualifications of the Care Coordinator. All Care Coordinators shall complete a comprehensive training curriculum that includes CCC Plus Members' various medical/behavioral health needs, including training in specialized areas (e.g., dementia, substance use disorders); person-centered, culturally competent care; and, standards of care. The

Contractor's Care Coordinators shall also be trained and knowledgeable about the CCC Plus program and services described in the *CCC Plus Covered Services Chart.* Care Coordinators shall also be knowledgeable of involuntary psychiatric admissions related to emergency custody orders and temporary detention orders. Care coordination staff shall also be trained in providing assistance to Members in crisis. Care coordination staff shall have demonstrated ability to communicate with Members who have complex medical needs and who may have communication barriers.

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 dependent on life sustaining equipment.

For all other Members with LTSS needs (institutional and community-based), the Care Coordinator shall meet the qualifications in 5.6.1.

5.6.2 Care Coordinator Supervisor

The Care Coordinator's direct supervisor shall be a licensed clinical social worker, licensed Mental Health Professional (as defined in 12VAC35-105-20) or registered nurse with a minimum of one (1) year of relevant health care (preferably long-term care) experience or behavioral health experience if supervising complex behavioral health cases. All supervisors shall have access to the Contractor's Medical Director for review of cases. Care supervisors shall have demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.

5.6.3. Use of Community Based Organizations or Subcontractors for Care Coordination Services

The Contractor may subcontract with Community Based Organizations (CBOs) including, but not limited to, Centers for Independent Living (CILS), Community Services Boards (CSBs), and Area Agencies on Aging (AAAs) for the provision of care coordination as long as the Contractor ensures that CBO care coordination staff and supervisors meet all contractual standards and Federal conflict of interest requirements particularly in the area of functional eligibility assessments. Administrative firewalls should exist to ensure that staff within the contracted CBOs who perform direct care services, such as personal care, are not the same staff who provide care coordination services. CMS and DMAS do not consider case management to be a direct care service and therefore, case managers are not prohibited from performing care coordination functions. Reference additional guidance provided by CMS at: https://www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf. Also reference *Care Coordination Partnerships* below.

5.6.4 Regional Dedicated Transition Care Coordinator

The Contractor shall have at least one (1) dedicated transition Care Coordinator in each region without a caseload (other than individuals in transition) to assist individuals with care transitions. Care transitions include transitioning individuals from NFs, hospitals, inpatient rehabilitation, or other institutional settings into the community, and assisting individuals who desire to remain in

their community setting. Transition Care Coordinators shall meet the qualifications of a Care Coordinator as described Section 5.6.1 above. See *Care Coordination with Transitions of Care*.

5.7 CARE COORDINATION PARTNERSHIPS

Contractors may form innovative partnerships with community-based organizations that perform care coordination functions and offer support services to CCC Plus Members, such as options counseling, facilitating transitions from an institution to the community, etc. When requested by the Department, the Contractor shall participate in collaborative planning with the Department and its community partners. Partnering organizations may include, but are not limited to, Centers for Independent Living (CILS), CSBs, AAAs, adult day health care centers (ADCCs), health systems, and nursing facilities. The Contractor shall submit to the Department prior to implementation, upon revision, or upon request, a detailed description of any innovative partnership(s), the type and scope of the partnership(s), specific services and/or functions to be carried out through or in tandem with the partnership, geographic area(s) served, the number of Members expected to be served and related value based payment incentives. The report shall further explain the extent of the partnership(s) (e.g., contract signed, in negotiations, etc.).

5.8 CARE COORDINATOR STAFFING RATIOS

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

CCC Plus Care Coordination Staffing Ratios by Population			
High-Risk Populations			**Moderate to Low Risk Populations**
CCC Plus Waiver Populations	**Nursing Facility Populations**	**Other High-Risk Populations**	**Emerging High-Risk**
1:70	1:175	1:100	1:400
CCC Plus Waiver including Technology Assisted and Standard levels of care; Section 5.1.1(a).	Nursing Facility including Specialized Care and Long-Stay Hospital Section 5.1.1(b).	Individuals with Serious Mental Illness (SMI) Individuals (duals and non-duals) with complex or multiple conditions who are identified by the plan or self-identified as having conditions that are not well managed, e.g. multiple ED visits, multiple inpatient admits, or have a lack of medication adherence, etc.	All other individuals (duals and non-duals) not already identified in the high-risk population groups; includes populations (duals and non-duals) with complex or multiple conditions who are well managed. Populations listed in 5.1.1, (d-o), including DD Waiver individuals are included unless they meet high-risk criteria.

		Section 5.1.1 (c – n) if they meet high-risk criteria per 2 above.	
See Section 5.1.1			

Care Coordinators may have a "blended" caseload, comprised of Members in more than one sub-population to meet business operational needs or provide continuity of care for Members as long as the standard ratio thresholds are met. For example Care Coordinator A is assigned CCC Plus Waiver Members, residing in NF, and other emerging high risk populations. The Contractor must identify the FTE percentage the Care Coordinator works, and must provide the FTE percentage allocated to CCC Plus Waiver Members, residing in NF, and other emerging high risk subpopulation Members. If the Care Coordinator is allocated 30% time for CCC Plus Waiver Members, 30% time for NF Members, and 40% time for other emerging high risk population Members, the Care Coordinator must have no more than 21 CCC Plus Waiver Members 52 NF, and 140 other Members with emerging high risks. Caseloads must be adjusted according to employment status of full or part-time hours per week i.e. a .5 staff position would equate to .5 of the standard ratio. Multiple percentage split variations may occur to make up a total 100% caseload among various populations but the case assignments must not exceed the total combined established ratio.

On a monthly basis, the Contractor shall provide DMAS with a care coordination staffing report that demonstrates its level of compliance with the Department's care coordination ratio requirements. The report must include caseload ratios on a proportionate full time equivalent (FTE) basis, providing the FTE percentage for each subpopulation with whom a Care Coordinator has been assigned. DMAS may require the Contractor to provide a regional breakdown of Care Coordinator staffing.

5.9 CARE COORDINATION REQUIREMENTS

5.9.1 Care Coordination

The Contractor shall ensure that care coordination is locally and regionally based (and not simply telephonic). The Contractor may utilize telephonic care coordination services from a central location within Virginia. Care Coordinators assigned to conduct face-to-face care coordination activities shall be located in each of the contracted regions. All Care Coordinators, those providing centralized telephonic care coordination and those located throughout the regions shall be aware of region-specific community resources. In addition to those subpopulations that require face-to-face assessments and care planning activities, the Contractor shall accommodate any Member request or need for face-to-face visits, regardless of population type. The Contractor may accomplish this through innovative partnerships with community-based organizations that perform local care coordination functions. See *Care Coordination Partnerships.*

The Member shall be assigned a Care Coordinator on or before the Member's enrollment effective date. The Contractor shall send a notice to the Member within 14 days of enrollment providing the name and contact information for their assigned Care Coordinator.

In addition, Care Coordinators shall:

1) Meet face-to-face requirements as outlined in this Contract.
2) Act as the primary point of contact for Members and the Interdisciplinary Care Team (ICT).
3) Ensure that Members have access (e.g., a telephone number, e-mail address) to their Care Coordinator.
4) Engage Members in care coordination activities.
5) Communicate with Members about their ongoing or newly identified needs on at least a monthly basis (or a frequency as requested by the Member), to include a phone call or face-to-face meeting, depending on the Member's needs and preferences. For Members in nursing facilities or receiving HCBS Waiver services, contact with Members shall be at a frequency of at least every ninety (90) calendar days, even if the Member requests less frequent contact.
6) Notify Members if there is a change in their assigned Care Coordinators.
7) When possible, ensure continuity of care when Care Coordinator changes are made whether initiated by the Member or by the Contractor.
8) As the leader of ICTs, Care Coordinators must execute the following responsibilities:
9) participate in HRAs for care planning;
10) Ensure that ICT meetings and conference calls are held periodically;
11) Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the Member;
12) Ensure the ICP is developed updated as necessary;
13) Ensure that appropriate mechanisms are in place to receive Member input, complaints and grievances, and secure communication among relevant parties;
14) Incorporate but not duplicate Targeted Case Management (TCM) for applicable Members; and
15) Solicit and comply with the Member's wishes (e.g., advance directive about wishes for future treatment and health care decisions, prioritization of needs and implementation of strategies, etc.).

5.9.2 Enhanced Care Coordination for Vulnerable Subpopulations

All Members identified as a "Vulnerable Subpopulation" shall receive the minimum care coordination activities as specified above; additionally, they must receive Enhanced Care Coordination services as identified during the HRA, ICP and ICT processes.

Enhanced Care Coordination for these Members includes:

1) Setting up appointments and in-person contacts as appropriate;
2) Building strong working relationships between Care Coordinators, individuals, caregivers, and physicians;
3) Setting up evidence-based patient education programs;
4) Arranging transportation as needed
5) For dual-eligible Members, assisting with referrals and access to Medicare-covered services as requested by the Member when the need is identified and included in the ICP;
6) Providing enhanced monitoring of functional and health status;
7) Providing coordination of seamless transitions of care across specialties and settings;
8) For Members with disabilities, providing effective communication with health care providers and participate in assistance with decision making with respect to treatment options;

9) Coordination with early intervention providers, including for children who "age-out" 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 (PT, OT, speech, etc.);
10) Connecting Members to services that promote community living and help avoid premature or unnecessary nursing facility or other residential placements or inpatient hospitalizations (medical or psychiatric);
11) Coordinating with social service agencies (e.g.; local departments of health, LDSS, AAAs, and CSBs) and referring Members to state, local, and other community resources; and,
12) Working with nursing facilities and community-based LTSS providers to include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the LTSS benefit.

The Contractor shall have formalized systems and operational processes in place that assist the Care Coordinator with performing Enhanced Care Coordination activities for this Member subpopulation. These processes shall include methods for identifying these Members and for securing the identified add-on services and benefits available as necessary for these Members.

5.9.3 Care Coordination with Behavioral Health

The Contractor shall abide by all requirements and conditions as set forth in 7.5 of this Contract and within the *BHSA/CCC Plus MCO Coordination Agreement* and toward ensuring that coordination efforts occur for Member's as needed and on a frequent and on-going basis with the BHSA. Care coordination activities between the Contractor's Care Coordinator and the BHSA shall ensure:

1) comprehensive care planning;
2) necessary crisis services;
3) provider collaboration; and,
4) on-going monitoring.

5.10 CARE COORDINATION WITH TRANSITIONS OF CARE

5.10.1 Regional Transition Care Coordinator Roles and Responsibilities

5.10.1.1 Transition from Nursing Facility to the Community

The Contractor's Regional Transition Care Coordinators shall provide transition support to Members who have the desire to, and can safely transition from Nursing Facilities to the community (and maintain or improve their health status). The scope of transition services that the Contractor shall provide includes assessing not only medical/health needs but also assessing the Member's social determinants of health (e.g., housing, transportation, social interactions, etc.). The Contractor shall develop an inclusive and realistic transition plan for the Member and assist in addressing the components of a transition plan, i.e. assist with finding housing; setting up non-medical transportation; helping the individual integrate into the community through clubs, volunteering/work, faith organizations, etc. The Contractor shall provide consistent follow up during the first year after discharge and shall make adjustments to the transition plan to assure acclimation and integration into the community as needed by the Member.

Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframes specified in this Contract, prior to the discharge date, during and after transition; the coordination of community-based services with the Care Coordinator; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation.

5.10.1.2 Transition between Levels of Care

The Regional Transition Care Coordinator shall work closely with the Member and the Member's Care Coordinator and treatment team to ensure safe and effective transitions between levels of care. The Member's Transition Care Coordinator shall

1) Participate in discharge planning for Members transitioning from acute institutional settings to lower levels of care, including Long Stay Hospitals, Nursing Facilities, and the community. Single, non-recurrent (within 30 calendar days) medical stays of two nights or less do not require the participation of the Transition Care Coordinator unless indicated by the Member's needs and circumstances;
2) Coordinate with the assigned Care Coordinator in discharge planning activities to ensure a safe transition that meets the Member's needs and preferences;
3) Coordinate with Utilization Management staff, as indicated regarding discharge planning;
4) Coordinate with Nursing Facility staff, the Member's assigned Care Coordinator, and the Member when it is identified that the Member wishes to transition from NF care to the community;
5) Provide support to Care Coordinators to maintain Members in the community in lieu of transitioning to institutional settings, as needed; and,
6) For Dual eligible Members enrolled in a DSNP, the Regional Transition Coordinator shall also work with the DSNP Care Coordinator upon approval of the Member, to coordinate the above activities.

5.10.2 Transition Coordinator and Care Coordinator Activities

Collaboration between the transition coordinator and the Care Coordinator is vital for ensuring smooth transitions to and from hospitals, nursing facilities and the community. The Member's Care Coordinator shall:

1) Work closely with the Transition Coordinator to ensure the Member's needs and preferences are met;
2) Ensure the completion of the reassessment and updating the ICP for triggering events, to include detailed care coordination interventions and strategies to provide seamless transitions and avoid delays in services and supports
3) Work closely with the Transition Care Coordinator to ensure that communication of a hospital admission or discharge will be conveyed to the PCP and community providers within 24 hours;
4) Communicate with providers of waiver services that an admission has occurred immediately upon notification of admission and as soon as a tentative discharge date is known;
5) Ensure that admissions and lengths of stay are appropriate to the Member's needs;
6) Ensure that there is timely and adequate discharge planning and medication reconciliation;

7) Work to reduce the need for hospital transfers and emergency room use;
8) Use HRA information and work with nursing facility staff (including obtaining MDS Section Q data), hospital staff, community care providers, screening teams, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This includes utilizing local contact agencies in order to facilitate transitions and linking with other community resources that provide support (including housing and employment options) to individuals and their families/caregivers, such as CILs, CSBs, and local AAAs;
9) Ensure services are provided in the least restrictive environment;
10) Utilize community resources and work with staff (e.g., community LTSS providers, hospital staff, and the state Long-Term Care Ombudsman) to facilitate transitions when Members need a higher level of care (e.g., an emerging high risk Member needs to transition to LTSS). This includes when the need for the transition to a higher level of care is communicated to internal staff and to the Members or families/caregivers how individuals are referred to community resources in order to facilitate transitions and are linked with other community resources that provide support to individuals and their families/caregivers, such as CILs, CSBs, and local AAAs. This also includes necessary referrals for screening activities being completed prior to transition when required;
11) Utilize and partner with community resources (e.g. CILs, CSBs, AAAs, etc.) and works with staff to facilitate transitions when a Member transitions to a lower or less restrictive level of care (e.g., a NF Member wishes to transition to the community, a Member in inpatient hospital (medical or psychiatric) transfers to a NF or the community, a CCC Plus Waiver Member no longer meets NF criteria, etc.). The description shall include strategies to be put in place to ensure successful and seamless transitions. It shall also include a description of how the Contractor will ensure necessary screening activities are completed prior to transition when required;
12) Ensure the ICT is scheduled and held as required;
13) For dual-eligible Members, coordinate with the DSNP Care Coordinator upon the approval of the Member, when the Member is enrolled in a DSNP;
14) Provide education to Members, authorized representatives, family/caregivers, and providers regarding importance of notification of inpatient admissions in order to effectuate successful transitions;
15) Provide outreach to providers of Medicare services regarding the role of the Care Coordinator related to transitions of care and the model of care; and,
16) Coordinate with providers of inpatient services to incorporate transition needs as identified above, into the ICP.

5.10.3 Discharge Planning Interventions

The Contractor's treatment and discharge planning activities shall include at least all of the following:

1) Identification and assignment of a facility based Care Coordinator for the Member if different than the community Care Coordinator for planned transitions to a NF. This Care Coordinator shall be involved in the establishment and implementation of treatment and discharge planning;
2) Notification and participation of the Member's ICT in discharge planning, coordination, and re-assessment as needed;
3) Identification of non-clinical supports and the role they serve in the Member's treatment and after care plans;

4) Assistance with scheduling of discharge/aftercare appointments in accordance with the access and availability standards;
5) Identification of barriers to aftercare, and the strategies developed to address such barriers;
6) Assurance that the appropriate behavioral health providers provide a discharge plan following any behavioral health admission to ICT Members;
7) Activities that ensure that Members who require medication monitoring will have access to such services within fourteen (14) calendar days of discharge from a behavioral health inpatient setting or as medically advised;
8) Best efforts to ensure a smooth transition to the next service or to the community, and
9) Documentation of all efforts related to these activities, including the Member's active participation in discharge planning; and,
10) Within the continuity of care provisions described in section 5.14.

5.11 VIRGINIA EMERGENCY DEPARTMENT CARE COORDINATION PROGRAM

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

The Contractor shall participate in the statewide program as required by state law for Medicaid health plans by June 30, 2018 when the technology solution is required to be implemented. 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 new statewide technology solution to improve outcomes for high risk and high cost CCC Plus Members with high utilization of EDs or other high risk, priority populations.

5.12 COORDINATION WITH THE MEMBER'S MEDICARE OR OTHER MCO PLAN

Dual eligible Members enrolled in CCC Plus program may receive their Medicare benefits from the Contractor's companion D-SNP, Medicare fee-for-service, or through another Medicare Advantage (MA) Plan. The Contractor shall encourage its CCC Plus program enrolled Members to also enroll in their companion D-SNP for the Medicare portion of their benefits, in order to provide consistency and maximize the Contractor's ability to coordinate services for the Member.

The Contractor shall work with the Department to align, whenever possible, enrollment of dual eligible Members in the same plan for both Medicare and Medicaid services.

The Contractor shall remain responsible for coordinating care and services for Members who do not participate in the Contractor's companion D-SNP. The Contractor also shall be responsible for coordinating Medicaid payments for dual eligible Members and shall be responsible for paying crossover claims.

In accordance with 42 CFR 438.208(b)(2)(ii), the Contractor shall implement procedures to coordinate services the Contractor furnishes the Member with the services the Member receives from any other MCO, PIHP, or PAHP. When a dual eligible Member is enrolled either with the Contractor's D-SNP or MA plan for his/her Medicare benefits, or with a D-SNP or MA plan, or another MCO not affiliated with the Contractor, the Contractor shall be responsible for coordinating all benefits covered under this contract and the Member's Medicare plan or other MCO. In this effort the Contractor shall at a minimum:

1. Provide the Member's Medicare plan other MCO with contact information of the person and division responsible for coordination of the Member's Medicaid benefits;
2. Provide the Member's Medicare plan or other MCO with contact information of the person or division responsible for coordination of cost sharing between Medicare or the Member's primary MCO and Medicaid;
3. Request a representative from the Member's Medicare plan or primary MCO carrier to participate in all needs assessments and person centered planning;
4. Provide the Medicare plan or primary MCO carrier with the results of all needs assessments and person-centered planning;
5. At a minimum, provide the Medicare plan or Member's primary MCO with timely (within 48 hours of becoming aware, of hospital, emergency department and Nursing Facility admissions and discharges and within 72 hours of the diagnoses of, or significant change in the treatment of, a chronic illness) inpatient hospital, emergency department and Nursing Facility admissions and discharges and the diagnosis of, or significant change in the treatment of, a chronic illness in order to facilitate the coordination of benefits and cost sharing between the Medicare and Medicaid plan;
6. Coordinate with the Medicare plan or Member's primary MCO regarding discharge planning from an inpatient setting, including hospital and Nursing Facility;
7. Request a representative from the Member's Medicare plan or primary MCO to participate in all ICT meetings;
8. Receive, process and utilize in a timely manner (within 72 hours at a maximum or sooner if circumstances necessitate a faster response) information, including Member-specific

health data from the Member's Medicare plan or the Member's primary MCO, regarding the effective coordination of benefits and cost sharing;

9. At the request of a Medicare plan or the Member's primary MCO, the Contractor shall participate in training of the Medicare or Member's primary MCO plan's staff regarding coordination of benefits and cost sharing between Medicare and Medicaid;
10. Coordinate with a Member's Medicare or primary MCO plan to ensure timely access to medically necessary covered benefits needed by a Member enrolled in the CCC Plus program;
11. Submit to a Member's Medicare or primary MCO plan, as applicable and appropriate, referrals for care coordination and/or disease management; and,
12. Receive and process from a Member's Medicare or primary MCO plan a referral for transition from a Nursing Facility to the community, and coordinate with the Member's Medicare or primary MCO plan to facilitate timely transition, as appropriate, including coordination of services covered by the Contractor and services covered by the Medicare or Member's primary MCO plan.

The Contractor shall utilize both Medicare and Medicaid health care data and data from the Member's primary MCO to coordinate all aspects of the Member's health care, including but not limited to: Medicare A, B, and D; data from the Member's primary MCO; historical data; Medicaid historical data; data from the State's BHSA (Magellan of Virginia); discharge planning; disease management; chronic conditions; and, care management.

The Contractor shall coordinate behavioral health benefits with the Department's contracted BHSA when appropriate. Care coordinators shall be trained and knowledgeable about all Medicaid covered behavioral health services to ensure that Members have access to the full continuum of care. Care coordinators shall be informed of the required activities as outlined in section 7.5 of this Contract and within the *BHSA/CCC Plus MCO Coordination Agreement.*

The Contractor shall train staff working on services provided under this Contract, including Care Coordinators and other related staff, on available Medicare benefits and coordination of Medicare and Medicaid benefits. Training shall also include procedures for coordinating with the Member's primary MCO as applicable. The Contractor shall also be required to train staff on topics as requested by the Department and within a timeframe designated by the Department.

1. Train network providers on available D-SNP and CCC Plus program benefits and services as requested by provider and/or provider associations.
2. Establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CCC Plus Members, that Care Coordinators are notified/engaged as appropriate
3. Maintain daily reports for audit to determine appropriate and timely engagement in discharge planning.
4. Coordinate with a Member's D-SNP or MA Plan or other primary MCO regarding CCC Plus program services that may be needed by the Member; however, the D-SNP or MA Plan or primary MCO carrier shall remain responsible for ensuring access to all benefits covered by the Member's primary payer, including nursing facilities and home health, and shall not supplant such medically necessary covered services with services available only through the CCC Plus program.

5. Provide to D-SNPs and MA plans and any other MCO carrier with whom the Member has coverage, training on the Contractor's NF Diversion program, including the referral process.
6. Accept and process from a Member's D-SNP, MA plan, or other MCO carrier a referral for HCBS in order to delay or prevent NF placement.
7. Develop, for review and approval by the Department, policies, and procedures and training for the Contractor's staff, including Care Coordinators, regarding coordination with a Member's Medicare Plan or primary MCO plan. The Department expects all items described in this section to be reflected in the resulting documents.

5.13 CLINICAL WORKGROUP MEETINGS

The Contractor shall participate in an ongoing clinical workgroup with the Department related to care coordination. The Department's representatives will meet with the Contractor's nursing/medical Care Coordinator and behavioral health care management leadership to review cases that offer integrated care opportunities and to clarify the expectations around care coordination. The Department will advise the Contractor of any required documentation in preparation and advance of each meeting. The clinical work group meetings shall be held on a quarterly basis. The Department reserves the right to require the Contractor to attend clinical workgroup meetings more frequently based on the Contractor's performance and any concerns identified during the Department's contract monitoring activities. The Contractor shall attend the clinical workgroup meetings in person unless otherwise permitted by DMAS. The clinical workgroup meeting locations will rotate between being held at the Department and the offices of the CCC Plus program's contracted health plans. Each health plan will be expected to host a clinical workgroup meeting on a rotational basis and share best practices.

5.14 CONTINUITY OF CARE

The Contractor shall provide or arrange for all medically necessary services, whether by sub-contract or by single-case agreement in order to meet the needs of its Members, including during care transitions to the Contractor's health plan. The Contractor shall also work closely with the Department, other Contracted health plans, and DMAS Contractors toward the goal of ensuring continuity of care for Members whose enrollment changes between the Contractor's plan, DMAS fee-for-service, or another CCC Plus Contractor. The Contractor shall develop and implement strategic processes that support collaborative efforts among contractors for smooth care transitions and that prevent a Member from having interrupted or discontinued services, throughout the transition, and until the transition is complete.

In accordance with 42 CFR § 438.62, the Contractor's strategic processes shall include: the Contractor's compliance with requests for historical utilization data when the Member is enrolled in a new MCO; the ability for the Member to retain the access to services consistent with the access they previously had and is permitted to retain their current provider during the continuity of care period (refer to Section 5.14.1) if that provider is not in the network; the Contractor refers the Member to appropriate providers of service that are in the network; and, the Member's new providers are able to obtain copies of the Member's medical records.

The Contractor must have systems and operational processes in place for sharing data to/from DMAS, reviewing the data for potential high-risk Member needs, and utilizing the data to

support the transition process. Transition data shall include but not be limited to Member's claims and service authorizations. The process shall require the Contractor to, at a minimum:

1) Ensure that there is no interruption of covered services for Members;
2) Accept the transfer of all medical records and care coordination data, as directed by DMAS; and,
3) Send service authorization data to support continuity of care for Members transitioning between fee-for-service and CCC Plus. Reference the Medical Transition Report (MTR) File section for more information.

5.14.1 General Provisions

The Contractor shall ensure continuity of care for all Members upon enrollment into the Plan. During the time period set below, the Contractor shall maintain the Member's current providers at the Medicaid FFS rate and honor service authorizations (SAs) issued prior to enrollment for the specified time period.

The continuity of care period is as follows: Within the first ninety (90) calendar days of a Member's enrollment, the Contractor shall allow a Member to maintain his or her current providers (including out-of-network providers). For Members effective on or after April 1, 2018, the continuity of care time period will change to a minimum of thirty (30) calendar days. The Contractor shall extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the Contractor or the Member's safe and effective transition to a contracted provider.

During the continuity of care period, the Contractor shall make reasonable efforts to contact out-of-network providers who are providing services to Members, and provide them with information on becoming credentialed, in-network providers. If the provider does not join the network, or the Member does not select a new in-network provider , the Contractor shall facilitate a seamless transition to a participating provider (with the exception of NF residents).

During the continuity of care period, the Contractor may change a Member's existing provider only in the following circumstances:

1. The Member requests a change;
2. The provider chooses to discontinue providing services to a Member as currently allowed by Medicaid;
3. The Contractor or DMAS identify provider performance issues that affect a Member's health or welfare; or,
4. The provider is excluded under State or Federal exclusion requirements.

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) during the continuity of care period or through the expiration date of the active service authorization including services authorizations approved by DMAS' Drug Utilization Review (DUR) Board. This would not preclude the health plan from working with the Member and his treatment team to resolve polypharmacy concerns. Additionally, a Member that is, at the time of enrollment receiving a prescription drug that is not on the Contractor's formulary or PDL shall be permitted to continue to receive that drug if medically necessary.

5.14.2 Members With Service Authorizations (SA)

The Contractor shall honor SAs issued by the Department or its Contractors as provided through DMAS transition reports and DMAS' contracted entities for the duration of the Service Authorization or the duration of the continuity of care period, whichever comes first. If the authorization ends before the Contractor completes the HRA, and the provider has requested a continuation of services, the Contractor shall extend the continuity of care period until after the HRA is completed and a new person-centered individualized care plan has been implemented.

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. For DRG provider contracts, in accordance with the *Hospitalized at Time of Enrollment* section, the Contractor is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any Member actively enrolled in the MCO on the date of admission, regardless of the Members' disenrollment from the MCO during the course of the inpatient hospitalization.

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

5.14.3 Members In Nursing Facilities

Members in a Nursing Facility at the time of CCC Plus program enrollment may remain in that NF as long as they continue to meet DMAS level of care criteria for Nursing Facility care, unless they or their authorized representatives prefer to move to a different NF or return to the community. The only reasons for which the Contractor may require a change in NF is if: (1) the Member requests a change, (2) the provider is excluded under State or Federal exclusion requirements, or (3) due to one or more deficiencies that constitute immediate jeopardy to resident health or safety, per direction from DMAS, the Virginia Department of Health (VDH) – Office of Licensure and Certification (OLC) or Adult Protective Services. Such reasons are described in the DMAS Nursing Home Manual, Chapter IX, 42 CFR §488.410, 12VAC30-20-251, and http://www.vdh.virginia.gov/OLC/LongTermCare/survey.htm. If it is determined that a NF is not able to safely meet the needs of a Member (e.g., due to dangerous behaviors) or because the Member no longer meets the NF level of care requirement, the Contractor shall continue to pay the facility until the Member is transitioned to a safe and alternate placement.

Where a Member who resides in an out of network NF is hospitalized, the Contractor shall allow the member to return to the out of network NF upon discharge from the hospital when all of the following criteria are met:

- Returning to the nursing facility meets the Member's preferences and level of care needs; and,
- There is a bed available at the Member's prior NF; and,
- The NF will accept the Member at Medicaid rates (or negotiated rate between the Contractor and the facility. The negotiated rate must be in accordance with the required payment terms for nursing facilities as described in this Contract).

In the event of a NF closure, or as necessary to protect the health and safety of residents, the Contractor shall arrange for the safe and orderly transfer of all Members and their personal effects to another facility. In addition to any notices provided by the facility, the Contractor shall provide timely written notice inclusive of the required elements in CFR 483.75 (r) and work cooperatively with the Department of Aging and Rehabilitation, including the local Departments of Social Services, the Long Term Care Ombudsman and other state agencies in arranging the safe relocation of residents. The Contractor's Care Coordinator shall coordinate the relocation plan and act as a resource manager to other agencies and as a central point of contact for Member relocations.

5.14.4 Members Who Transition Between Contractors

In accordance with 42 CFR 438.208(b)(2)(ii), the Contractor shall implement procedures to coordinate services the Contractor furnishes the Member with the services the Member receives from any other MCO, PIHP, or PAHP. The Contractor shall transfer SA, HRA, ICP, and other pertinent information necessary to assure continuity of care to another Contractor, to DMAS, or its designated entity for Members who transfer to another Contractor or back to Fee-For-Service. The SA information shall be provided within three (3) business days from receipt of the notice of disenrollment to the Contractor in the Medical Transition Report (MTR) method and format specified by the Department. Reference *Medical Transition Report (MTR) File*. The Contractor shall work with the other MCO Contractor in facilitating a seamless transition for the Member.

5.14.5 Members Receiving CMHRS

The CMHRS transition to CCC Plus will occur January 1, 2018. On this date, Magellan of Virginia, DMAS's Behavioral Health Services Administrator (BHSA) will no longer administer CMHRS for CCC Plus enrolled members. Instead, CMHRS will transition into the CCC Plus MCO contract, utilizing DMAS' current CMHRS coverage criteria and program requirements. Reference the October 23, 2017 Medicaid Memo regarding *Transitioning Community Mental Health Rehabilitation Services (CMHRS) into CCC Plus*.

5.14.5.1 Continuity of Care Provisions for CMHRS Until April 1, 2018

Regardless of whether the member is new to CCC Plus on January 1, 2018, or has been enrolled in CCC Plus prior to the CMHRS transition on January 1, 2018, to ensure continuity of care and a smooth transition for its CCC Plus Members, the Contractor shall:

1. Maintain the Member's current CMHRS providers for up to ninety (90) days, and
2. Honor service authorizations (SAs) issued prior to enrollment, including with out of network providers, for up to ninety (90) days or until the authorization expires, whichever comes first; and,
3. Extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the Contractor or the member's safe and effective transition to a qualified provider within the Contractor's provider network or as authorized by the Contractor.

5.14.5.2 Continuity of Care Provisions for CMHRS After April 1, 2018

For Members transitioning to the Contractor on and after April 1, 2018, the general continuity of care provisions described in this Section of the Contract shall also apply for CMHRS.

5.15 CARE DELIVERY MODEL POLICY AND PROCEDURES

The Contractor shall submit to the Department for review and approval prior to Contract implementation, upon revision, or upon request, the policies and procedures as specified herein. All policies and procedures shall include how the Contractor will meet all requirements as stated throughout this Contract.

5.15.1 Model of Care

The Contractor shall have policies and procedures in place to address all aspects of the Model of Care.

5.15.2 HRA and Reassessments

The Contractor shall submit its HRA policies and procedures and HRA tool to the Department for approval prior to implementation, at revision, or upon request. This Contractor shall also include its policies and procedures related to the reassessment tool and the reassessment tool (if different than the HRA) that will be used to identify the specialized needs of its Members upon a triggering event and at specified timeframes. The Contractor's HRA and reassessment processes and tools 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 HRAs and reassessments and annual ICP reviews are conducted for each Member (e.g., initial assessment upon enrollment, reassessments and ICP reviews within prescribed timeframe of last assessment; conducted by phone interview (for the emerging high risk population), face-to-face, written form completed by Member, etc.).
2) When the stratification is conducted (e.g., how far in advance of effective date).
3) How the results of the HRAs are used to confirm the appropriate stratification level.
4) The personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.).
5) How the Contractor involves Members, authorized representatives, family Members and caregivers in the HRA process, including the Contractor's efforts to obtain documentation, including signatures, to signify that Members, authorized representatives, and family Members and caregivers understand and consent to the HRA process.
6) Describes efforts the Contractor will use for completing the HRAs for the different populations, including Members residing in nursing facilities, Members enrolled in the waivers, and best efforts for the community well population.
7) A description of triggering events and the reassessment process.

5.15.3 ICP

The Contractor shall submit ICP policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract and:

1) The method of stratification, the person-centered and culturally competent ICP development process, and how the ICP development process will incorporate and not duplicate Targeted Case Management (if applicable).

2) How the Contractor will ensure the Member and family/preferred support system is engaged in the initial and ongoing development of their ICP and receives any assistance and accommodations to prepare for and fully participate in the care planning process and ICP development.
3) How the Care Coordinator will obtain the Member's signature on the initial ICP and any subsequent updates and revisions by the ICT or during other contacts with the Member.
4) How the ICT will be involved in the ICP ongoing development and how the Care Coordinator leads the development of the comprehensive, person-centered, culturally competent, individualized ICP that is tailored to the Member's needs and preferences.
5) The personnel who review the person-centered ICP and how frequently the ICP is reviewed and revised (e.g., initially developed by the Member and Care Coordinator and reviewed/revised by the ICT, including the Member and family/preferred support system whenever feasible, and other pertinent specialists required by the Member's health needs; reviewed and revised at least annually and as otherwise required, etc.).
6) How the person-centered ICP is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and Member either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.).
7) How services included during the continuity of care period are incorporated into the ICP and how Medically Necessary services will be continued after the continuity of care period is over.
8) Assurances that the Contractor shall explain the service authorization process to the Member and that there may be a change in the services provided based upon the HRA completion.
9) How information from the UAI, when available, will be incorporated into the ICP for individuals in the CCC Plus Waiver.
10) The Contractor's process for obtaining nursing facility MDS data and how it will be incorporated into the ICP.
11) How the Contractor will incorporate and leverage external existing plans of care (e.g. NF, Personal Care, ADHC, TCM, etc.)
12) How the ICP is developed, maintained, and monitored to ensure all treatment needs are met and that all changes and updates are reflected accurately and timely.

5.15.4 ICT

The Contractor shall submit ICT policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract and:

1) The method used to facilitate the participation of the Member, the Member's authorized representative, and other required participants whenever feasible.
2) How the Contractor will accommodate the Member's needs and preferences related to location of ICT meetings (e.g., in the home/facility for LTSS Members, transportation to other locations, etc.).
3) How the Contractor will coordinate with other existing ICT meetings, including but not limited to, those held in NFs, ADHC, CSB, etc. Include provider outreach and education regarding ICT requirements and expectations.
4) How the scheduled ICTs will operate, document, and communicate (e.g., frequency of meetings, process for documenting proceedings in a Member's medical records and

retention of records, notifications and invitations about ICT meetings, dissemination of ICT reports to all ICT participants and invitees, etc.).

5) Description of the advanced notice that will be provided to the Member and other required attendees in order to maximize participation (for planned ICT meetings, notice must be provided at least one (1) week in advance) and how documentation will be maintained if an invitee cannot attend.
6) Description of how the ICT will solicit input from required participants who are unable to participate in the ICT meeting and how these participants will be informed of information discussed and outcomes of the ICT meeting.
7) The communication mechanism the Contractor institutes to notify the ICT, provider network, Members, etc. about the HRA and stratification results (e.g., written notification, secure electronic record, etc.).
8) Description how the provider network coordinates with the ICT and the Member to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the Member in a timely and quality way, how reports on services delivered are shared with the Contractor and ICT for maintenance of a complete Member record and incorporation into the care plan, how services are delivered across care settings and providers, etc.).
9) How the ICT process will be used to empower and support the ICT in proactively recognizing signs of emerging issues (e.g., depression, fall risk, etc.) and mechanism for follow-up on identified risks.
10) Description how the ICT process will interface with the ongoing development of a comprehensive ICP.

5.15.5 Care Coordination Partnerships

The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract and a detailed description of how the Care Coordination Partnerships work within the framework of the Contractor's systems. The policies and procedures shall address monitoring and oversight of the activities performed by community partners

5.15.6 Care Coordination

The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract to provide care coordination and:

1) How all Members shall have access to the following supports: (i) a single, toll-free point of contact for assistance; (ii) assurance that referrals result in timely appointments; (iii) communication and education regarding available services and community resources in a mode and manner that is culturally, developmentally appropriate and that considers the Member's physical and cognitive abilities and level of literacy; and, (iv) assistance with developing self-management skills to effectively access and use services.

2) How Members are notified of the name of their assigned Care Coordinators and how to contact them.

3) In addition to the required HRAs, re-assessments, ICTs, and ICPs, the policy and procedures shall describe how Care Coordinators will work with all Members to ensure their ongoing care coordination needs are identified and met, using a person-centered planning approach. The policy and procedures must also describe how the Contractor will incorporate chronic condition management and disease management into the care coordination approach for all Members. The Contractor shall design programs to proactively provide the support needed to maintain current health status and avoid functional decline.

4) If the Care Coordinator is not available to the Member, how the Care Coordinator shall be notified by the next business day of any issues/changes/concerns of the Member (this includes contacts from the Member or the Member's authorized representative or caregiver made through a Member support line, 24-hour clinical triage line that offers nurse advice and behavioral health crisis response. Should the Care Coordinator not be available for an extended period of time, back-up coverage shall be identified and made available by the Contractor's staff.

5) How the Care Coordinator is made aware of grievances and appeals filed by Members or by providers (when providers file an appeal based on a denial of service)

6) How the Contractor will ensure continuity of care when Care Coordinator changes are made whether initiated by the Member or by the Contractor.

7) How providers, including nursing facilities, are notified of the name and contact information of their clients' or residents' assigned Care Coordinators and any changes to this assignment.

8) Describe strategies to: (1) outreach to and engage Members who are hard to contact/locate (e.g., incorrect address information, missing or incorrect phone number, Members who are homeless); and (2) re-engage Members who previously refused to engage in care coordination activities.

9) Describe the strategies the Contractor shall use to document attempted contacts. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members. Upon request, the Contractor shall provide DMAS with detailed documentation of efforts taken (dates, times, type of attempts made, etc.) to reach specific Members and with an explanation of the reason why they were unable to successfully reach Members and complete contract deliverables (including HRAs, ICPs, etc.).

10) Describe strategies the Contractor shall use to assist Members who are determined to have high-risk behaviors. Safety plans for Members and Contractor staff shall be included in the Contractor's policies and procedures.

11) How training of Care Coordinators is confirmed and verifying that training or any certifications remain current. Training shall include the process for involuntary admissions.

12) Describe how the Contractor will address non-compliance with training by Care Coordinators.

13) Annually, at the Department's request, prior to implementation, or if revised, the Contractor shall identify the types of training, including the frequency and modes of training the Contractor will provide to its Care Coordinators.

5.15.7 Enhanced Care Coordination

The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract to provide enhanced care coordination functions for its Vulnerable Subpopulation CCC Plus Members and:

1) The identification strategy, including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information that are used to identify Members meeting criteria for enhanced care coordination.

2) How the ICP will be developed and how the ICT will engage the Member to provide enhanced care coordination.

3) The Contractor shall have documented procedures to ensure the interface with the BHSA is conducive to open communication and collaboration in the best interest of the Member's integrated care needs,

4) The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures on discharge planning. The Contractor shall implement policies and procedures that (1) ensure timely and effective treatment and discharge planning; (2) establish the associated documentation standards; (3) involve the Member; and (4) begin on the day of admission.

5) The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures for its care transition programs. The policy and procedures should include partnerships with community-based organizations, the metrics used to measure outcomes associated with transitions (e.g., hospital re-admission rates), and outcomes data. The Contractor's policies and procedures shall describe the processes, systems, and goals.

5.15.8 Care Coordination and Transitions of Care

The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract as related to transitions of care and discharge planning.

5.15.9 Coordination with Member's Medicare Plan

In accordance with 42 CFR§ 438.208(b)(2)(ii), the Contractor shall implement procedures to coordinate services the Contractor furnishes the Member with the services the Member receives from any other MCO, PIHP, or PAHP. The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract related to coordinating with Medicare Services for Dual eligible individuals when the Member:

1) Is enrolled in the Contractor's D-SNP plan,
2) Is enrolled in a different CCC Plus Contractor's D-SNP plan, is enrolled in a different health plan's D-SNP or Medicare Advantage plan, or,
3) Is receiving Medicare via the traditional fee-for-service model of service delivery.

5.15.10 Continuity of Care

The Contractor shall submit policies and procedures that reflect how the Contractor will meet the requirements stated in this Contract related to all continuity of care provisions, and:

1) How the Contractor will automatically generate service authorizations for continuity of care for Members whose authorization information is included in the MTR file received from the Department prior to enrollment and how this information is disseminated internally and to whom.,
2) How the Contractor will notify Members and providers in writing of the continuity of care authorization, including the service or item, name of the provider, authorized units or amounts, and authorized dates of service.
3) How the Contractor will ensure Medically Necessary services are continued without gaps in care at the end of the continuity of care period and the role of the Care Coordinator to ensure services needed on an ongoing basis do not lapse.
4) Outreach efforts to non-participating providers and pharmacies to ensure services are not discontinued during the continuity of care period.

SECTION 6.0 UTILIZATION MANAGEMENT REQUIREMENTS

6.1 GENERAL UTILIZATION MANAGEMENT REQUIREMENTS

The Contractor's UM program shall reflect the UM standards from the most current NCQA accreditation standards. The UM program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles. If the Contractor delegates (subcontracts) responsibilities for UM to a subcontractor, the Contract must have a mechanism in place to ensure that the standards described in this Contract are met by the subcontractor.

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 regarding its utilization management (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 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 Contractor's UM program shall demonstrate that Members have access to all services covered under this contract, as described in the attached *CCC Plus Coverage Chart*, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

Consistent with Mental Health Parity rules described in 42 CFR §438 Subpart K, the Contractor may place limits on behavioral health services, including mental health benefits or addiction, recovery, and treatment benefits in a manner that is no more restrictive than similar limits on

medical/surgical benefits and no more restrictive than limits in place under FFS Medicaid. Since the State imposes limits on less than one-third of all medical/surgical benefits, the Contractor may not place maximum benefit limits on behavioral health services. This does not preclude the Contractor from limiting coverage for medical surgical and behavioral health services on the basis of medical necessity.

6.2 SERVICE AUTHORIZATION

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 *CCC Plus Coverage Chart*.

6.2.1 Service Authorization Policy and Procedures

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services shall follow written policies and procedures and shall include effective mechanisms to ensure consistent application of review criteria for authorization decisions.

6.2.2 Medical Necessity Criteria

The Contractor shall use the Department's service authorization criteria or other national standard(s) approved by the Department in making medical necessity determinations.

The Contractor's medical necessity criteria shall not be more restrictive than that the Medicaid FFS Medicaid program criteria, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy manuals. For ARTS, reference *Critical Elements of the Contractor's ARTS System of Care.*

In accordance with §438.236, the Contractor's medical necessity guidelines shall be evidence based and at a minimum:

1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
2) Are adopted in consultation with contracting health care professionals in the Contractor's service area;
3) Are developed in accordance with standards adopted by national accreditation organizations;
4) Are updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
5) Are evidence-based, if practicable; and,
6) Are applied in a manner that considers the individual health care needs of the Member.

In accordance with 42 CFR §438.236 the Contractor shall use ASAM criteria for medical necessity determinations for all Addiction and Recovery Treatment Services (ARTS) to any Member or contracting provider upon request.

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 not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member.

2) 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.
3) The Contractor shall ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the Member's ongoing need for such services and supports and considers the Member's functional limitations by providing services and supports to promote independence and enhance the Member's ability to live in the community;
4) 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.
5) The Contractor shall ensure that services are authorized in a manner that supports:
    a. the prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder, health impairments and/or disability,
    b. ability for a Member to achieve age-appropriate growth and development,
    c. ability for a Member to attain, maintain, or regain functional capacity,
    d. in the case of EPSDT, correct, maintain or ameliorate a condition.
    e. opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

6.2.3 Members with Service Authorizations (SA)

The Contractor (the Member's current MCO) shall assume responsibility for all managed care contract covered services and shall honor authorizations by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in this Contract. No service (including CCC Plus Waiver services) can be reduced during the continuity of care period of a Member's enrollment with the Contractor. The Contractor shall honor SAs issued by the Department or its Contractors as provided through DMAS transition reports and DMAS' contracted entities for the duration of the Service Authorization or during the continuity of care period, whichever comes first. If the authorization ends before the initial HRA is completed, the continuity of care period continues until after the HRA is completed and a new person-centered Individualized Care Plan has been implemented. Reference the *Continuity of Care* Section 5.14 of this contract.

6.2.4 EPSDT Provisions for Service Authorizations

The Contractor shall submit its EPSDT Review Process Policy and Procedures to DMAS for review and approval prior to implementation, upon a revision or as requested. The EPSDT review policies and procedures must allow providers to contact Care Coordinators to explore alternative services, therapies, and resources for Members when necessary. No service requested for a child under 21 can be denied as "non-covered" unless specifically noted as "non-covered," "out-of-network" and/or "experimental". Instead, the Contractor's determination must be made on the basis of medical necessity.

The Contractor shall not issue an adverse determination on a service request for a child under age 21 until the case is first reviewed by a physician who has appropriate expertise in addressing the child's medical, behavioral health, or long-term services and supports needs (Per 42 CFR §438.210).

6.2.5 Behavioral Health Services

6.2.5.1 Traditional Behavioral Health Services

The Contractor's medical necessity guidelines, program specifications and service components for behavioral health services shall, at a minimum, be submitted to DMAS annually for approval no later than thirty (30) calendar days prior to the start of a new Contract Year, and no later than thirty (30) calendar days prior to any change.

6.2.5.2 Community Mental Health Rehabilitation Services

The Contractor shall follow the service authorization or registration requirements in accordance with the recommendations from the CMHRS Standardization Workgroup. Discretion with the utilization management requirements described below is allowed by the Contractor with DMAS approval, per provider payment related provisions in Section 12.4.2 and value based payment provisions described in Section 13.5.

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INITIAL Request	Registration vs. Authorization CONTINUED STAY Request
Mental Health Case Management	H0023	R	R
Therapeutic Day Treatment (TDT) for Children	H0035 HA	A	A
Day Treatment/ Partial Hospitalization for Adults	H0035 HB	A	A
Crisis Intervention	H0036	R	A
Intensive Community Treatment	H0039	A	R
Mental Health Skill-building Services (MHSS)	H0046	A	A
Intensive In-Home	H2012	A	A
Psychosocial Rehab	H2017	A	A
Crisis Stabilization	H2019	R	A
(ABA) / Behavioral Therapy	H2033	A	A
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A

6.2.6 LTSS

The Contractor's authorization process for LTSS shall be based on a Member's current needs assessment and consistent with the Member's person-centered service plan. Coverage decisions for LTSS shall be provided in a manner that supports a participant in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The Contractor shall cover appropriate LTSS based on needs identified through the Uniform Assessment Instrument (UAI), other comprehensive assessments, and subsequent level of care reviews.

6.2.7 Emergency and Family Planning Services

The Contractor must ensure that the service authorization requirements do not apply to emergency care, family planning services including access to or quantity limits for long acting reversible contraceptives (LARCs), preventive services, and basic prenatal care.

6.2.8 Early Intervention Services

Service authorizations shall not be required for Early Intervention Services. Reference Section 4.5 *Early Intervention (EI) for additional information.*

6.2.9 Pharmacy Utilization Management

Reference *Utilization Management For Pharmacy Services*

6.2.10 Service Authorization Timeframes

6.2.10.1 Standard Authorization

For standard authorization decisions, provide written notice as expeditiously as the Member's condition requires and within State-established timeframes described in the table below, with a possible extension of up to fourteen (14) additional calendar days, if the Member or the provider requests extension; or the Contractor justifies (to the State agency upon request) that the need for additional information is in the Member's interest.

Service Authorization Decision Timeframes (See above description for extensions.)	**Turnaround Times**
Physical Health	
Inpatient (Standard or Expedited)	1 business day if all clinical information is available or up to 3 business days if additional clinical information is required or as expeditiously as the Member's condition requires
Outpatient/EPSDT Outpatient (Standard)	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required.
Outpatient (Expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the Member's condition requires
Long Term Services and Supports to include – CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Long Stay Hospital, etc. (Standard)	5 business days
Long Term Services and Supports to include – CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Long Stay Hospital, etc. (Expedited) Hospice (considered expedited)	No later than 72 hours from receipt of request; or, as expeditiously as the Member's condition requires
Behavioral Health	
Standard UM Review (to include outpatient and CMHS)	3 business days if all clinical information is available or up to 5 business days if additional clinical information is required or as expeditiously as the Member's condition requires.

Initial and Concurrent Inpatient	1 business day if all clinical information is available or up to 3 business days if additional clinical information is required or as expeditiously as the Member's condition requires.
Expedited Urgent – Pre-service Inpatient	3 hours
Expedited Urgent reviews for other urgent services	24 hours

6.2.10.2 Expedited Authorization Decision Timeframe

For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide written notice as expeditiously as the Member's health condition requires within the timeframes described in the table below and no later than 72 hours after receipt of the request for service. The Contractor may extend the 72-hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies (to the State agency upon request) that the need for additional information is in the Member's interest.

6.2.10.3 Extending Timeframe for Service Authorization Decision

In accordance with 42 CFR § 438.404(c)(4), if the Contractor meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with 42 CFR § 438.210(d)(1)(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.

6.2.11 Covered Outpatient Drug Decisions

In accordance with 42 CFR § 438.3, the Contractor shall provide decisions for all covered outpatient drug authorizations by telephone or other telecommunication device within twenty four (24) hours of a request for authorization, in accordance with Section 1927(d)(5)(A) of the Social Security Act.

6.2.12 Adverse Benefit Determination

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 condition or disease. Additionally, the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the UM staff or entity to deny, limit, or discontinue medically necessary services to any Member. All adverse determinations shall be reviewed by the Contractor's Medical Director or physician designee.

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.

The Contractor shall provide a written *Notice of Adverse Benefit Determination* to the requesting provider, and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Contractor's notice shall include the reason for denial, a list of titles and qualifications, including specialties, of individuals participating in the authorization review, and shall meet the requirements of 42 CFR §438.404 and *Code of Virginia* § 32.1-137.13. See Section 15.3.

6.2.12.1 Timing of Notice

In accordance with 42 CFR §438.404(c)the Contractor shall mail the adverse benefit determination notice within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 CFR §§431.211, 431.213, and 431.214.
2. For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
3. For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).
4. In accordance with 42 CFR § 438.404(c)(1); the Contractor shall mail the *Notice of Adverse Benefit Determination* by the date of the action when any of the following occur:
    i. the Member has died;
    ii. the Member submits a signed written statement requesting service termination;
    iii. the Member submits a signed written statement including information that requires service termination or reduction and indicates that he/she understands that service termination or reduction will result;
    iv. the Member has been admitted to an institution where he/she is ineligible under the plan for further services;
    v. the Member's address is determined unknown based on returned mail with no forwarding address;
    vi. the Member is accepted for Medicaid services by another local jurisdiction, state, territory, or Commonwealth;
    vii. a change in the level of medical care is prescribed by the Member's physician;
    viii. the *Notice* involves an adverse determination with regard to preadmission screening requirements of Section 1919(c)(7) of the Act; or,
    ix. the transfer or discharge from a facility will occur in an expedited fashion.

6.2.13 Appeal Determinations

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 21). Disputes between the Contractor and Members about medical necessity may be appealed in accordance with the *Member and Provider Grievances and Appeals* section of this Contract.

The Contractor shall authorize and 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.

6.2.14 LTSS Service Reductions and Denials

The Contractor shall report LTSS service reductions, suspensions, or terminations to DMAS on a monthly basis as described in the CCC Plus Technical Manual. The Department will review a sample of the Contractor's LTSS plans of care that include a reduction, suspension, or termination in personal care and/or private duty nursing services to ensure that reductions, suspensions and terminations were done appropriately. This review will also include a determination of whether, consistent with 42 CFR 438.420, enrollees were provided all appeal rights afforded through the Contractor and state fair hearing process with the ability to continue services per 42 CFR § 438.420 during the appeal.

6.3 PATIENT UTILIZATION MANAGEMENT & SAFETY (PUMS) PROGRAM

The Contractor must have a Patient Utilization Management & Safety 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 care coordination 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.

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

- The Contractor's specific utilization review of the Member's past twelve (12) months of medical and/or billing histories indicates the Member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications found in the CCC Plus Technical Manual and as noted below in 6.3.1.1 PUMS Placement Criteria. Note that Members with a cancer diagnosis are excluded. For additional information regarding ARTS, refer to http://www.dmas.virginia.gov/Content_Pgs/bh-sud.aspx .

- Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

At the end of the twelve (12) month period, the Member must be re-evaluated by the Contractor to determine if the Member continues to display behavior or patterns that indicate the Member should remain in the PUMS program.

6.3.1.1 PUMS Placement Criteria

- **(PUMS1) Buprenorphine Containing Product***: Therapy in the past thirty (30) days – **AUTOMATIC LOCK-IN**
  - *If on monoproduct (indicating pregnancy), refer to case management.
  - **Exclude members using Butrans and Belbuca only when used for the treatment of pain.
- **(PUMS2) High Average Daily Dose**: ≥ one hundred and twenty (120) 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**: ≥ three (3) prescribers OR ≥ 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 Abuse 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 abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

6.3.2 PUMS Program Details

Once a Member meets the placement requirements, the Contractor may limit a Member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the Contractor and the circumstances of the Member. The Contractor shall limit a Member to providers and pharmacies that are credentialed in their network.

6.3.3 PUMS1 Lock-In Process Requirements

Members identified for placement in PUMS1 shall be automatically locked-in to an in-network Buprenorphine waivered prescriber. The Contractor shall review automatic lock-ins and transition Members to a preferred Office Based Opioid Treatment (OBOT) practice when available. The Contractor shall lock-in the Member to all health plan credentialed Buprenorphine waivered prescribers associated with the OBOT practice.

6.3.4 PUMS Member Rights Notifications and Requirements

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

1) A brief explanation of the PUMS program;
2) A statement that the Member was selected for placement into the program;
3) An explanation that the decision is appealable;
4) A statement that the Contractor 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;
5) A statement clearly outlining the provisions for emergency after hours prescriptions if the Member's selected pharmacy does not have 24-hour access; and,
6) A statement indicating the opportunity and mechanisms by which the Member may choose a pharmacy, primary care provider, controlled substance provider, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types. The language must clearly state that if the Member does not select the relevant providers within fifteen (15) calendar days of enrollment into the PUMS program, the Contractor may select one for the Member.

6.3.5 Reporting Requirements

- **Annual PUMS Plan**
  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, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as substance abuse treatment services, etc.).
- **Summary Report**
  The Contractor must report a detailed summary of Members enrolled in its PUMS program on a Monthly basis (see CCC Plus Technical Manual).

6.4 ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM

Electronic Visit Verification (EVV) provides "real time" monitoring of a service provision, verifies that service visits occur, and documents the precise times service provision begins and ends. The Contractor shall work with providers of agency directed services and the Department to establish connectivity, transfer data, and fulfill program requirements. If the Department develops and implements an EVV system, the CCC Plus contractor could either use the Department's EVV system, or establish an interface and connectivity with DMAS' EVV system to share data.

6.5 NOTIFICATION TO THE DEPARTMENT OF SENTINEL EVENTS

A sentinel event is 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. The Contractor shall maintain a system for identifying and recording any Member's sentinel event. The Contractor shall provide the Department with reports of sentinel events upon discovery. See the CCC Plus Technical Manual for details.

SECTION 7.0 SUBCONTRACTOR DELEGATION AND MONITORING REQUIREMENTS

7.1 GENERAL REQUIREMENTS FOR SUBCONTRACTORS

The Contractor may utilize subcontracts with third party administrators (TPAs) for the purpose of processing claims and other operational or administrative functions. All subcontracts shall ensure the level and quality of care required under this Contract. Subcontracts with the Contractor for delegated administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing/re-credentialing, utilization management, Member services, claims processing, or provider services shall be submitted to the Department at least thirty (30) calendar days prior to their effective date, and then annually or upon amendment thereafter. This includes subcontracts for transportation, vision, behavioral health, prescription drugs, or other services.

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 CCC Plus Technical Manual for details.

The Contractor shall ensure that its subcontractors collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to DMAS on a monthly basis. The word “subcontractors” in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

The Contractor shall ensure that subcontractors 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.

All subcontracts are subject to the Department’s written approval. The Department may revoke such approval if the Department determines that a subcontractor fails to meet the requirements of this Contract. Subcontracts which require that the subcontractor be responsible for the provision of covered services shall include the terms set forth in the CCC Plus Technical Manual and, for the purposes of this Contract, that subcontractor shall be considered both a subcontractor and network provider.

The Contractor may enter into subcontracts for the provision or administration of any or all covered services or enhanced services. Subcontracting does not relieve the Contractor of its responsibilities to the Department or Members under this Contract. The Department shall hold the Contractor accountable for all actions of the subcontractor and its providers. Additionally, for the purposes of this Contract, the subcontractor’s actions and/or providers shall also be considered providers of the Contractor.

The Contractor shall provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a TPA. Assurances must include an assessment, performed by an independent Contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. The Contractor and TPA shall provide assurances that all service level agreements with the Department will be met or exceeded. Contractor staff shall be solely responsible to the single entity contracted with the Department.

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).

The Contractor shall ensure that any contracts or agreements with all Subcontractors performing functions on the Contractor's behalf are in compliance with the terms of this Contract and are in accordance with 42 CFR §§ 438.3 and 438.230. All subcontracts entered into pursuant to this Contract shall meet the following delegation and monitoring requirements and are subject to audit by the Department.

7.2 DELEGATION REQUIREMENTS

1) All subcontracts shall be in writing;
2) Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations;
3) Shall require the Subcontractor to require its provider contracts to comply with all provider provisions of this Contract and applicable Federal and State laws and regulations;
4) Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor;
5) Subcontracts shall provide that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract;
6) Subcontracts shall clearly state that the subcontractor shall comply with Member privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E; and
7) 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.
8) Subcontracts shall provide that the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor's subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related

activities or work is conducted. 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.

7.3 MONITORING REQUIREMENTS

1) The Contractor shall perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements.
2) The Contractor shall perform a formal performance review of all subcontractors at least annually.
3) 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.
4) The Contractor shall monitor the subcontractor's provider enrollment, credentialing, and re-credentialing policies and procedures to assure compliance with Federal disclosure requirements described in this Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against federally funded health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federal health care programs as described in this Contract.
5) 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.
6) The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract.

7.4 DATA SHARING CAPABILITIES

The Contractor shall ensure that the interface between the Contractor and its subcontractors includes data sharing capabilities, and ensures that data sharing occurs timely and effectively and remains seamless to the Member. The interface shall include a viable means of exchanging clinical, authorization, and service information between the Contractor and its subcontractors.

7.5 BEHAVIORAL HEALTH SERVICES ADMINISTRATOR

The Contractor shall sign a contract agreement (refer to Attachment 3 – *BHSA/CCC Plus Coordination Agreement*) with the Department's BHSA (Magellan of Virginia) no later than the effective date of this Contract. Such agreement shall include provisions to work cooperatively on behalf of CCC Plus program Members to coordinate care in a manner that fully supports timely access to appropriate person-centered services through a seamless continuum of care that is based on the individual clinical needs of the Member.

The agreement between the Contractor and the BHSA shall include procedures to share specific points of contact with names and contact information for a primary and back-up behavioral health Care Coordinator for use by the Department, the BHSA, and the Contractor as necessary for care coordination purposes.

The Contractor and the Department's BHSA shall work closely together and with the Department to expand these care coordination policy and procedures as needed to facilitate highly effective and efficient referral, care coordination, and treatment arrangements; to improve quality of care; and to eliminate duplicative services or conflicting treatment plans, on behalf of Members served by the Contractor and the Department's BHSA.

Care coordination opportunities that shall be included in the agreement between the Contractor and the BHSA shall include, but are not limited to, the following circumstances:

1) Receiving referrals for services covered under this Contract from the BHSA;
2) Referring Members seeking CMHRS to the Department's BHSA;
3) Providing care coordination assistance along with referrals for Members with special medical and/or behavioral health needs, high-risk cases, and other circumstances as warranted;
4) Ensuring warm transfer of telephone calls from Members to the correct entity and collaborative discussions between the Member's Care Coordinator and the BHSA;
5) Facilitating effective transition and continuity of care for Members who move between fee-for-service and CCC Plus enrollment, or who move between levels of care managed by the Contractor and BHSA, or who need or receive services concurrently through the Contractor and the BHSA;
6) Sharing clinically relevant information for care coordination purposes in a manner that complies with State and Federal confidentiality regulations, including: HIPAA regulations at 45 CFR parts 160-164, allowing for the exchange of clinically relevant information for care coordination of services (i.e., without the need of a patient release of information form), and Federal regulations at 42 CFR§ 2.31(a) pertaining to substance abuse preventing and treatment services, which requires Member consent, and where such consent must include the Member's name, the description of the information to be disclosed, the identity of the person or class of persons who may disclose the information and to whom it may be disclosed, a description of the purpose of the disclosure, an expiration date for the authorization, and the signature of the person authorizing the disclosure. [Member consent is not required in instances related to "public interest," when required by law (court-ordered warrants, law enforcement); when appropriate to notify authorities about victims of abuse, neglect, or domestic violence; and, when necessary to prevent or lessen serious and imminent threat to a person or the public, where information shared must be limited as needed to accomplish the purpose.]

7.6 CONSUMER DIRECTION FISCAL/ EMPLOYER AGENT

The Contractor shall maintain a Business Associate Agreement (BAA) with the Department's designated 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 processing all required IT and data exchange processes.

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 policies and procedures shall reflect the timeframes for data exchange as well as the internal process controls and implementation plan for all required IT and data exchange necessary for the consumer directed services with the F/EA. The Contractor shall have a dedicated project

manager for Consumer Directed services and shall report updates on the status of each task, subtask, and deliverable on a weekly frequency. Refer to the CCC Plus Technical Manual for the required format. If consumer directed personal care services will be offered as an enhanced benefit, the Contractor shall contract with and reimburse the F/EA for all of the administrative costs associated with the F/EA functions for this benefit. Reference sections *Consumer Direction and Contract with the Department's Fiscal/Employer Agent (F/EA)* and *Enhanced Benefits*.

SECTION 8.0 PROVIDER NETWORK MANAGEMENT

8.1 GENERAL NETWORK PROVISIONS

The Contractor shall include in its network or otherwise arrange care by providers specializing in early childhood, youth and geriatric services, and providers who are specialized in and have demonstrated competency in meeting the unique needs of the CCC Plus program population.

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 the Members are able to access and receive the full continuum of treatment and rehabilitative medical, behavioral health, ARTS, Nursing Facility, hospice, and waiver services and supports needed.

8.1.1 Network Elements

In accordance with 42 CFR §438.68, in establishing and maintaining the its network, the Contractor shall consider all of the following elements:

1) The anticipated CCC Plus enrollment;
2) The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated CCC Plus program population to be served and the existing patterns of utilization, including in localities that fall adjacent to another region and localities that border with other States;
3) The number and types (in terms of network training status, experience, and specialization) of network providers required to furnish the services covered under this Contract;
4) The number of network providers who are not accepting new membership from the Contractor;
5) The geographic location of network providers and CCC Plus Members, considering distance, travel time, the means of transportation ordinarily used by CCC Plus Members;
6) The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
7) The ability of network providers who have the demonstrated capacity to actively deliver services within the model of care, ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for CCC Plus Members with physical or mental disabilities;
8) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;
9) Elements that support a Member's choice of provider;
10) Strategies that ensure the health and welfare of the Member and support community integration of the enrollee; and
11) Other considerations that are in the best interest of the Members that need LTSS.

The Contractor is not required to contract with all willing providers; however, its network must meet the access to care standards described in Section 9.

8.2 SPECIALIZED NETWORK PROVISIONS

8.2.1 DD Waiver Providers

Individuals enrolled in the HCBS waivers that serve the DD populations (Building Independence, Community Living, and the Family and Individual Supports waivers) will be enrolled in CCC Plus program only for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). The Contractor shall ensure that it develops and maintains adequate network of qualified providers to meet the non-waiver integrated care needs of the DD subpopulation through a person centered delivery model. See *CCC Plus Model of Care.*

8.2.2 Inpatient 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.

8.2.3 Urgent Care

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

8.2.4 Health Homes

Beginning January 1, 2018, the Contractor shall establish health homes for Members with complex health conditions. Health homes should leverage existing community systems that serve individuals with complex health and social needs. Examples may include, but are not limited to, health homes for individuals with dementia utilizing area agencies on aging, rural health clinics, adult day health care centers, or other community providers.

8.2.5 Behavioral Health Homes

The Contractor may develop and implement behavioral health homes (BHHs) using an effective model that integrates medical and behavioral health services. The Contractor shall work with DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) to develop and implement BHHs appropriate for individuals with serious mental illness (SMI) using CSBs and other community systems. The Contractor shall notify DMAS of their intent to offer BHHs and shall include a description of the delivery model, prior to implementation the model. Submissions shall be sent to cccplusreporting@dmas.virginia.gov.

As DBHDS implements Certified Community Behavioral Health Clinic (CCBHC) elements, the Contractor shall develop, implement and modify BHHs reflecting the elements. Goals of the BHHs align with the CCC Plus program and include:

1) Improving health and behavioral health outcomes and opportunities for community integration for BHH Members using evidence-based practices;
2) Empowering medical and behavioral health providers to collaborate and exchange information for aligned care planning to provide person-centered care at the right time in the least restrictive environment/mode;
3) Improving the experience of care, quality of life and consumer satisfaction and promote a seamless and timely experience for enrolled individuals;

4) Improving access to primary and urgent care services, lowering the rates of hospital emergency department (ED) use, reducing hospital admissions and re-admissions and decreasing reliance on long term care facilities and other high cost services; and,
5) Providing Member education for medical, behavioral health, pharmacy and other community services, supports and needs, including principles of recovery and resiliency as defined by SAMHSA.

8.2.6 Behavioral Health (Including ARTS and CMHRS)

The Contractor shall develop a network of behavioral health providers, including inpatient, outpatient, and community based treatment providers sufficient to cover the full scope of behavioral health services as defined in the *CCC Plus Coverage Chart* attached to this Contract. 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 behavioral health and ARTS services covered by the Contractor. The Department will assess the MCO's inpatient, community based and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

The Contractor's CMHRS network shall ensure Member access to timely care through a sufficient network of high quality, credentialed, and knowledgeable providers in each level of care. The Department will continuously monitor the CMHRS network for staff roster, clinical staff credentialing and agency network adequacy for each level of care. The Contractor's CMHRS Network Readiness Plan shall have adequate numbers of providers by region and CMHRS Level of Care and identify which lack specific provider types by CMHRS Level of Care and plan for further network development.

The Contractor shall provide monthly updates on the CMHRS network to the Department as defined in the NSRM.

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 including ASAM Levels 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7. 4.0 as well as Opioid Treatment Programs and Office-Based Opioid Treatment providers defined in 12VAC130-5000 et.al.. The Department will continuously monitor the ARTS network for adequacy and for the ASAM Level of Care each provider meets. The Contractor's ARTS Network Readiness Plan shall have adequate numbers of providers by region and ASAM Level of Care and identify which lack specific provider types by ASAM Level of Care and plan for further network development.

The Contractor shall provide monthly updates to the Department by the 1st of each month, all ARTS credentialed provider organizations by ASAM Level of Care and by region in the Contractor's network as defined in Section 10.15 of this Contract. The report must include ASAM Levels 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0 as well as Opioid Treatment Programs and Office-Based Opioid Treatment providers.

The Contractor must have appropriate Residential Treatment Providers at all ASAM Levels of Care (including ASAM Level 3,1, 3.3, 3.5 and 3.7) in each region. During the first year of implementation, the Contractor's network shall include at least one residential ASAM sublevel level of care per region. Within three (3) years, all ASAM levels and sublevels of care

delivering ARTS benefits will be required to be available to beneficiaries within the Contractor's network. The Contractor shall ensure that its provider network meets access to timely care for services, including where the provider travels to the Member's home to provide services as set forth in the *Access to Care Standards* section of this Contract.

The Department recognizes that challenges may exist with achieving network adequacy in certain regions for certain types of providers, including ARTS, in the first year of implementation due to the lack of providers. The Department will not consider plans to be in violation of their contract if they do not have a specific provider type in a region because those providers do not exist and if they have exhausted all providers in the State, both in and out of their networks.

The Contractor shall have policies and procedures that outline how the Contractor is able to identify behavioral health providers who provide services deemed to be inappropriate to meet the behavioral health needs of the Member receiving the services. The Contractor shall report to the Department, per the Technical Manual, the providers that have been disenrolled from the network for these reasons.

Refer to *Subcontractor Delegation and Monitoring Requirements* section of this Contract.

8.2.7 Long Term Services And Supports (LTSS)

The Contractor shall enter into provider contracts for the provision or administration of covered LTSS, including hospice, NF, and CCC Plus Waiver covered services. These providers shall be reflected in the Contractor's networks. Provider qualification requirements for CCC Plus covered LTSS services can be found at the regulatory and DMAS manual cites provided in the *CCC Plus Coverage Chart* attached to this Contract. The Contractor shall ensure that it develops and maintains a network of high-quality waiver and non-waiver service providers, with sufficient capacity to serve its full CCC Plus membership, within the access standards defined in this Contract. In order to ensure adequate LTSS provider participation, the Contractor shall adhere to continuity of care standards and special payment provisions, and shall provide dedicated training and technical assistance to LTSS providers. See *Dedicated Assistance for LTSS Providers.*

8.2.8 Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCS)

The Contractor shall make a best effort to contract with the FQHCs and RHCs available in their service area. Prior to FQHC or RHC contract signature, the Contractor shall notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Contractor shall ensure that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the Contractor shall provide supporting documentation at the Department's request.

If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHCs or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of CCC Plus Members.

Within thirty (30) calendar days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of FQHC payment arrangement it has established.

8.2.9 Physical/Mental Abuse, Neglect, and Domestic Violence

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

8.2.10 Early Intervention Providers

The Contractor shall develop and maintain a network of early intervention providers, certified by DBHDS, with sufficient capacity to serve its CCC Plus Members in need of early intervention services. Early intervention providers shall be reflected in the Contractor's networks. 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 Services Manual*, and the DBHDS Practice Manual. Early intervention providers must be contracted with or have memorandum of agreement with the local lead agency for the catchment area in which the Member resides. In order to ensure adequate early intervention provider participation, the Contractor shall adhere to the Department's early intervention coverage rules and shall comply with special payment provisions described in Section 12.4.2.

8.2.11 Community Service Board (CSB)/Behavioral Health Authority (BHA)

Effective January 1, 2018, the Contractor shall contract with all Community Service Boards (CSBs) as well as Behavioral Health Authority (e.g., Richmond Behavioral Health Authority) to provide sufficient network access for its CCC Plus Members. The Contractor shall notify the Department in the monthly NSRM report when efforts to contract with any CSB are not successful. At the time of notification, the Contractor shall provide all dates of contact and describe any attempts to meet the needs of the provider.

8.3 CERTIFICATION OF NETWORK ADEQUACY

The Contractor's network shall meet or exceed Federal network adequacy standards at 42 CFR §438.68 and the full scope of access standards as described in Section 9 of this Contract and as described in the *CCC Plus Network Submission Requirements Manual (NSRM*). The Contractor shall assess and certify the adequacy of its provider networks monthly and when there is a substantial change to the program design (e.g., new populations, benefits, etc.). Refer to the CCC Plus Technical Manual 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 to the DMAS network

standards 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 Contractor network sufficiency. Network sufficiency for 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. Reference *Access to Care Standards* in Section 9.0.

8.4 PROVIDER CREDENTIALING STANDARDS

8.4.1 General Requirements

The Contractor shall utilize 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, ARTS, and LTSS network providers and those 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 §438.12, the Contractor's credentialing standards shall not discriminate against particular 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 physicians and other health care professionals 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 ensure all orders, prescriptions or referrals for items, or services for Members originate from appropriately licensed practitioners. The Contractor shall credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to Medicaid Members.

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.

8.4.2 Provider Accessibility

The Contractor and its network providers shall comply with all applicable Federal and State laws assuring accessibility to all services by individuals with disabilities pursuant to the Americans with Disabilities Act (ADA) (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members. Accessibility includes physical accessibility of service sites and medical and diagnostic equipment. Vehicles shall comply with the Americans with Disabilities Act (ADA) specifications for transportation, 49 CFR § 38, subparts A and B. The Contractor shall review compliance of provider accessibility at the time of credentialing and re-credentialing of its providers.

8.4.3 Prohibition Against Discrimination

In accordance with 42 USC§1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's provider network who is acting within the scope of the provider's license or certification under applicable Federal or State law, solely on the basis of such license or certification. The Contractor shall provide each provider or group of providers whom it declines to include in its network written notice of the reason for its decision. Nothing in the Contract may be construed to require the Contractor to contract with providers beyond the number necessary to meet the needs of its Members; or, precludes the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

If a discrimination complaint against the Contractor is presented to the Department for handling, the Contractor shall cooperate with the investigation and disposition of such complaint.

8.4.4 Network Provider Licensing and Certification Standards

The Contractor shall verify that providers are appropriately licensed by the State and have received proper certification or training to perform medical and clinical services contracted for 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.

8.4.5 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 12VAC30-50-226, 12VAC30-60-143, 12VAC30-50-130 and 12VAC30-60-61. ARTS providers shall meet the requirements in 12VAC30-130-5000, et.al. and the Department's most current behavioral health provider manuals, including the ARTS, community mental health rehabilitative services, mental health clinic, and psychiatric services provider manuals found at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual .

8.4.6 Credentialing of CCC Plus Waiver Providers

The Contractor shall monitor and ensure that network providers providing services to CCC Plus Waiver Members comply with the provider requirements as established in the DMAS provider

manuals available at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal and the following regulations: 12VAC30-120-900 through 12VAC30-120-995.

The Contractor shall require that all providers of CCC Plus Waiver services (including ADHC) maintain compliance with the provisions of the CMS Home and Community Based Settings Rule as detailed in 42 CFR § 441.301(c)(4)-(5) prior to executing a provider agreement.

As part the annual assessment and plan of care review, the Contractor's Care Coordinator or another entity as approved by the Department shall conduct, in a format prescribed by the Department, an Individual Experience Survey in order to ensure that the Member's services and supports are provided in a manner that comports with the setting provisions of the HCBS regulations in 42 CFR § 441.301(c)(4)-(5). DMAS will develop the survey in collaboration with the CCC Plus health plans.

The Care Coordinator shall be responsible for one hundred percent (100%) remediation of any instance in which the Member's services do not comport with requirements set forth in the HCBS regulations, and the Contractor shall analyze data from the Individual Experience Survey by provider and by setting as part of its ongoing quality monitoring and re-credentialing processes.

At a minimum, re-credentialing of CCC Plus Waiver providers shall include verification of continued licensure and/or certification (as applicable); quality of care provided, compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and compliance with the setting provisions of the CMS HCBS regulations detailed in 42 CFR § 441.301(c)(4) and 42 CFR § 441.301(c)(5).

8.4.7 Credentialing of Early Intervention Providers

In accordance with 12 VAC 30-50-131, all individual practitioners providing Early Intervention services must be certified by the Department of Behavioral Health and Developmental Services (DBHDS) to provide Early Intervention services. Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as an Early Intervention Service Coordinator.

8.4.8 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.

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 consistent with requirements described in Sections 2.10 – 2.12 of this Contract.

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.

8.4.9 Provider Monitoring

The Contractor shall continuously monitor the quality of services provided by its network providers. The provider's performance shall be included as an element of consideration during the re-credentialing process.

8.4.10 Credentialing Related Reporting

The Contractor shall have in place a mechanism for reporting immediately to the appropriate authorities any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license. The Contractor shall report to DMAS quarterly all providers who have failed to meet accreditation/credentialing standards, been denied application (including terminated providers), and/or have had program integrity-related and adverse benefit determination. The Contractor shall report ARTS providers separately. (See the CCC Plus Technical Manual).

8.5 PROVIDER AGREEMENTS

In accordance with 42 CFR § 438.206, the Contractor's network shall be supported by written agreements. Prior to CCC Plus program Contract signing, the Contractor shall submit to the Department each type of provider agreement template for services covered under this Contract, including any attachments applicable to the template. Ongoing, the Contractor shall submit for review any new or revised network provider agreement template at least thirty (30) calendar days prior to the effective date of use, and upon request thereafter.

The Department may approve, modify and approve, or deny network provider agreement templates under this Contract at its sole discretion. The Department may, at its sole discretion, impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and participating Members.

The Department will approve or disapprove any new or revised template within thirty (30) calendar 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) calendar days.

In circumstances where the Department determines that a change to the template is required, the Contractor shall have no greater than one hundred and twenty (120) calendar days to modify the agreement as approved by DMAS. This implementation timeline requirement may be shortened by the Department if the health and safety of Members is endangered by continuation of an existing agreement.

8.5.1 Provider Enrollment into Medicaid

The Contractor shall make its best effort as part of its credentialing process, to encourage all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), to apply for participation in the Medicaid fee-for-service program. The Department may request the Contractor to identify what efforts have been made to support this effort.

8.5.2 National Provider Identifier (NPI)

The Contractor shall require all providers rendering services under this Contract to have an NPI. The NPI is provided by the CMS which assigns the unique identifier through its National Plan and Provider Enumeration System (NPPES). The Contractor shall be required to have an NPI or an Administrative Provider Identification Number (APIN).

8.5.3 Elements That Shall Not Be Included in Provider Agreements

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

8.5.4 Elements That Shall Be Required in Provider Agreements

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

8.5.4.1 Elements Required in All Provider Agreements

1) Provider shall have a National Provider Identifier (NPI) number.
2) Provider shall meet the Contractor's standards for licensure, certification, and credentialing, and these shall be included in the Contractor's provider network contracts.
3) Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL #06-010.
4) Provider shall maintain records for ten (10) years from the close of the provider contract. For children under age 21 enrolled in the CCC Plus Waiver, the Contractor shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12VAC30-120-1730.
5) Provider shall provide copies of Member records and access to its premises to representatives of Contractor, as well as duly authorized agents or representatives of the

Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit.

6) Provider shall maintain and provide a copy of the Member's medical records, in accordance with 42 CFR § 438.208(b)(5), to Members and their authorized representatives as required by the Contractor and within no more than 10 business days of the Member's request.
7) Provider shall disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 CFR § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
8) Provider shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of its employees/contractors have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to the Contractor any exclusion information discovered. The provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CCC Plus Members.
9) Provider shall submit utilization data for Members enrolled with the Contractor in the format specified by the Contractor, consistent with Contractor obligations to the Department as related to quality improvement and other assurance programs as required in this contract.
10) Provider shall comply with corrective action plans initiated by the Contractor.
11) Contractor shall clearly specify referral approval requirements to its providers and in any sub-subcontracts.
12) In accordance with 42 CFR § 447.15, Provider shall accept Contractor payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member's period of Contractor enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a CCC Plus recipient for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where the provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions.
13) Should an audit by the Contractor or an authorized state or federal official result in disallowance of amounts previously paid to the provider, the provider will reimburse the Contractor upon demand. The provider shall not bill the Member in these instances.
14) Any conflict in the interpretation of the Contractor's policies and MCO Network Provider contract shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals. Provider shall comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.

15) Provider agreements shall include claim processing and payment provisions as described in the *Provider Payment System* section.

8.5.4.2 Special Provisions For Certain Provider Agreements

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

8.5.5 Network Provider Contract Supplement

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Network Provider Contract. 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 Contract. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Network Provider Contract.

If the Contractor uses the Provider Manual as a supplement to the Network Provider Contract, all sections pertaining to Medicaid must be submitted to the Department for approval prior to signing original contract, upon revision (changes only or with changes highlighted), upon request, and as needed.

8.5.6 Termination of a Contracted Provider

8.5.6.1 Policies and Procedures

The Contractor must have in place the following written policies and procedures related to the termination of a contracted provider.

1) Procedures to provide a good faith effort to give written notice of termination of a contracted provider, 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)]
2) Procedures to provide a good faith effort to transition Members to a new PCP or specialist at least thirty (30) calendar days prior to the effective date of provider termination;
3) Procedures for the reassessment of the provider network to ensure it meets access standards established in this Contract per Section 8.3 and 9.18; and,
4) Procedures for notifying the Department within the time frames set forth in this Contract and the CCC Plus Technical Manual including but not limited to Sections 8.3, 8.4.10, 9.4, 9.17, 14.2, and 14.10.

8.5.6.3 Notice to the Department

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

1) At least thirty (30) business days in advance (when possible) of a contract termination that could reduce Member access to care, and no later than within thirty (30) business days of implementing any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider where the termination, pending termination, or pending modification could reduce Member access to care;
2) in advance of, as soon as possible, and 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, see Section 8.3;
3) as soon as possible and within forty-eight (48) hours for suspected or actual fraud or abuse per Section 14.10;
4) immediately, including notice to the appropriate authorities for any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license See Section 8.4.10.

The Contractor shall also notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems. This written notice must occur in advance of the formal notification of hospital's termination from the Contractor's network. Reference Section 16.9 Data Quality Requirements for provider file Submission requirements and the CCC Plus Technical Manual.

SECTION 9.0 ACCESS TO CARE STANDARDS

9.1 GENERAL STANDARDS

The Contractor shall be solely responsible for arranging and administering covered services to enrolled Members and shall ensure that its delivery system provides available, accessible, and adequate numbers of facilities, locations and personnel for the provision of covered services, including all emergency services on a 24 hour-a-day, 7 day-a-week basis. Emergency services shall be provided per Section 4.6 of this contract.

The Contractor's network shall meet or exceed Federal network adequacy standards at 42 CFR §438.68 and shall have sufficient types and numbers of traditional and LTSS providers in their networks to meet historical need and must be able to add providers to meet increased Member needs in specific geographic areas. Adequacy will be assessed along a number of dimensions, including: number of providers, mix of providers, hours of operation, providers not accepting new patients, accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); and geographic proximity to beneficiaries (provider to Members or Members to provider). See *Provider Network Management* section of this Contract.

9.2 CHOICE OF PROVIDER STANDARDS

9.2.1 Providers Requiring Member Travel

The Contractor shall provide Members with a choice of at least two (2) providers for each type of service listed below in accordance with time and distance standards specified in Section 9.3 or where an exception is granted by the Department as described in Section 9.4.

- PCP (Primary Care Provider)
- Pediatrician
- Specialist
- Outpatient Behavioral Health
- CMHRS - Psychosocial Rehabilitation, Day Treatment/Intensive Outpatient, Therapeutic Day Treatment
- Nursing Facility – Skilled
- Nursing Facility – Custodial
- Pharmacy
- OB/GYN

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 9.3 below or where an exception is granted by the Department as described in Section 9.4.

- Adult Day Health Care
- Hospital (General)
- Hospital (Psychiatric/ ASAM Level 4 Inpatient Detox)

9.2.2 Providers that Travel to the Member

The Contractor shall ensure that its provider network meets access to timely care for all services, including where the provider travels to the Member's home to provide services. The Contractor shall provide Members with at least two (2) providers for each type of service listed below in each CCC Plus locality unless where an exception is granted by the Department.

- Home Health
- LTSS – Personal Care, Respite Care and Respite Care LPN
- LTSS – Skilled Nursing, Congregate Nursing, and Congregate Respite Nursing
- LTSS – Service Facilitation
- CMHRS – Crisis Stabilization, Crisis Intervention, Intensive In-Home, Mental Health Skill Building, Peer Supports, (EPSDT) Behavior Therapy, Intensive Community Treatment

For CMHRS - Mental Health Case Management, this service is provided by the local Community Services Board and is exempt from the two (2) provider requirement.

The Contractor shall provide Members with at least one (1) provider for each type of service listed below in each CCC Plus locality unless where an exception is granted by the Department.

- LTSS - Assistive Technology Only
- LTSS – Personal emergency response systems (PERS)
- LTSS – Environmental Modification,
- Durable Medical Equipment (DME) and Supplies

The Contractor may need to submit more than the minimum number of required providers within a given locality to ensure that Members have access within the contractually required time and distance standards described in this Section.

9.2.3 Individuals With Special Health Care Needs

When a Member with special health care needs has been identified through an assessment to need a course of treatment or regular care monitoring, and in compliance with 42 CFR § 438.208(c)(4), the Contractor shall have a mechanism in place to allow the Member to directly access a specialist, as appropriate for the Member's condition and identified needs.

9.3 MEMBER TRAVEL TIME AND DISTANCE STANDARDS

The Contractor shall ensure that the travel time and distance standards described in this section are met for services in which the Member travels to receive care, as described in Section 9.2.1. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). Travel time and distance standards do not apply to providers who travel to provide a service (e.g., PERS, home health, personal care, respite, etc.).

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

Member Time & Distance Standards Tidewater, Central, Charlottesville/Western & Northern/Winchester Regions		
Standard	**Distance**	**Time**
Urban		
• PCPs	15 Miles	30 Minutes
• Other Providers including Specialists*	30 Miles	45 Minutes
Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes
Member Time & Distance Standards Roanoke/Alleghany & Southwest Regions		
Standard	**Distance**	**Time**
Urban and Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes

9.4 EXCEPTIONS TO ACCESS STANDARDS

In accordance with 42 CFR §438.68 (d), 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; for example, certain ARTS provider types, urgent care facilities, hospital facilities, Adult Day Health Care facilities, etc. 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 8.3., *Certification of Network Adequacy.*

9.5 TWENTY-FOUR HOUR COVERAGE

The Contractor shall maintain adequate provider network coverage to serve its enrolled Members twenty-four (24) hours per day, seven (7) days a week. The Contractor shall make arrangements to refer Members seeking care after regular business hours to a covering physician or shall direct the Member to go to an urgent care or emergency room when a covering physician is not available. Such referrals may be made via a recorded message. Refer to *Warm Transfer to a Clinical Professional Staff* for more information.

9.6 URGENT CARE ACCESS

All CCC Plus enrolled Members must have access to at least one (1) urgent care facility (where available) to alleviate inappropriate use of hospital emergency rooms. These facilities must meet time and distance standards for care. Urgent care transportation must be provided for medically necessary care.

9.7 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 network facilities or through arrangements with other subcontractors. The Contractor must designate emergency sites that are as conveniently located as possible for after-hours emergency care.

The Contractor shall negotiate provider agreements with emergency care providers to ensure prompt and appropriate payment for emergency services. Such network provider agreements shall provide a process for determining the medical necessity of an emergency.

9.8 INPATIENT HOSPITAL ACCESS

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

9.9 MEMBER PRIMARY CARE ACCESS (ADULT AND PEDIATRIC)

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 this Contract. Except for dual eligible Members, the Contractor shall ensure that each Member has an assigned Primary Care Provider (PCP) at the date of enrollment. Members shall be allowed to select or be assigned a new PCP when requested by the individual, when the Contractor has terminated a PCP, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding.

9.9.1 Primary Care Physician (PCP) Assignment for Members

The Contractor shall have written policies and procedures for assigning a PCP for each of its non-Medicare enrolled Members. The Contractor shall also have an established mechanism to identify the PCP of all Members (including dual eligible) and incorporate the information into the Members' medical records to improve care coordination, including maintaining current PCP contact information. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department.

9.9.2 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 CCC Plus program Members (excluding dual eligible), and there must be one (1) FTE PCP with pediatric training and/or experience for every 1,500 Members under the age of eighteen (18). No PCP may be assigned Members in excess of these limits, except where mid-level practitioners are used to support the PCP's practice or where assignments are made to group practices.

Each contract between the Contractor and any of its network providers who are willing to act as a PCP must indicate the number of open panel slots available to the Contractor for Members under this Contract. This standard refers to the total CCC Plus program Members under enrollment by the Contractor. 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.

9.9.3 Providers qualifying as PCPs

1) Pediatricians;
2) Family and General Practitioners;
3) Internists;
4) Obstetrician/Gynecologists;
5) Specialists who perform primary care functions within certain provider classes, care settings, or facilities including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or,
6) Other providers approved by the Department.

9.9.4 Nursing Facility PCP

The Contractor shall work closely with nursing facility providers to ensure that physicians who are credentialed with a Nursing Facility to serve as a PCP are also credentialed with the Contractor. Refer to section 4.7.3 for more information.

9.9.5 Default Assignment of PCP

If the Member does not request an available PCP prior to the twenty-fifth (25th) day of the month prior to the enrollment effective date, then the Contractor may assign the new Member (without Medicare) to a PCP within its network, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), age and sex, and area of residence. The Contractor shall notify the Member in writing, on or before the effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

9.9.6 Timing of PCP Assignment

The Contractor shall ensure its Members have an assigned PCP from the date of enrollment with the plan. (Except for Members who have Medicare coverage.)

9.9.7 Change in PCP

The Contractor shall allow Members to select or be assigned 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 shall make the Member's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

CCC Plus Program Members may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children whose PCP is a specialist receive scheduled EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these Members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

9.10 TIMELINESS ACCESS STANDARDS

The Contractor shall arrange to provide care as expeditiously as the Member's health condition requires and according to the Department's requirements.

9.10.1 Emergency Services

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

9.10.2 Urgent Medical and Symptomatic Office Visits

All urgent care and symptomatic office visits shall be available within no more than twenty-four (24) hours of the Member's request; however, as quickly as the symptoms demand. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting. Transportation to these services shall be provided by the Contractor.

9.10.3 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) calendar days, or for routine specialty services like dermatology, allergy care, etc.

9.10.4 Maternity Care Appointment Standards

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

1) First trimester - Within fourteen (14) calendar days of request.
2) Second trimester - Within seven (7) calendar days of request.
3) Third trimester - Within five (5) business days of request.
4) High Risk Pregnancy - Within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

9.10.5 Behavioral Health Services

The Contractor shall ensure that members are able to receive behavioral health appointments as expeditiously as the member's condition requires and within no more than 5 business days from the Contractor's determination that coverage criteria is met. See *Service Authorization Timeframes* in Section 6.2.10.

9.10.6 LTSS

The Contractor shall ensure that members are able to receive LTSS as expeditiously as the member's condition requires and within no more than 5 business days from the Contractor's determination that coverage criteria is met. See *Service Authorization Timeframes* in Section 6.2.10.

9.11 SECOND OPINIONS

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

9.12 OUT-OF-NETWORK SERVICES

The Contractor shall provide services out-of-network in all of the following circumstances:

1) When the Contractor has pre-authorized out of its established network;
2) When emergency and family planning services are rendered to a Member by a non-participating provider or facility, as set forth in this Contract;
3) When the Member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract;
4) When the needed medical services or necessary supplementary resources or services furnished in facilities or by practitioners outside the Contractor's network are not available in the Contractor's network;
5) When the Contractor cannot provide the needed specialist, as specialist is defined in this contract, within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;
6) When the type of provider needed and available in the Contractor's network does not, because of moral or religious objections, furnish the service the Member seeks;
7) During the Member's continuity of care period and the Member's provider is not part of the Contractor's network, has an existing relationship with the Member, and has not accepted an offer to participate in the MCOs network;
8) In accordance with Section 5.14.3 of this contract for Members in nursing facilities; and,
9) When DMAS determines that the circumstance warrants out-of-network treatment.

When the Contractor is unable to provide necessary services in-network, in addition to paying out of network, the Contractor must coordinate with the provider for payment and ensure that the cost to the Member is no greater than it would be if the services were furnished within the Contractor's network.

9.13 OUT-OF-STATE SERVICES

The Contractor is not responsible for services obtained outside the Commonwealth except under the following circumstances:

1) Necessary emergency or post-stabilization services;
2) Where it is a general practice for Members in a particular locality to use medical resources in another State; and,
3) The required services are medically necessary and not available in-network and within the Commonwealth.
4) While the Contractor is honoring a transition of care plan authorized by the Contractor, another MCO, or the Department until services can be safely and effectively transitioned to a provider in the MCO's network within the Commonwealth.

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).

9.14 PROVIDER TRAVEL CONSIDERATIONS

Many CCC Plus program services are provided in the Member's home. The Contractor shall ensure that CCC Plus providers who are not located in the city/county of the Member's residence are willing and able to service residents of that city/county.

Recruiting and retaining agency- and community-based LTSS providers may be challenging due to low pay, limited benefits, and transportation costs. Urban areas generally have the advantage of public transportation systems. However, the distances workers have to travel, variable gas prices, other costs associated with automobile ownership, seasonal road and weather conditions, and serving fewer individuals per day due to travel time can present challenges in rural areas. Therefore, the Contractor should consider implementing creative solutions such as: carpooling, scheduling based on geography, reimbursing workers for mileage expenses, arranging with rental companies to rent fuel-efficient cars for workers to use, etc., in these rural areas.

9.15 POLICY OF NONDISCRIMINATION

The Contractor shall ensure that its providers provide contract services to Members under this Contract in the same manner as they provide those services to all non-Medicaid Members. Additionally, in accordance with 42 CFR § 438.206, the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial Members or other Virginia Medicaid programs, if the provider serves only Medicaid Members.

9.16 ACCOMMODATING PERSONS WITH DISABLITIES

The Contractor shall provide at contract implementation, at revision, or upon request, written policies and procedures to assure that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services from the Contractor.

The Contractor shall accommodate all Members and ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. The Contractor and its network providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members by:

1) Providing flexibility in scheduling to accommodate the needs of the Members;
2) Providing interpreters or translators for Members who are deaf and hard of hearing;
3) Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:
    a. Ensuring safe and appropriate physical and communication access to buildings, services and equipment;
    b. Ensuring providers allow extra time for Members to dress and undress, transfer to examination tables, and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information; and,

c. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical, communication and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies.

9.17 ASSURANCES THAT ACCESS STANDARDS ARE BEING MET

The Contractor shall establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must provide a quarterly report by provider type that demonstrates to the Department that these access standards are being continuously monitored by the Contractor and that standards have been met.

9.18 NATIVE AMERICAN HEALTH CARE PROVIDERS

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

1) Provide coverage for services from an Indian Health Service or Tribal provider, including out-of-network Indian Health Service (HIS) or Tribal providers, in accordance with the State Health Official Letter (SHO #16-002)(available at https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf). When an Indian Health Care Provider (IHCP) is not enrolled in Medicaid regardless of whether it participates in the network of a contracted health plan, the IHCP has the right to receive its applicable encounter rate published by the HIS, or in the absence of a published rate, the amount it would receive if the services were provided under the state plan's fee-for-service payment methodology;

2) Offer Native American Members the option to choose an Indian Health Care Provider as a PCP if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;

3) Demonstrate that there are sufficient Indian Health Care Providers in the network to ensure access to Covered Services;

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

5) Reimburse non-network Indian Health Care Providers that are FQHCs for the provision of services to an Native American Member at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider; and,

6) Not impose enrollment fees, premiums, or similar charges on Native Americans served by an Indian Health Care Provider.

SECTION 10.0 QUALITY MANAGEMENT AND IMPROVEMENT

10.1 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) Quality of LTSS;
4) Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS providers and services;
5) Continuity and coordination of care across all care and services settings, and for smooth transitions in care and maximum care continuum; and,
6) Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

10.2 CONTINUOUS QUALITY IMPROVEMENT PRINCIPLES AND EXPECTATIONS

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

1) Most current state endorsed healthcare quality improvement methodology and techniques;
2) Align with Virginia Medicaid Quality Strategy and Annual CCC Plus Quality Work Plan;
3) Quantitative and qualitative data collection and data-driven decision-making;
4) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
5) Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities;
6) Issues identified by the Contractor, and the Agency; and
7) Ensure that the quality management and improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health, LTSS, and care coordination.

10.3 QUALITY INFRASTRUCTURE

The Contractor shall structure its QI program for CCC Plus separately from any of its existing Medicaid, Medicare, or commercial lines of business. Specifically, required measures and reports for the CCC Plus Contract must reflect information only on the CCC Plus population according the specifications provided by the Department, and shall not include data from the CCC Demonstration, Medallion 3.0, and FAMIS programs.

The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and

understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 CFR § 438, including Subpart E, Quality Measurement and Improvement and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements. The Contractor shall:

1) Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;
2) Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;
3) Seek the input of providers and medical professionals representing the composition of the Contractor's Provider Network in developing functions and activities;
4) Establish internal processes to ensure that the QM activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in this section of this Contract and, in addition, the following elements:
    a. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the merged Member Experience and Quality of Life Survey, network provider and Member satisfaction survey, and other measurement results in designing QI activities;
    b. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 CFR Part 456 or corresponding section in the Medicaid managed care final rule once in effect. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to the Department;
    c. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures;
    d. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in consumer advisory boards; and
    e. In collaboration with and as further directed by the Department, develop a customized medical record review process to monitor the assessment for and provision of Behavioral Health and LTSS.
5) Keep written minutes of all quality committee, key workgroup meetings, and Member advisory boards. A copy of the signed and dated written minutes for each meeting above shall be available on-file after the completion of these meeting. These minutes shall be available for review upon request by the Department, its contractor (such as EQRO) or other entities (such as NCQA accreditation review). The Contractor shall provide advance notice to the Department about any of the meetings listed above. To the extent allowed by law, the Department or its designee, may attend any of these meeting at his/her option.

10.4 QI PROGRAM DESCRIPTION, WORK PLAN, AND EVALUATION

The Contractor shall have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall:

1) Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;
2) Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS providers with respect to QI program;
3) Detail how the Contractor's QI program will have oversight of its subcontractor's QI program and how its subcontractors will contribute overall to the Contractor's 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 ensures 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 CCC Plus Quality Work Plan; and,
7) Be updated, at a minimum, on an annual basis.

The Contractor shall submit to Department an annual QI Description and Work Plan by June 1 of the calendar year if not otherwise specified in the CCC Plus Technical Manual that shall include, at a minimum, the following components as directed by the Department:

1) QI infrastructure;
2) The goals for planned clinical and non-clinical initiatives with measureable, improvable and meaningful objectives;
3) All performance measurements used including inventory, measure frequency, and a description of Contractor's internal data quality control processes to ensure accurate and timely performance measure reporting;
4) Planned clinical and non-clinical initiatives;
5) The short and long term timeframes within which each of the clinical and non-clinical initiative's objectives are to be achieved;
6) The individual(s) responsible for each clinical and non-clinical initiative;
7) Any issues identified by the Contractor and its subcontractors, the Department, Members, and providers, and how those issues are tracked and resolved over time;
8) Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually;
9) Process for correcting deficiencies; and,
10) Annual QI evaluation process and how QI achievement and lessons learned will be disseminated and used for further improvement in future years.

The Contractor shall evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the Department. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services,

effectiveness of Member care management/care coordination program, accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan, and based on recommendations for next year's QI Strategic work plan. The evaluation should be comprehensive, cover all key components of the Contractor's CCC Plus line of business and at minimum include the following domains: annual population analysis, quality infrastructure, performance measurements, Member safety, quality improvement activities, utilization management, access and availability of services, network access and adequacy, practice guidelines, external quality reviews activities, Member experiences including grievances, appeals, Member surveys and Member advisory committee, waiver quality assurances, care management/coordination, behavioral health, Long Term Services and Supports (LTSS), provider experience, credentialing and recredentialing, provider profiling, and any delegated and subcontractors' QI activities.

10.5 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. QI staff shall include:

1. Key Contractor and subcontractor staff who can represent all major areas of the Contractor's CCC Plus 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; ARTS Care Coordinator as defined in 12 VAC 30-130-5020 (if different from the designated behavioral health clinician who should have oversight of all behavioral health services); and, a professional with expertise in the assessment and delivery of long term services and supports with substantial involvement in the QI program;
3. A qualified individual dedicated to serve as the QI Director who will be directly accountable to the Contractor's Project Manager or Medical Director/Chief Medical Officer and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Contractor's executive leadership team. This individual shall be responsible for:
    a. Overseeing all QI activities related to Members, ensuring compliance with all quality activities, and maintaining accountability for the execution of, and performance in, all such activities;
    b. Maintaining an active role in the Contractor's and subcontractor's overall QI structure; and,
    c. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:
        i. Physical;
        ii. Behavioral health;
        iii. Pharmacy management;
        iv. Care management;
        v. LTSS;
        vi. Financial;
        vii. Statistical/analytical;
        viii. Information systems;

ix. Marketing, publications;
x. Enrollment;
xi. Network;
xii. Utilization Management;
xiii. Grievance and appeal;
xiv. Operations management; and
xv. Subcontractor Oversight;

d. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by the Department, or its designee, and that may be attended by representatives of the Department, a Department contractor, or other entities, as appropriate; and,
e. Serve as liaison to, and maintaining regular communication with, Virginia QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

10.6 PERFORMANCE MEASUREMENT

The Contractor's reporting of quality performance measures shall at minimum cover the following four (4) domains:

1) Enhance Member experience and engagement in person-centered care;
2) Improve quality of care;
3) Improve population health; and,
4) Reduce per capita costs.

Within these four (4) domains, the Department has identified five (5) priority areas and selected measures that align with Federal, State and CCC Plus quality improvement aims and priorities. These measures are listed in the *CCC Plus Core Performance Measures List* and their reporting requirement specifications are outlined in the *CCC Plus Performance Measure Reporting Requirements* included in the CCC Plus Technical Manual. The Department reserves the right to add, delete, or update this document on a quarterly basis. The Contractor shall report on all of these measures according the specifications listed in the *CCC Plus Performance Measure Reporting Requirements* document. The Contractor shall have an internal reporting data quality review and compliance process to ensure performance measure data is complete, accurate and timely. The Department will implement a performance measure reporting compliance program. Its results will impact the Contractor's score and rating in the CCC Plus Quality Incentive program and overall Annual Contract Evaluation and Compliance program.

A subset of the CCC Plus performance measures are designated as *CCC Plus Key Performance Indicators* as listed in the *CCC Plus Key Indicators List*, which will also be noted in the *CCC Plus Performance Measure Reporting Requirements* document. Key Performance Indicators represent CCC Plus performance measures and quality improvement priority areas. The Department reserves the rights to add, delete and modify any *CCC Plus Key Performance Indicators* list on a quarterly basis at the Department's discretion. *CCC Plus Key Performance Indicators* will require more frequent and early reporting requirements. The Contractor shall ensure full compliance with the *Key Performance Indicators* rigorous reporting requirements.

The Department will require certain measures to be reported based on a specific member population. For example, for the ARTS services, certain measures will be required to be reported based on Members receiving these services. The Department reserves the rights to add, delete and change such specific performance measure reporting designation on a quarterly basis at its own discretion. These performance measure requirements will be noted in the *CCC Plus Performance Measure Reporting Requirements* document. The Contractor shall be able to report these designated specific program performance measures at the specific program level according the specifications in the *CCC Plus Performance Measure Reporting Requirement* document.

In addition, the Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. The Contractor must have policies and procedures in place to ensure accurate and timely performance measure reporting to the Department. Department (or its designee) will evaluate these policies and procedures and will perform an independent validation on at least a sample of the Contractor's performance measures. The Contractor shall collect performance data and contribute to all QI-related initiatives as follows:

1) Collect and submit to the Department, in a timely manner, according to the Department's specifications, data for the measures specified in the *CCC Plus Performance Measure Reporting Requirements*;
2) Contribute to all Department data quality assurance processes, which shall include, but not be limited to, responding in a timely manner, to data quality inadequacies identified by Department, and rectifying those inadequacies as directed by the Department;
3) Contribute to the Department's data regarding the individual and aggregate performance of the Contractor with respect to the noted measures;
4) Contribute to the Department's processes culminating in the publication of any technical or other reports related to the noted measures; and,
5) Demonstrate how to utilize results of the measures specified in *CCC Plus Performance Measure Reporting Requirements* in designing future QI initiatives.

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

1) Conduct an annual CAHPS survey. The Contractor shall enter into agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The Contractor's vendor shall perform the CAHPS Adult Version Medicaid survey, CAHPS Child Version, Children with Chronic Conditions Medicaid survey using the most current CAHPS version specified by NCQA. Survey results shall be reported on the CCC Plus program separately for each required CAHPS surveys listed above with results specifically for the CCC Plus program. Survey results shall be submitted to the Department and NCQA annually by June 15 of each calendar year beginning in 2018;
2) Conduct, as directed by the Department, the HCBS Experience survey for Members utilizing LTSS. Survey methodology and tools will be jointly developed via a collaborative effort between the Department and the CCC Plus program Contractors. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;
3) Conduct, as directed by the Department, a merged Member satisfaction survey on care management, ARTS member experience, and quality of life. Survey methodology and

tools will be jointly developed via a collaborative effort between the Department and the CCC Plus program Contractors;

4) Design and administer network providers and Member satisfaction surveys regarding their satisfaction with the Contractor. The Contractor can use the merged Member satisfaction, ARTS member experience, and quality of life survey as the Members satisfaction survey, or administer a separate Member satisfaction survey. The Contractor shall submit a survey plan and all related survey materials to the Department for approval at least 60 calendar days before survey administration and shall submit the results of the survey to the Department within the required timeline;
5) Conduct any other surveys as deemed necessary by the Department. The Contractor shall also assist with any Department CCC Plus Member survey, if any;
6) If not required specifically, the Contractor shall prepare detailed reports summarizing the survey results for submission to the Department per required timelines. The Department may require the Contractor to present individual survey results to various groups of audiences. The Contractor shall also prepare and conduct presentations, if requested by the Department, for each survey. These presentations shall include survey background, methodology, timeline, results, best practices, lessons learned, and how the Contractor utilizes the results for QI initiatives and system/process changes; and,
7) The Contractor shall demonstrate best efforts to utilize Member experience survey results in designing QI initiatives and implement system and process changes.

The Contractor shall contribute to data quality assurance processes, including responding in a timely manner to data quality inadequacies identified by the Department and rectifying those inadequacies, as directed by the Department. The Contractor shall contribute, as directed by the Department, to processes culminating in the development of CCC Plus quality reports regarding CCC Plus quality of care and performance.

10.7 PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

The Contractor shall perform at least two (2) clinical and two (2) non-clinical PIPs, beginning in CY2018. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, behavioral health, long term services and supports, high-volume services, high-risk services, and/or high-cost services. Non-clinical PIPs include projects focusing on availability, accessibility, cultural competency of services, interpersonal aspects of care, appeals, grievances, complaints, care transition and continuity, coordination of care and care management, and/or Member satisfaction.

The Department will require the four (4) above mentioned mandatory PIPs to address specific topic areas and use specific performance measures with input from the CCC Plus Quality Collaborative. If not specified by the Department, the duration of each PIP should be three (3) years starting from the approval of the PIP work plan by the Department. Within 30 days after initial signing of the CCC Plus program Contract, the Contractor shall identify at least two (2) qualified representatives with leadership responsibilities of the PIPs to serve on a CCC Plus Quality Collaborative with the Department. These representatives shall include at least the Contractor's QI Director and Chief Medical Officer or Medical Director with responsibility for clinical oversight of the PIPs.

This Collaborative shall brainstorm and propose PIP topic areas for the four (4) mandatory PIPs above and key PIPs performance measures (based on the CCC Plus Core Performance Measure set) as recommendations to the Department. The Department will make the final decision regarding the specific topics for each of the four (4) mandatory PIPs and the key performance measures for each PIP.

The two (2) clinical PIPs shall include one (1) in the area of a major chronic condition medical management (such as cardiovascular disease, diabetes, pulmonary disease, and mental health) and one (1) in the area of behavioral health that is relevant to ARTS.

One (1) of the two (2) non-clinical PIPs shall be in the area of long-term care and LTSS diversion; and, one (1) in the area of care management, care coordination, and/or care transitions.

The Contractor can plan and implement additional PIPs outside the required four (4) mandatory PIPs above. For all PIPs, including the four (4) mandatory PIPs and any additional PIPs proposed by the Contractor, the Contractor shall submit a PIP project plan to the Department according to the times and template provided by the Department for review and approval before implementation.

The Contractor shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented using the format and submission guidelines specified by Department in annual guidance provided for the upcoming contract year.

The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs which will be submitted to the Department for review and approval. The Contractor shall collect information and data in accordance with PIPs' specifications for its Members. For any PIPs, if performance measures are not selected by the Department, the Contractor should consider the *CCC Plus Core Performance Measure* set in selecting PIP performance measures. The Contractor shall implement PIPs in a culturally competent manner, to achieve their objectives using the Plan Do Study Act (PDSA) improvement model defined by the Institute for Health Care Improvement. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goals set for each PIP and promote sustained improvements.

Using the submission guidelines specified by the Department, the Contractor shall develop comprehensive written PIPs reports on a semi-annual basis. Such reports shall include information regarding PDSAs, progress on QI Project Requirements, performance on key PIP performance measures and progress toward achieving performance goals, barriers encountered and new knowledge gained. As directed by the Department, the Contractor shall present this information to the Department upon receipt of requirements by the Department; The Contractor shall evaluate the effectiveness of PIP continuously based on implementation of PDSA results and plan and initiate processes to sustain achievements, and encourage best practices to continue improvements. The Department will review PIPs progress reports and provide feedback. The Contractor shall address any questions, concerns, and direct guidance from the Department regarding PIPs plan and implementation.

After the initial PIPs implementation period, the Contractor shall evaluate to determine if any specific PIPs should be continued. Prior to discontinuing a PIP, the Contractor shall identify a new PIP and submit a new PIP project plan to the Department for approval. The new PIP focus areas will be mandated by the Department after gathering recommendations from the Quality Collaborative. The Contractor must receive the Department's approval to discontinue the previous PIP and perform the new PIP.

The Contractor shall conduct additional PIPs, special projects, focus studies, and research outside of the four (4) mandatory PIPs if mandated by the Department.

10.8 EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by the Department, in accordance with 42 CFR § 438.358 or corresponding section in the Medicaid managed care final rule. EQR activities shall include, but are not limited to:

1) Annual validation of performance measures reported to the Department, as directed by the Department, or calculated by the Department;
2) Annual validation of quality improvement projects required by the Department;
3) At least once every three (3) years, review of compliance with standards mandated by 42 CFR Part 438, or corresponding section in the Medicaid managed care final rule, and at the direction of the Department, regarding access, care coordination, structure and operations, scope and quality of care and services furnished to Members, and other standards;
4) Annual validation of the Contractor's provider network adequacy;
5) Any other optional EQRO activities the Department may contract with the EQRO to conduct including validation of encounter data, administration or validation of consumer or provider surveys of quality of care, calculation of performance measures in addition to those reported by health plans, conduct PIPs in addition to those mandated to be conducted by health plans, focus studies, and assistance with the health plan quality rating system development required by CMS; and,
6) The Contractor shall take all steps necessary to support the EQRO in conducting EQR activities including, but not limited to:
    a. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:
        i. Oversee and be accountable for compliance with all aspects of the EQR activity;
        ii. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO or the Department in a timely manner;
        iii. Serve as the liaison to the EQRO and the Department and answer questions or coordinate responses to questions from the EQRO or the Department in a timely manner; and
        iv. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR activity and as requested by the EQRO or the Department.

b. Maintaining data and other documentation necessary for completion of EQR activities specified above. The Contractor shall maintain such documentation for a minimum of ten (10) years;
c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or the Department;
d. Participating in health plan-specific and cross-health plan meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and the Department;
e. Implementing actions, as directed by Department, to address recommendations for QI made by the EQRO, and sharing outcomes and results of such activities with the EQRO or the Department in subsequent years; and
f. Participating in any other activities deemed necessary by the EQRO and approved by Department.

10.9 WAIVER ASSURANCES

The Department must meet Federal requirements for all Medicaid Waivers that provide the Department with authority to implement the CCC Plus program and any component of the CCC Plus program such as ARTS. The Contractor shall fully comply and implement to the Department's satisfaction any delegated activities by the Department for any Federal waiver requirements. An example of these requirements is the HCBS waiver assurances under the following domains: 1) Level of Care; 2) Service Plan; 3) Qualified Providers; 4) Health and Welfare; 5) Financial Accountability; and 6) Administrative Authority. Delegated by the Department, the Contractor shall conduct quality management reviews for the HCBS waivers and programs. Quality management reviews (QMRs) focus on the creation and implementation of the plan of care (POC). Reviewers determine if the plan is person centered, based on the assessment, addresses the individual's needs and personal goals. Provider documentation of services is reviewed to determine if services were delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. QMR details are discussed with the provider at an exit conference during the review and are further explained in a letter sent to the provider. These reviews will be monitored by the Department in accordance with parameters required through the Department's waiver application and related policies and procedures. The Contractor shall follow all of these quality assurances procedures and protocols which will be provided by the Department.

The Contractor shall report on the Waiver assurance measures according to the requirements and timelines described in the CCC Plus Technical Manual.

10.10 QI FOR UTILIZATION MANAGEMENT ACTIVITIES

The Contractor shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.
The QI activities for the UM program shall include:

1) Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
2) At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director,

or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of long term services and supports representative of the Contractor or subcontractor, with substantial involvement in the UM program; and

3) A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

10.11 CLINICAL PRACTICE GUIDELINES

The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long term services and supports in the relevant field, community-based support services or the Contractor's approved behavioral health performance specifications and clinical criteria;
2) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of LTSS;
3) Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, Virginia Department of Health or other State agencies;
4) Prior to adoption, have been reviewed by the Contractor's medical director, as well as other Contractor practitioners and network providers, as appropriate;
5) Are reviewed and updated, as appropriate, or at least every two (2) years;
6) Are reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;
7) For guidelines that have been in effect two (2) years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;
8) Disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's web site. The Contractor shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made;
9) Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services; and,
10) Submit to Department a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

10.12 QUALITY COLLABORATIVE AND OTHER WORKGROUPS

As directed by the Department, the Contractor shall actively participate in the CCC Plus Quality Collaborative, including attendance at all meetings by the QI Director and the Contractor's Chief

Medical Officer or Medical Director. 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 to 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 CCC Plus Health Plan Rating System development, etc.

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.

10.13 QUALITY PERFORMANCE INCENTIVE PROGRAM

The Contractor shall meet specific performance requirements in order to receive incentive payments over the course of the Contract. In order to receive any incentive payments, the Contractor shall comply with all Department incentive measure requirements while maintaining satisfactory performance on all other Contract requirements. The Department will publish a separate document to outline any performance incentive program methodology and benchmarks. Reference *Value Based Payments*.

10.13.1 Member Incentives

The Contractor may offer non-cash incentives or discounts to their enrolled Members for the purpose of rewarding healthy behaviors (e.g., immunizations [EPSDT, flu, shingles, pneumonia, etc.], prenatal visits, provider visits, or participating in disease management, HEDIS or HEDIS related measures/activities, etc.).
The Contractor shall also ensure that incentives are made available in equal amount, duration, and scope to the Contractor's Membership in all localities served. Incentives shall be limited to a value of no more than $50.00 for each medical goal, unless otherwise approved by the Department.

Incentives over $50 per medical goal must be approved by the Department prior to implementation; DMAS reserves the right to deny healthy incentive initiatives that do not align with DMAS or CMS policy. Non-cash incentives may include gift cards or discounts for services. The Contractor shall have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash; cash incentives are not permitted.

Annually the Contractor shall report its healthy incentives plan, including the various incentives that will be offered to its Members. The report must describe how the Contractor will measure

the success of the incentives offered and shall provide anticipated outcomes and return on investment. The Contractor shall maintain a database and track incentives by individual and must provide information to the Department upon request. Additionally, as part of the Contractor's annual report to DMAS, the Contractor shall report regarding the value/impact of the Contractor's healthy incentive initiatives on Member health outcomes.

10.14 BEHAVIORAL HEALTH SERVICES OUTCOMES

1) The behavioral health outcome measures will help to assess the standards of care and adherence to best practices within behavioral health. The goals are to increase the overall health of the population, improve the care for Members and to gain efficiencies in health care delivery leading to reduced care costs.
2) The Contractor shall require behavioral health providers to collect clinical outcomes data as determined by the Contractor and approved by the Department.
3) The Contractor's behavioral health provider contracts shall require the provider to make available behavioral health clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes;
4) The Contractor shall use outcome measures based on best practices within behavioral health care. As directed by the Department, the Contractor shall collaborate with DBHDS, other state agencies, CSBs/BHAs and behavioral health providers to develop outcome measures that are specific to each covered behavioral health service.
5) Outcome measures may include and are not limited to:
    a. Recidivism;
    b. Adverse occurrences;
    c. Treatment terminations or discharges against medical advice;
    d. Community tenure;
    e. Utilization measures such as access to care, hospital admissions and readmissions, emergency department visits and coordination with medical care;
    f. Social determinants of health such as employment or school attendance, availability of housing, social connectedness and criminal justice;
    g. Recovery oriented measures;
    h. Member satisfaction; and,
    i. Cost measures.

10.15 ARTS SPECIFIC MEASUREMENT AND REPORTING

The Contractor shall report reliable and valid data to DMAS including for the ARTS specific quality measures listed in the table below, per the guidelines in the ARTS Technical Manual. The Department has authority to add and remove ARTS specific quality measures to the list below as its discretion. The Contractor shall report these ARTS specific quality measures on the ARTS population only, according the specifications outlined in the Contractor's *Performance Measure Reporting Requirements*. The Contractor shall also be able to report these measures for the general population if any measures are also listed within the Contractor's *Core Performance Measures List*, according the specifications outlined in the DMAS *Performance Measure Reporting Requirements*. The ARTS Measures and Member Experience Survey listed below are due to the Department no later than September 1, 2018.

Source	Measure

NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
NQF # 1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
NQF #2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
NQF #0648 (modified)	Timely Transmission of Transition Record
PQA; NQF #2940	Use of Opioids at High Dosage in Persons Without Cancer (PQA)
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)
PQA	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)
NQF # 2960 CMS	180 day readmission rate for residential treatment for SUDs
NQF # 2960 CMS	Fourteen day readmission rate among Medicaid beneficiaries for inpatient treatment for SUDs
NQF #2599	Alcohol Screening and Follow-up for People with Serious Mental Illness
NQF #3175	Continuity of Pharmacotherapy for Opioid Use Disorder
ARTS Member Experience Survey	The Contractor shall also conduct an ARTS Member experience survey, including ten (10) questions to be provided by the Department. The Contractor shall complete the ARTS Member experience survey for a statistically significant sample of Members who have received an ARTS service. The Contractor shall report the results of its satisfaction survey separately to the Department no later than September 1, 2018.

10.15.1 ARTS Quarterly Dashboard Reporting

The Contractor shall submit quarterly dashboards specific for ARTS according the specifications and template given by the Department. The Dashboard at minimum will include data elements outlined below. The Department will have authority to change any dashboard specifications and template, and follow up on questions and issues identified via dashboard data. The Contractor shall respond in a timely manner to all Department questions and concerns and resubmit dashboard data if deemed by the Department as needed.

- **Process measures**
  - Number of CCC Plus Members served by region;
  - Number of licensed and credentialed providers of each ASAM Level of Care, including Opioid Treatment Programs and Office Based Opioid Treatment organizations, and peer supports by region; and,
  - Member and provider grievances and appeals by region.

- **Outcome measures**
  - ED utilization rates;

    - Hospitalization rates; and,
    - Readmission rates to the same level of care or higher.

- **Utilization rates for each service to include any denials for services, including peer supports.**

- **Office Based Opioid Treatment quality measures** based on the specifications and frequency determined by the Department and the CMO and Pharmacy Workgroup.

- **Monthly report of residential length of stays over 30 calendar days for ASAM Levels 3.1, 3.3, 3.5 and 3.7** and reason for Member not transitioning to lower level of care (such as due to lack of provider availability in lower ASAM level of care).

10.16 QUALITY SYSTEM

The Contractor's quality information system or core systems shall support all quality related activities as described in this Contract. The system shall accurately track and report all the QI performance measures at the frequency and timeframe required by the Department. The system must be flexible with creating and customizing performance measures to support the full scope of QI initiatives performed under this Contract.

10.17 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

The Contractor shall obtain and retain Medicaid health plan accreditation by the National Committee for Quality Assurance (NCQA). When the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) calendar days of receiving the report. The Department must also be notified in writing within ten (10) calendar days of any change to the Contractor's accreditation level. Denial or revocation of NCQA accreditation or a status of "Provisional" may be cause for the Department to impose remedies or sanctions as described in Section 18.5 to include suspension, depending upon the reasons for denial by NCQA.

Beginning January 1, 2019, Contractors with existing NCQA accreditation shall obtain NCQA LTSS Distinction at their next health plan accreditation (HPA) renewal.

If the Contractor is seeking NCQA New Health Plan accreditation for its Virginia Medicaid line of business, it must adhere to the following timeline of milestones for NCQA Accreditation set forth by the Department and provide documentation upon completion of each milestone:

1) Participate in EQRO comprehensive onsite reviews 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 CCC Plus Members).
3) Obtain NCQA accreditation with LTSS distinction status of at least "Accredited" within 36 months of the onset of delivering care to CCC Plus Members.

The Contractor shall 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 Re-credentialing, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and CAHPS survey.

If the Contractor provides coverage for more than one product line for the Department (e.g., Medallion 3.0, Commonwealth Coordinated Care, Commonwealth Coordinated Care Plus), the Contractor shall report its HEDIS and CAHPS separately for each product line.

The Contractor shall 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 change in accreditation status, loss of accreditation, etc.).

DMAS may require the Contractor to seek NCQA's Long-Term Services and Supports Distinction in the future. The Department encourages CCC Plus health plans to obtain NCQA's LTSS Distinction as it aligns with the Department's goals for conducting comprehensive assessments, managing care transitions, performing person-centered assessments and planning and managing critical incidents.

SECTION 11.0 MEMBER SERVICES AND COMMUNICATIONS

11.1 MEMBER CALL CENTERS

The Contractor shall operate adequately staffed toll-free telephone lines to respond to the various Member concerns, health crises, inquiries (e.g., covered services, provider network), complaints and questions regarding the Virginia CCC Plus program. The calls may be generated from a CCC Plus program Member, the Member's family, or the Member's provider.

The Contractor's call centers shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues. Further, the Contractor's call centers shall be adequately staffed with qualified personnel who are trained to accurately respond to Members.

The Contractor shall develop Member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, monitoring of calls via recording or other means, and compliance with standards. The Contractor shall measure and monitor the accuracy of responses and phone etiquette, taking corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

11.1.1 Staffing Requirements

The Contractor shall ensure that the Member customer service line is staffed adequately to respond to Members' questions and concerns that are specific to the Virginia CCC Plus program during the required hours of operation. The Member customer service call center shall be staffed with qualified clinicians to triage crisis, urgent, and emergency calls from Members and to facilitate the transfer of calls to clinical triage personnel or Care Coordinators from or on behalf of a Member that requires immediate attention.

The Contractor's customer service staff shall be trained to apply a low threshold in identifying crisis calls; that is, they only need to suspect a crisis to initiate crisis call procedures including assessing eminent risk and immediately engaging a licensed care manager. When the staff hear verbal cues or other indications that suggest an emergency, he or she shall immediately pass the call "live" to a clinical triage crisis care manager.

The Contractor's call centers' staff shall be trained to respond to the unique needs of the CCC Plus program populations including calls from Members with cognitive, physical, or mental disabilities, or from Members with limited English proficiency (including access to interpreter and translation services as necessary).

The Contractor may have a separate clinical triage line that meets all of the operating requirements detailed herein.

11.1.2 Member Clinical Triage Line

The Clinical Triage line shall be dedicated to providing the management of all crisis calls (e.g., behavioral health, ARTS, medical), nurse advice, and care coordination support. The Clinical Triage line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified clinicians to triage behavioral health, ARTS, urgent care and emergency calls from Members.

The Clinical Triage line shall facilitate the transfer of calls to a Care Coordinator from or on behalf of a CCC Plus program Member that requires immediate attention. Through the Clinical Triage line, clinical staff will work with Members to determine their needs, discuss behavioral health/ARTS service options and assist them in identifying an appropriate provider. If at any time, a caller is in distress or appears to have complex needs or a complicating condition, a clinical care manager shall provide the appropriate triage and referral.

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

11.1.3 Warm Transfer to Clinical Professional Staff

The Contractor shall ensure that all calls from CCC Plus program Members that require immediate attention are transferred via a "warm transfer" when necessary to a medical, behavioral, or ARTS professional with appropriate clinical expertise to assist the Member, and to connect the Member with their assigned Care Coordinator. These "warm transfer" calls shall be delineated separately in reports and metrics from other call center contacts.

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

1) Date of call, Member name and ID, Member FIPS, and contact information
2) call reason,
3) Assessment and referral,
4) Member status,
5) Identified treating provider(s),
6) Outcomes, and
7) Follow-up treatment and monitoring activities.

11.1.4 Appropriate Call Transfers

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

11.1.5 Communication /Interpreter Assistance

The Contractor shall provide language assistance services and auxiliary aids, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, large print or Braille, free of charge to Members and/or the Member's representative.

11.1.6 Monitoring By The Department

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

11.1.7 Member Services Hours Of Operation

1. General customer service helpline (available 8:00 am-8:00 pm, seven (7) days a week). Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays.
2. Clinical triage line, (available 24 hours per day; 7 days per week) shall include:
   a. behavioral health/ ARTS crisis line;
   b. care coordination support; and,
   c. clinical/nurse advice.

11.1.8 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.

11.1.9 Performance Standards

The Contractor's call centers shall:

1) Answer 85% of all calls within 30 seconds or less;
2) Limit the average hold time to less than two (2) minutes (defined as the time spent on hold by the caller after the IVR system/touch tone response system/recorded greeting and before reaching a live person;
3) Limit the disconnect (abandonment) rate of all incoming calls to five (5) percent). *Calls abandoned are the number of calls where the caller disconnects while on hold waiting for an agent. An abandoned call is one that hangs up after 60 seconds. If the caller hangs up before 60 seconds, it's not considered abandoned;*
4) Have a process to measure the time from which the call is answered to the point at which a Member reaches an Enrollee Service Representative (ESR) capable of responding to the Member's question in a manner that is sensitive to the Member's language and cultural needs;
5) Record 100% of incoming calls from the Member helplines using up-to-date call recording technology. Call recordings shall be searchable by provider NPI, Member ID # (if available), phone number (when identified), and date and time of the call. Recordings shall be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call;

6) Measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff;
7) Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance;
8) Report on CCC Plus program calls separately from other Virginia lines of business, if any; and,
9) Report by region and by service area (i.e., ARTS, Mental Health, LTSS, Nursing Facility, Primary and Medical Services, Transportation Services). The Contractor's call system shall also track and report the number of mental health and ARTS crisis calls received.

11.2 MEMBER INQUIRIES

The Contractor shall provide a timely response to all inquiries received from Members or on behalf of Members while ensuring HIPAA compliance. Additionally, in any instance where the Contractor receives a claim for payment filed by the Member, the Contractor shall respond to the Member, in writing, and at the time of any action affecting the claim. This response to the Member is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the Member regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

11.3 MEMBER RIGHTS AND PROTECTIONS

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; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

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

1. Receive information in accordance with 42 CFR § 438.10.
2. Be treated with respect and with due consideration for his or her dignity and privacy.
3. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.
4. Participate in decisions regarding his or her health care, including the right to refuse treatment.
5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
6. Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.
7. Have free exercise of rights and the exercise of those rights does not adversely affect the way the Contractor and its providers treat the Member.
8. Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in this Contract.

11.4 ADVANCED DIRECTIVES

In accordance with 42 CFR §438.3(j)(1) and (2); the Contractor shall educate staff concerning their policies and procedures on advance directives.

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

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

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.

11.5 CULTURAL COMPETENCY

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. The Contractor shall demonstrate cultural competency in all forms of communication. Furthermore, the Contractor shall ensure that cultural differences between providers and Members do not impede access and quality health care.

11.6 COST-SHARING

The Contractor shall not impose any cost sharing obligations on Members for covered and non-covered services. The Contractor may not impose co-payments on prescription drugs covered under this Contract. CCC Plus program Members will be exempt from cost sharing other than for any Patient Pay established by DSS towards LTSS services, including skilled and custodial nursing facility and CCC Plus Waiver services. (Refer to *Patient Pay* section of this Contract for more information.)

11.7 PROTECTING MEMBER FROM LIABILITY FOR PAYMENT

In accordance with 42 CFR § 438.106 and 42 CFR § 447.15, the Contractor, shall ensure that its Members are not held liable for payment for any services provided under this Contract other than for any Patient Pay established by DSS towards LTSS services. The Contractor shall assure that all in-network provider agreements include requirements whereby the Member shall not be charged for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.

The Contractor shall not deny and shall ensure that its providers and subcontractors do not deny any service covered under this Contract to an Member for failure or inability to pay any applicable charge or where the Member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid.

The Contractor shall ensure Provider Network compliance with all Member payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any Member of the Contractor's Provider Network that does not comply with such provisions.

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 USC § 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 USC § 1396u-2 (b)(6)), and in accordance with 42 CFR § 438.106 the Contractor and all of its subcontractors shall not hold a Member liable for:

1. Debts of the Contractor in the event of the Contractor's insolvency.
2. Covered services provided to the Member for whom the Contractor has not received payment from the Department for the services; or, the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor.
3. Payments in excess of the contracted amount
4. Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the Member if the service had been received directly from the Contractor.
5. Coinsurance, copayments, deductibles, financial penalties, or any other amount other than any Patient Pay established by DSS towards LTSS services.

11.8 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 CCC Plus program management and Member care. The Contractor shall ensure that the Member Advisory Committee (1) meets at least quarterly beginning the second quarter of CY 2018 and (2) is comprised of a reasonably representative sample of the LTSS Members, or other individuals representing Members including family Members, independent advocates and other caregivers that reflect the diversity of the CCC Plus program population, including individuals with disabilities and individuals residing in NFs. The Contractor shall advise all Members of this Committee and provide a procedure for interested Members, family members, independent advocates, and other caregivers to participate on the Committee. The Department reserves the right to review and approve Committee Membership.

The Contractor shall include Ombudsman reports in quarterly updates to the Member Advisory Committee and shall participate in all statewide stakeholder and oversight meetings as requested by the Department.

11.9 PROTECTION OF CHILDREN AND AGED OR INCAPACITATED ADULTS

The Contractor shall report as follows:

Suspected or Known Child Abuse or Neglect

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

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

Suspected or Known Abuse of Aged or Incapacitated Adults

In accordance with Section 63.2-1606 of the *Code of Virginia*, the Contractor shall report immediately upon learning of any suspected or known abuse of aged or incapacitated adults to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline at: **(888) 832-3858.** The Contractor shall make available to the Department upon request information pertaining to these reports. All staff training must include policies and procedures regarding mandated reporting.

11.10 PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS

In accordance with 42 USC §1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a provider from advising a Member about his/her health status or medical care or treatment options for the Member's condition or disease; information the Member needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Member's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the provider is acting within the lawful scope of practice.

11.11 MEMBER COMMUNICATIONS AND ENROLLMENT MATERIALS

11.11.1 Prior Approval Process

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

11.11.2 Written Material Guidelines

In accordance with CFR 438.10(c)(4)(i), the definitions provided in the Attached *Common Definitions For Managed Care Terminology* shall be used by the Contractor in all Member communications and materials. In accordance with 42 CFR 438.10(c)(4)(ii), the Contractor shall utilize the DMAS Member notice templates as developed and directed by the Department.

The Contractor shall ensure that documents for its Membership, such as the Member handbook, are comprehensive and written to comply with readability requirements. All written material for Members shall be in a font size no smaller than 12 point. All information provided to Members or potential Members shall use easily understood language and formats, and shall meet the information requirements outlined in 42 CFR § 438.10. CMS published a health literacy tool kit that provides guidance for how to make written material clear and effective, available at: https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html. Part 7 of the Tool Kit provides cautionary information on using readability formulas and suggests alternative methods to make written material easier for individuals to understand. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

The Contractor shall 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, in English and Spanish and shall include taglines in the top fifteen (15) other prevalent non-English languages spoken in Virginia. Reference: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15-non-english-by-state-MM-508_update12-20-16.pdf . .

Written materials shall be made available in alternative languages and formats upon request of the Member at no cost. Auxiliary aids and services shall also be made available upon request of the Member at no cost. Written materials shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's Member/customer service unit. Materials shall also include information that indicates that the Member can access free interpreter services to answer any questions. Large print means printed in a font size no smaller than 18 point. [42 CFR § 438.10(d)]

11.11.3 Distribution of Member Materials

11.11.3.1 Electronic Information

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

1) The format is readily accessible; and,
2) The information is placed in a location on the Contractor’s Web site that is prominent and readily accessible; and,
3) The information is provided in an electronic form which can be electronically retained and printed; and
4) The information is consistent with the content and language requirements described in 42 CFR §438.10; and
5) The Member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

11.11.3.2 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 Member materials shall include:

1) Welcome/introduction Letter
2) Identification Card that Includes the Medicaid ID Number
3) Member Handbook. The Contractor shall provide the handbook to the Member using one of the following methods:
   a) provides via a paper copy by mail; or,
   b) provides by email, after obtaining the Member's agreement to receive the information by email; or
   c) posts the handbook on the Contractor's Web site, where the Contractor must advise the Member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address. This method must ensure that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
   d) provides the information by any other method that can reasonably be expected to result in the Member receiving that information. This method must be documented in the Member's record. An example could include a paper copy hand-delivered by the Care Coordinator.
4) Provider Directory, or a separate notice on how to access this information online and how to request a hard copy
5) Formulary Information, or a separate notice on how to access this information online and how to request a hard copy
6) PCP assignment (for non-duals)
7) Care Coordinator Contact Information.
   a) The member shall be assigned a Care Coordinator on or before the Member's enrollment effective date. Additionally, the Contractor shall send a notice to the Member simultaneously with the enrollment packet or within 14 days of enrollment, providing the name and contact information for their assigned Care Coordinator.

11.11.4 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, 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) CCC Plus program logo;
2) Name of the Member;
3) Member's Medicaid identification number;
4) Member's Contractor identification number;
5) Name and address of the Contractor;
6) Telephone number to be used to access after-hours non-emergency care;
7) Behavioral health and ARTS crisis line number (if different);
8) Instructions on what to do in an emergency;
9) Any other information needed to process claims;
10) Telephone contact information for the *Smiles For Children* program;
11) Telephone number for transportation services
12) Telephone number for the Contractor's Care Coordination Department (required no later than July 1,2018.)

The Contractor shall submit and receive approval of the identification card from the Department prior to production of the cards.

11.11.5 Member Handbook

In accordance with 42 CFR § 438.10, the Contractor shall develop a Member handbook that includes all required elements as defined in the Department's CCC Plus program handbook template, available on the CCC Plus web page at: http://www.dmas.virginia.gov/Content_pgs/mltss-meminfo.aspx. 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. The Contractor shall revise its Member handbook to coincide with changes that DMAS makes to the handbook template and as directed by DMAS. Changes to the printed version of the handbook shall be revised to incorporate needed changes at least on an annual basis or as directed by DMAS. If a significant mid-year change is required, the plan may revise through the use of an insert. Changes to the on-line version of the handbook shall be revised to incorporate needed changes within thirty (30) calendar days receipt notice of the required change.

11.11.6 Provider Network Directory

The Contractor shall make available in paper form upon request and electronic form, a provider directory that includes the following information about its network providers, including physicians, specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers in accordance with all requirements described in 42 CFR § 438.10. The Department will periodically monitor the Contractor's provider directories to ensure compliance with these content requirements. See the Compliance Violations in Section 18.3.3.2.

11.11.6.1 Content of Provider Directory

The provider directory must include, at a minimum, the following information for all providers in the Contractor's provider network:

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

11.11.6.2 Maintenance and Distribution

1) The Contractor shall maintain, update, and distribute the directory as follows:
   - Update information in its paper directory at least monthly;
   - Update information in its online and printed directories no later than thirty (30) calendar days after receipt of provider updates;
2) Provide either a copy, or a separate notice about how to access this information online or request a hard copy within 5 business days at no charge, to all new Members and annually thereafter;
3) Provider directories must be made available on the Contractor's Web site in a machine readable file and format;
4) When there is a significant change to the network, the Contractor shall send a special mailing to Members;
5) Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 CFR §438.10; Consistent with 42 CFR §438.10(f)(1) the Contractor shall make a good faith effort to give written notice of termination of a contracted provider, 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;

6) Include written and oral offers of such provider and pharmacy directories in its outreach and orientation sessions for new Members.
7) Make available on the Contractor's Web site in a machine readable file and format per 42CFR§438.10(h).

11.11.7 Prescription Drug Formulary

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

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

11.11.8 Member Disenrollment

Upon disenrollment from the Contractor's plan, the Contractor shall notify the Member through a disenrollment notice that coverage in the Contractor's plan will no longer be effective. The disenrollment notice should identify the effective date of disenrollment and, whenever possible, should be mailed prior to the Member's actual date of disenrollment.

11.12 MARKETING 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.

11.12.1 DMAS Review and Approval

The Contractor shall submit all marketing materials and information regarding planned activities to the Department for review and approval prior to their planned use and in accordance with the timeframes below.

11.12.1.1 Marketing Plan

The Contractor shall annually, submit a complete marketing plan to the Department for informational purposes. Any changes to the marketing plan shall be submitted to the Department for approval prior to use.

11.12.1.2 Marketing Materials

The Contractor shall submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Department will approve, deny, or ask for modifications to the materials within thirty (30) calendar days of the date of receipt by the Department (42 CFR § 438.104).

11.12.1.3 Other Marketing Venues

The Contractor shall 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.

DMAS may conduct additional types of review of Contractor marketing, outreach, and communications activities, including, but not limited to:

1) Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.
2) Random reviews of actual marketing, outreach, and communications pieces as they are used in the marketplace.
3) "For cause" review of materials and activities when complaints are made by any source, and DMAS determines it is appropriate to investigate.
4) "Secret shopper" activities where DMAS requests Contractor materials, such as Enrollment packets.

11.12.2 Federal and State Laws

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

The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor or its subcontractor(s) knows or should know is likely to influence the Member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid.

The Contractor shall be prohibited from offering rebates or other cash inducements of any individuals.

The Contractor shall be subject to fines or other sanctions if it conducts any marketing activity that is not approved in writing by the Department (42 CFR § 438.700).

11.12.3 Use of Subcontractors

The Contractor 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.

11.12.4 Marketing Activities Prior to Effective Date

The Contractor may not begin marketing activities until the Contractor has entered into this Contact, passed the readiness review, had materials reviewed and approved by the Department, and is able to receive payment and enrollment files.

The Contractor may not begin Marketing, Outreach, and Member Communications activities to individuals more than ninety (90) calendar days prior to the effective date of Member enrollment.

11.12.5 Distribution of Marketing Materials

The Contractor shall distribute marketing materials to the Contractor's eligible population within its participating region. The Department must approve a request for a smaller distribution area on a city or countywide basis and also through the Contractor's website.

11.12.6 Marketing Material Formats

All information including marketing and informational materials provided to Members or potential Members shall use easily understood language and formats, and shall meet the information requirements outlined in 42 CFR § 438.10. CMS published a tool kit that provides guidance for how to make written material clear and effective, available at: https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html.

The Contractor shall ensure that all information provided to enrolled Members and Eligible Members is provided in alternate manners and formats according to the needs of enrolled Members and eligible Members, taking 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, oral interpretation services, ASL video tape, and information read aloud to a Member. Information should be written with cultural sensitivity and be provided in large print (at least 18-point font), if requested.

The Contractor shall update materials to reflect any changes in Federal or State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

11.12.7 Permitted Marketing and Outreach Activities

The Contractor may engage in the following promotional activities:

11.12.7.1 General Public

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

11.12.7.2 Pre-Approved Mail Campaigns

For potential Members, pre-approved mail campaigns are handled through the Department or its mailing vendor and will be sent to all potential Members. Mail campaigns are only allowed during open enrollment. The Contractor shall pay the mailing vendor directly for the cost of the mail campaign. DMAS shall not be responsible for any costs related to the Contractor's mail campaign.

11.12.7.3 Pre-Approved Informational Materials

The Department must pre-approve informational materials prior to use via television, radio, and newspaper dissemination.

11.12.7.4 Potential Member Request

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

11.12.7.5 Home Visits for Marketing Purposes

The Contractor is prohibited from making unsolicited offers of individual appointments. However, to the extent a Contractor provides individual appointments, a Contractor can make an individual appointment to an Member, Potential Member, or his/her authorized representative if the Member/representative has contacted the Contractor to request assistance or information. The

Contractor shall make reasonable efforts to conduct an appointment in the Member or Eligible Beneficiary's preferred location. The Contractor cannot require that an individual appointment occur in a Member or Potential Member's home. The appointment must be staffed by a trained Member service representative.

11.12.7.6 Community Sites

The Contractor shall convene all pre-approved educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Members or eligible Members, including persons with disabilities and persons using public transportation.

11.12.7.7 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 and/or Departments of Behavioral Health and Developmental Services may be present. The Contractor shall make available informational material that includes the enrollment comparison chart. The Contractor is allowed to collect names and telephone numbers for marketing purposes; however, no Medicaid ID numbers may be collected at the event. DMAS will supply copies of comparison charts upon proper notification.

11.12.7.8 Health Screenings

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

11.12.7.9 Promotional Items or "Giveaways"

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

11.13 PROHIBITED MARKETING AND OUTREACH ACTIVITIES

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

11.13.1 Certain Informational Marketing Activities

Engaging in any informational or marketing activities which could mislead, confuse, or defraud Members or misrepresent the Department (42 CFR§438.104).

11.13.2 "Cold Call" Marketing Activities

Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites (42 CFR § 438.104).

11.13.3 Direct Mailing

All mailings must be processed through the Department or its agent except mailings to CCC Plus program Members of the Contractor.

11.13.4 Home Visits/Direct Marketing or Enrollment

The Contractor is not permitted to conduct unsolicited personal/individual appointments. Making home visits for direct marketing or enrollment activities is allowed only when requested by the Member or his/her authorized representative.

11.13.5 Incentives

Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll in the Contractor's plan.

11.13.6 Prospective Member Marketing

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

11.13.7 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 eligible individuals with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract.

11.13.8 Targeting on Basis of Health Status

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

11.13.9 Contacting Members After Disenrollment Date

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

11.13.10 Marketing a Rebate or Discount

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

11.13.11 Marketing at DSS Offices

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

11.13.12 Statements of Endorsement (Government)

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

11.13.13 Enroll to Keep Benefits

No assertion or statement that the Member must enroll with the Contractor in order to keep from losing benefits (42 CFR § 438.104).

11.13.14 Renewal of Medicaid Benefits/Reason for Disenrollment

Contacting Members at any time for the purpose of determining the need for, or providing assistance with, recertification/renewal of Medicaid benefits. In addition, health plan may not solicit reason for disenrollment from Members leaving Contractors plan.

SECTION 12.0 PROVIDER SERVICES AND CLAIMS PAYMENT

12.1 PROVIDER CALL CENTER

The Contractor shall operate a toll-free provider call center to respond to questions, concerns, inquiries, and complaints, in accordance with the requirements detailed in this Contract. The Contractor's provider call center shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues.

The Contractor shall have written provider service line policies and procedures that address all areas of call center operations including staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

The provider call center shall be adequately staffed with representatives who are trained to accurately respond to questions regarding the CCC Plus program, covered services, Member enrollment, utilization management, referral requirements, care coordination, provider network contracting and credentialing, and claims payment.

The provider service line shall be adequately staffed to provide appropriate and timely responses regarding authorization requests. The Contractor may meet this requirement by having a separate utilization management line.

Consistent with requirements set forth in 42 CFR § 438.66 the Contractor shall maintain a log of provider complaints and shall report these to the Department as directed in the CCC Plus Technical Manual.

12.1.1 Dedicated Assistance for LTSS Providers

For all areas where the Contractor is operational, and for the full 2018 CCC Plus contract year, the Contractor shall maintain a dedicated queue to assist and support LTSS providers. The Contractor shall ensure that LTSS providers are appropriately notified regarding how to access the dedicated queue for assistance. The Department may extend the required dedicated assistance timeframe for additional years if necessary.

12.1.2 Hospital Emergency Department Assistance

For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the Contractor shall have a specific process in place whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for Members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The Contractor may use the 24/7 clinical triage line for this purpose or may use another line the Contractor designates. The Contractor shall track and report the total number of calls received pertaining to patients in emergency departments who need assistance in accessing care in an alternative setting. Reporting requirements for the 24/7 ED assistance line will be reflected in the CCC Plus Technical Manual.

12.1.3 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.

12.1.4 Monitoring by the Department

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

12.1.5 Hours of Operation

1. General customer service helpline (available 8:00 am-8:00 pm, seven (7) days a week). Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays.
2. Provider services and coverage determinations (available 8:00 am-6:00 pm, Monday through Friday)
3. Pharmacy Technical Support Line (hours of operation cover all hours for which any network pharmacy is open, seven (7) days a week)

The Contractor may employ an answering service or use an interactive voice response (IVR) system to route calls to the appropriate support outside of the general customer service hours (as opposed to a customer service representative needing to be available 24/7 to answer and route the call). Also refer to *Hospital Emergency Department Assistance*.

12.1.6 Performance Standards

The Contractor's call centers shall:

1. Answer 85% of all calls within 30 seconds or less;
2. Limit the average hold time to less than two (2) minutes (defined as the time spent on hold by the caller after the IVR system/touch tone response system/recorded greeting and before reaching a live person;
3. Limit the disconnect rate of all incoming calls to five (5) percent);
4. Record 100% of incoming calls from the provider helplines using up-to-date call recording technology. Call recordings shall be searchable by provider NPI, Member ID # (if available), phone number (when identified), and date and time of the call. Recordings shall 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;
5. Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance;
6. Report on CCC Plus program calls separately from other Virginia lines of business, if any; and,
7. Report by service area (primary, acute, behavioral health, and LTSS). The Contractor's systems shall also track and report on behavioral health crisis calls.

12.2 PROVIDER TECHNICAL ASSISTANCE

The Contractor shall provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. The Contractor shall also establish and conduct ongoing provider education and trainings to assist in contracting with qualified providers that meet the Contractor's requirements and with whom mutually acceptable provider contract terms, including rates, are reached.

The Contractor shall offer technical assistance to all CCC Plus program providers (in and out-of-network) for its Members. Technical assistance shall include activities such as:

1. Needs assessments;
2. Trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Direct one-on-one support/assistance; and,
4. Facilitating sharing of best practices.

12.3 PROVIDER EDUCATION

The Contractor shall also conduct continuous on-going technical advice/guidance/trainings to the CCC Plus program provider community. Trainings should encompass all basic information regarding managed care (e.g., what is managed care, what health plans will do for the provider, where the provider goes for assistance, protected health information, etc.); how the provider bills for services, edit checks, appeals process; and, prior authorizations. Trainings shall be specific to the needs of the CCC Plus program providers (e.g., model of care elements, how to achieve program goals, promoting health and wellness, providing coordinated care, improving beneficiary experience, how to recognize and report signs of elder abuse/neglect and financial abuse, and promoting efficient use of services). The Department reserves the right to have representatives attend the Contractor's trainings for either staff and/or providers. In addition to its own training commitments, the Contractor shall ensure staff attendance at all meetings and/or trainings required by the Department. The Department may further require trainings in neutral settings with the Department and other contracted health plans in attendance and participating. These trainings will be especially numerous during program start-up by region and during annual open enrollments.

The Contractor shall conduct ongoing provider education and training activities regarding the CCC Plus program and all applicable Federal and State requirements as deemed necessary by the Contractor or the Department in order to ensure compliance with this Contract.
Provider education and training activates include but are not limited to:

1) CCC Plus program covered services, including enhanced and carved-out services;
2) Policies and procedures (e.g., claims submission, process, payment, service authorizations);
3) Eligibility criteria and eligibility verification;
4) The role of the enrollment broker as the beneficiary support system for enrollment and disenrollment;
5) Special needs of Members that may affect access to and delivery of services (e.g., transportation needs);
6) Member's rights and responsibilities;
7) Grievance and appeals procedures;
8) Procedures for reporting fraud, waste and abuse;

9) References to Medicaid manuals, memoranda, and other related CCC Plus program documents;
10) Billing instructions which are in compliance with the Department's encounter data submission requirements; and,
11) Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

The Contractor shall notify the Department of any planned provider training event at least two (2) weeks prior to the date of the event.

12.3.1 LTSS Provider Training

The Contractor shall conduct ongoing provider education. Training and technical assistance topics shall include person-centered supports and compliance with CMS HCBS setting provisions, billing, and other necessary processes as directed and/or approved by the Department.

12.3.2 CMHRS Provider Training

The Contractor shall conduct ongoing education with community mental health and rehabilitation service providers. Training and technical assistance topics shall include CCC Plus model of care elements, person-centered treatment planning, culturally competent care, evidence based service planning/treatment planning methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning and strengths based treatment goal selection, as directed and/or approved by the Department.

12.4 PROVIDER PAYMENT SYSTEM

12.4.1 General Processing and Payment Rules

In accordance with Section 1932(f) of the Social Security Act (42 USC § 1396a-2), the Contractor shall pay all in and out-of-network providers (including Native American Health Care Providers) on a timely basis, consistent with the claims payment procedure described in 42 CFR § 447.45 and 42 CFR § 447.46 and Section 1902 (a)(37), upon receipt of all clean claims, as defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

The Contractor's timely filing requirements for all providers (in and out of network) shall not be less than three (3) months and not more than twelve (12) months from the date of service. If the Member has other coverage, the timeframe for submission would begin on the date of payment from the primary payer.

In accordance with Section 1932(b)(2)(D) of the Social Security Act and State Medicaid Director Letter 06-010, the Contractor shall pay non-contracted providers for emergency services no more than the amount that would have been paid if the service had been provided under the State's fee-for-service (FFS) Medicaid program. The Contractor shall reimburse out-of-network, and providers of emergent or urgent care, as defined by 42 CFR § 424.101 and 42 CFR § 405.400 respectively, at the Medicaid FFS payment level for that service. 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 and Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered members who are enrolled with the Contractor. 42 CFR § 447.45 defines timely processing of claims as:

- Adjudication (pay or deny) of ninety percent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all Virginia Medicaid clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 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.

See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, ARTS, and early intervention providers.

In compliance with Section 1903(i) of the Act (final sentence) and Section 1903(i)(17) of the Act, the Contractor is prohibited for paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or services not covered under the Medicaid State Plan.

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. Reference *Protecting Member From Liability For Payment*.

12.4.2 Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS and Early Intervention

1. The Contractor shall ensure clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS, CMHRS and Early Intervention providers are processed within fourteen (14) calendar days of receipt of the clean claim, as clean claim is defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

   Where the service is covered by Medicare, the fourteen (14) calendar day timeframe begins post Medicare adjudication, except if the Member is concurrently enrolled with the Contractor's D-SNP. If the Member is enrolled with the Contractor for both Medicare and Medicaid services, the claim shall be adjudicated within the fourteen (14) calendar day receipt of a claim.

Where the service is not covered by Medicare (e.g., custodial NF, most LTSS, community mental health rehabilitation services, etc.), the fourteen (14) calendar day payment rule of receipt of a clean claim is applicable.

2. The Contractor shall ensure LTSS (including when providing services covered under EPSDT) and Early Intervention providers are paid no less than the current Medicaid FFS rate. The Contractor can reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the Contractor; however, the rate paid shall not be less than the current Medicaid FFS rate. The Contractor's reimbursement for CCC Plus Waiver services shall include the Northern Virginia differential for qualifying localities, as described on the DMAS website, http://www.dmas.virginia.gov/Content_atchs/pr/NOVA%20Localities_Waiver.pdf. The Northern Virginia differential reimbursement for Waiver services is based upon the Member FIPS except for Adult Day Health Care (ADHC) services.

3. The Contractor shall reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule. The Contractor can reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the Contractor; however, the rate paid shall not be less than the current Medicaid FFS rate. The Department will publish ARTS rates by ASAM Level of Care prior to the beginning of each fiscal year available on the Department's website http://www.dmas.virginia.gov/Content_atchs/bh/Copy%20of%20Appendix%20B-ARTS%20Reimbursement%20StructureV6%2008312016.pdf.

4. The Contractor shall ensure CMHRS are paid no less than the current Medicaid FFS rate. The Contractor can reimburse based on an alternative payment methodology or value-based payment, with prior DMAS approval and if mutually agreed upon by the provider and the Contractor; however, the rate paid shall not be less than the current Medicaid FFS rate. CMHRS shall be paid in accordance with the DMAS rates for rural and urban rate regions.

5. The Contractor shall pay NFs no less than the Medicaid Resource Utilization Groups (RUGS) adjusted per diem rate for Medicaid covered days, using DMAS' methodology. If the RUGS adjusted reimbursement calculation exceeds the charges, the Contractor shall pay the RUGS adjusted payment rate. The lesser of billed charges payment rule shall not apply to RUGS Nursing Facility reimbursement payments. If the patient has a LTSS patient pay responsibility, the Contractor shall adjust the payment according to its Contract with the nursing facility provider. Reference guidance information at: http://www.dmas.virginia.gov/Content_atchs/pr/NF%20Price-Based%20FAQs%20as%20of%2006%2022%2015.pdf.

6. The Contractor may reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the Contractor; however, the rate paid shall not be less than the current Medicaid FFS rate. This includes and is not limited to Specialized Care Nursing Facilities, where MCOs can negotiate the process to develop their own protocols for identifying specialized care for reimbursement purposes;

this process can differ from the FFS process. For example, DMAS does not oppose the process agreed upon in meetings between Nursing Facility stakeholders and MCOs to use the recommended process of revenue code 199 with 65x modifier. DMAS will publish Medicaid rates by Nursing Facility prior to the beginning of each fiscal year.

Following the Department's policy, the Contractor shall receive a copy of the UAI if one has been completed prior to payment to a NF for that admission. In the event that a UAI has not been completed, the Contractor shall accept the MDS, and may request the DMAS-80, Patient Intensity Rating System Review (PIRS) form.

7. The Contractor shall reimburse out of network providers at the fee-for-service rate in effect on the date of service. For CCC Plus Waiver and home health services, the rate shall include the Northern Virginia differential.

12.4.3 Relocation of Claims Operations

The Contractor shall notify the Department 45 calendar days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations (except for its back-up claims processing system). 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.

12.4.4 Electronic Submission

The Contractor shall 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.

12.4.5 Interest Payments

The Contractor shall 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 (30) 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.

12.4.6 Legislative Mandated Rates

To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid specific Nursing Facility, home health, behavior health, ARTS, Early Intervention services or waiver service providers, and as identified by DMAS, and these rate adjustments are incorporated into the CCC Plus program capitation payment rates, where required by DMAS 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 upon by DMAS. The Department shall make every reasonable effort to provide at least thirty (30) calendar days advance notice to the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format.

12.4.7 Uniform Billing Practices

DMAS requires the Contractor to implement uniform billing practices and claims submissions processes for NFs, LTSS, early intervention, and community behavioral health providers. The Contractor shall participate in working sessions with the Department and other CCC Plus program Contractors to develop and implement such uniform billing practices. Consideration will be made towards the development of uniform billing procedures especially for small providers who are not familiar with electronic billing through managed care organizations. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected CCC Plus program Contractors.

12.4.8 Physician Incentive Plans

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

- No single physician is put at financial risk for the costs of treating a Member that are outside the physician's direct control;
- No specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Member; and,
- The applicable stop/loss protection, Member survey, and disclosure requirements of 42 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 Parts 422.208, 422.210, and 438.6(h). The Contractor shall submit all information required to be disclosed in the manner and format specified by the Department.

The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by DMAS that results from the Contractor's or any of its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 434 and 1003; however, the Contractor 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.

12.4.9 Hospital Payment Using DRG Methodology

If the Contractor has a contract with a facility to reimburse the facility for services rendered to its Members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, the Contractor 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 with the Contractor on the date of admission regardless if the Member is disenrolled during the course of the inpatient hospitalization.

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. See *Hospitalized at Time of Enrollment* section for more information.

12.4.10 Nursing Facility Mutual Aid Agreements

The Contractor shall work collaboratively and proactively with its nursing facility providers to support the mutual aid agreement (MAA) process for its membership. The MAA is a voluntary agreement between the disaster struck facility and one or more receiving facilities for the purpose of providing mutual aid at the time of a disaster. The Long-Term Care Mutual Aid Plan is an acceptable mutual aid agreement between facilities. The MAA addresses the loan of medical personnel, pharmaceuticals, supplies and equipment, and temporary residence for transferred residents. The disaster struck facility does not "discharge" its residents and the receiving facility does not "admit" the residents transitioning from the disaster struck facility. The receiving facility acts as a "contractor" to the disaster struck facility. The Contractor shall ensure that reimbursement for nursing facility care continues to the disaster struck facility (*Member's facility of record*) for nursing facility Members who transition temporarily to an alternate facility under a mutual aid agreement in the event of a disaster. The Contractor shall continue to reimburse the Member's facility of record for up to 30 calendar days, including in circumstances where services are furnished by a receiving facility through a mutual aid agreement. The Care Coordinator shall continue to work closely with the Member throughout the MAA disaster transition process. This provision does not preclude the Contractor from its contractual obligation and ability to ensure, for example through on-going care coordination and transition planning, that Members continue to receive appropriate high quality care, consistent with the Member's needs and preferences. All nursing facility treatment rules described in this contract remain in full effect throughout the MAA disaster related transition. If the disaster struck Nursing Facility determines that it is not able to reopen within 30 calendar days, it must discharge the individuals and work with the Contractor and the Member on long-term services and support placement options of their choice including home and community based services (HCBS) waiver, Program for All-Inclusive Care for the Elderly (PACE), or admission to other nursing facilities. Nothing shall preclude an individual from requesting to be discharged to home and community based services (waivers or PACE) or admission to other nursing facilities. Reimbursement to the disaster struck nursing facility shall cease when an individual is discharged.

12.4.11 Payment Coordination with Medicare

In accordance with 42 CFR §438.3(t), the Contractor shall enter into a Coordination of Benefits Agreement (COBA) with Medicare and participate in the automated claims crossover process for claims processing for its Members who are dually eligible for Medicaid and Medicare.

12.4.12 Payment Coordination with Other Coverage

Under Section 1902(a)(25) of the Social Security Act (42 USC §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources.

DMAS retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is

not permitted to initiate litigation to seek recovery of any non-health insurance funds. Members with these other resources shall remain enrolled in the CCC Plus program as long as they continue to meet eligibility requirements.

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

The Contractor shall provide Member claim history when requested by the Department's TPL Unit staff to aid in the pursuit of non-health insurance resources. A file layout and when the information must to be returned to DMAS will be provided in the CCC Plus Technical Manual.

12.4.12.1 Workers' Compensation

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

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

12.4.12.2 Estate Recoveries

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

12.4.12.3 Comprehensive Health Coverage

Members, determined by DMAS as having Medicare or comprehensive health coverage other than Medicaid will be assigned to the CCC Plus program. Members will not be disenrolled due to having Medicare or other comprehensive health coverage.

The Contractor, as payer of last resort, will be responsible for coordinating all benefits covered under this Contract. When the other payer is a commercial HMO organization, the Contractor is responsible for the full copayment amount. The Member may not be billed by the provider other than any Patient Pay established by DSS towards LTSS services.

Prior to processing a claim for payment, the Contractor shall NOT require a provider and/or pharmacist to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. The Contractor's request for an explanation of benefits (EOB) from the provider in these instances would delay timely payment of these services. Examples of these services include, but are not limited to, some Medicare over the counter (OTC) drugs and LTSS waiver services such as personal care and respite care services.

The Contractor can pay and pursue the Commercial insurance to assist with any potential delays of claim payments.

One waiver service exception is for private duty nursing (PDN) as these services are often covered through commercial insurance. The Contractor may only require an EOB for PDN services if the commercial carriers covers all or part of PDN services.12.4.12.4 Early Intervention

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

1) Those services federally required to be provided at public expense as is the case for
   a) assessment/EI evaluation,
   b) development or review of the Individual Family Service Plan (IFSP); and,
   c) targeted case management/service coordination;
2) Developmental services; and,
3) Any covered early intervention services where the family has declined access to their private health/medical insurance.

Under these circumstances, and in accordance with federal regulations, the Contractor shall require the Early Intervention provider complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form (http://infantva.org/documents/ovw-st-TaskF-Mtg-20090520Form-DecliningPriv_Ins.pdf) and submit it with the bill to the Contractor. The Contractor shall keep a copy of this form on the Member's file for a period of ten (10) years for audit purposes. Billing codes for EI services are reflected in the attached *CCC Plus Covered Services* chart.

The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage (e.g. Medicare, commercial insurance, and Workers' Compensation). Any moneys recovered by third parties shall be retained by the Contractor. The Contractor shall notify DMAS monthly of any Members identified during that past month that were discovered to have comprehensive health coverage.

12.4.13 Provider Preventable Conditions and Services (Never Events) Which Receive No Payment

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.

Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor (Thomas Reuters) used by DMAS. For example, an inpatient

claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

No payment shall be made for services for inpatients for the following Provider Preventable Conditions (PPC): (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.

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.

Reductions in provider payment may be limited to the extent that the following apply: (1) the identified provider-preventable conditions would otherwise result in an increase in payment; and, (2) the Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

The Contractor shall submit all identified provider preventable conditions as reflected in the CCC Plus Technical Manual.

12.4.14 Provider Payment for Members Who Become Disenrolled

The Contractor shall not be liable for the payment of services covered under this Contract rendered to a Member outside of the dates of enrollment with the Contractor except for: (1) specially manufactured DME that was prior-authorized/ordered by the Contractor; and/or, (2) the hospital DRG payment, if Member hospitalized (Refer to the *Hospitalized at Time of Enrollment* section). In certain instances, a Member may be excluded from participation effective with retroactive dates of coverage. Providers may submit claims to the Department for services rendered during this retroactive period. Reimbursement by the Department for services rendered during this retroactive period is contingent upon the Members meeting eligibility and coverage criteria requirements.

12.4.15 Payment to Excluded Providers

The Contractor shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act.

12.4.16 Payment to a Network Provider

In accordance with 42 CFR § 438.60, the Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this contract except those required by Title XIX of the Act or direct payments for graduate medical education approved under the State Plan.

12.5 INCREASED PAYMENTS TO ENSURE ACCESS

12.5.1 Payments to Ensure Access in Eastern Virginia/Tidewater

Increased Payments to Qualifying Physicians

Pursuant to Item 301, Section DDDD(2)(b) of the 2015 Appropriation Act, the Contractor shall use funds received from the Physician Access Adjustment component of the rates to increase payments to physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth.

The Tidewater Physician Access Adjustment PMPM has been calculated to raise total reimbursement to the affected physicians to a level consistent with the average commercial rate in aggregate. The increased payments only apply to the Tidewater region. Separate PMPMs have been calculated for the NonDual Community no LTSS rates, the NonDual CCC Plus Waiver- Standard Benefit (formerly EDCD) rate which will be blended with the NonDual Nursing Home (NH) rate, and the NonDual DD Waivers rate. These populations correspond to the populations in Medallion 3.0 included in the Tidewater Physician Access Adjustment. The Contractor shall provide documentation to the Department, as specified in the MCTM, that all funds received from the Tidewater Physician Access Adjustment component of the capitation rate are used in accordance with this Subsection.

12.5.2 Payments to Ensure Access to State University Teaching Hospitals

Increased Payments to Qualifying Physicians

The Contractor shall use funds received from the State University Teaching Hospital Physician Adjustment component of the rates to increase payments to physicians affiliated with the UVA and MCV medical schools in the Charlottesville/Western and Central regions of the State that are a political subdivision of the Commonwealth.

The State University Teaching Hospital Physician Adjustment PMPM has been calculated to raise total reimbursement to the affected physicians to a level consistent with State approved funding levels. The increased payments only apply to the Charlottesville/Western and Central regions and only for Community No LTSS populations, excluding the population in the *Age<1* rate cell. These populations correspond to the populations in Medallion 3.0 included in the State University Teaching Hospital Physician Adjustment component. The Contractor shall provide documentation to the Department, as specified in the MCTM, that all funds received from the State University Teaching Hospital Physician Adjustment component of the capitation rate are used in accordance with this Subsection.

SECTION 13.0 VALUE BASED PAYMENTS

13.1 BACKGROUND

Value Based Payments (VBP) is a broad set of payment strategies intended to improve quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care.

The Contractor shall establish a VBP strategy that follows the Alternate Payment Model (APM) framework in the Final White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on categories 3 and 4. The White Paper can be accessed at https://hcp-lan.org/2016/01/final-apm-framework-white-paper/.

Beginning in the CY 2019 contract year, the Department plans to set targets in the Contract for all VBP (categories 2-4) and Alternative Payment Models (APM) (categories 3-4). The Contractor shall expect the targets to increase by at least five (5) percentage points each year.

13.2 CONTRACTOR ANNUAL VBP PLAN

The Contractor's policies and procedures shall have an Annual VBP Plan for achieving and progressing APM. Each Annual VBP Plan, as specified in the CCC Plus Technical Manual, shall cover the current status and the strategies for the two following full contract years (CY 2018 and 2019). The Contractor's Annual VBP Plan shall be updated annually and shall align with the Department's Value-Based Payment Roadmap (currently under development). The Contractor's Annual VBP Plan shall, at a minimum, include:

1) Current State Review
   a. A detailed description of all APMs the Contractor is currently using with its provider network, by provider type and line of business, and the HCP-LAN APM framework category/sub-category in which the APM best fits (e.g., 2, 3, or 4); and,
   b. For the APMs identified above, the percentage of the Contractor's total as well as specific Medicaid medical expenses expected to be paid under each type of APM model in the current contract year (as well as a comparison of this percentage with an estimate of prior year expenditures of the same), including what methodology and number the Contractor is using for the numerator and denominator and the types of services (e.g., primary and acute, behavioral health, LTSS, and others) included in the numerator and denominator.

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. Three (3) APM strategies expected to be most effective for services and populations most relevant to this Contract, including how the APMs will serve to improve Member outcomes and experience without increasing associated spending. An assessment of how

such strategies are expected to impact Members' consumption of services and associated spending;

b. Specific objectives for APM implementation, including scope, provider performance, stakeholder engagement, and a timeline for implementation related to each of the proposed APM approaches; and,
c. Relationship to the Contractor's commercial VBP strategy and/or other payers such as Medicare in the Virginia health care marketplace and discussion of how these VBP strategies align with planned VBP efforts under the CCC Plus program.

The Contractor shall submit an Annual VBP plan on January 1st 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 the Department's Value-Based Payment Roadmap (currently under development). These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives in which Medicaid is a participant (i.e. multi-payer alignment of incentives across Medicare, Medicaid, and commercially insured populations in Virginia).

13.3 VBP STATUS REPORT

In tandem with creation and update of the Contractor's VBP Plan, the Contractor shall submit an Annual VBP Status Report which includes details of its VBP initiatives. At a minimum, the Contractor shall include the following information for each VBP initiative as specified in the CCC Plus Technical Manual:

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 payments to providers for services covered in 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 shall be due at the same date annually as the HCP-LAN Data Collection. The first VBP Status Report shall be submitted to the Department on April 1, 2018 for the 2017 baseline period. Future Annual VBP Status Reports are due on April 1st of subsequent Contract years.

13.4 CONTRACTOR HCP-LAN APM DATA COLLECTION SUBMISSION

The Department will use measurement methodologies developed by HCP-LAN, though the Department is not limited exclusively to these measurement methodologies. See https://hcp-lan.org/groups/apm-fpt/national-apm-data-collection-effort/.

Although the HCP-LAN APM data collection currently excludes LTSS, DMAS will use the measurement methodologies as the framework for VBP. Annually, each Contractor shall complete the Medicaid APM data collection tool for the twelve (12) months prior to the contract period. For the purposes of this Contract, Contractors shall complete the data collection tool for

CY 2017. The draft data collection tool is at https://hcp-lan.org/workproducts/Medicaid-Category-Metrics.pdf. The first submission is due to the Department by April 1, 2018 for CY 2017 data.

Future submissions of this data shall be submitted to the Department by April 1st following the end of the previous calendar year to coincide with submission of the Annual VBP Status Report submissions.

13.5 DMAS APPROVAL OF VBP FOR CERTAIN SERVICES

The Contractor shall have prior approval from DMAS before implementing an alternative payment arrangement, including models that waive service authorizations for high-quality providers or that revise the payment method for CMHRS, LTSS, ARTS, and Early Intervention Services.

SECTION 14.0 PROGRAM INTEGRITY (PI) AND OVERSIGHT

14.1 GENERAL PRINCIPLES

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste and abuse. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct and prevent fraud, waste, and abuse.

14.2 PROGRAM INTEGRITY PLAN, POLICIES, & PROCEDURES

The Virginia Medicaid Program Integrity 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 Virginia Medicaid Program Integrity Plan must be submitted annually (See the CCC Plus Technical Manual). The 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 CCC Plus Technical Manual:

1) PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
2) A listing of the health plan PI contractors (unless proprietary);
3) A process to act as or sub-contract with a Contractor for Recovery Audit purposes; and,
4) A plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid.

All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal government.

The Contractor shall develop a written program integrity plan specific to the CCC Plus program.

The Contractor shall have in place a process for assessment of all claims for fraudulent activity by Members and providers through utilization of computer software and through periodic audits of medical records.

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 CCC Plus Technical Manual.

The Contractor shall provide the Department, on March 31st of each contract year, an annual summary of prior year activities and results.

The Department shall share fraudulent provider activity with the Contractor on a quarterly basis.

The Contractor will be required to notify DMAS in a timely manner, within no more than five (5) business days, regarding all internal (such as identified patterns of outliers, audit concerns,

critical incidences) and external (such as hotline calls) allegations of potential improper payments and/or safety concerns of enrollees. The Contractor will be expected to promptly perform a preliminary review of all allegations of fraud, waste, or program abuse. The Contractor shall track each of these allegations and the outcome of the preliminary review and report them to the Department on the Quarterly Summary of PI Allegations table. A unique Case ID should be created for each allegation that is consistently used to identify that case in all reporting to the Department.

Once an allegation has been vetted and determined to warrant further investigation/audit, the Contractor shall notify the Department within forty-eight (48) hours of initiating a full investigation, using the *Notification of Provider Investigation* form (attached) via email at: CCCPlusReporting@dmas.virginia.gov. 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 establish 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.

In accordance with 42 CFR § 438.608, the Contractor's Program Integrity Plan must address the following requirements:

14.2.1 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. As required in 42 CFR § 455.1, the Contractor's Program Integrity Plan must include a method to verify whether services reimbursed were actually furnished to the Member. The Contractor must utilize a survey (telephonic or mail), explanation of benefits (EOB) mailing, or other method approved by the Department to accomplish this requirement. Regardless of the method utilized (EOB, Member survey, etc.), the Contractor's verification method must include a statistically valid sample of Members based upon a percentage of the Contractor's paid claims. The Contractor may exclude certain 'sensitive' services from these verification activities.

The Contractor 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 30 calendar 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 ensure that the Contractor and any subcontracator reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract;
6) 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;
7) Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct; and,
8) 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.
9) 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.
10) 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.
11) 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.
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 C.F.R § 438.608(a)(6)]

The Contractor shall have a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as PI audit recoveries. This process must assure that appropriate decisions are made as promptly as possible. Providers shall also have the right to appeal to DMAS after exhausting the Contractor's internal appeal process. Reference Section 15.6 *Provider Appeals*.

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.

14.2.2 Internal Monitoring and Audit

The Contractor shall establish and implement provisions for internal monitoring and auditing. Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable State and Federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

14.2.3 Internal Monitoring and Audit - Annual Plan

The Contractor shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Audit Schedule and Methodology, and Types of Auditing.

The annual plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or "spot checks," when developing the schedule. The Internal Monitoring and Audit Plan shall consist of two components: a detailed schedule of anticipated audits for the year, as well as a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

Audits Planned for the Upcoming Year

- Title/Type
- Description
- Priority/Risk Level
- Frequency.

Completed Audits

A retrospective analysis of the Internal Monitoring and Audit Plan, which would include, at a minimum, the following:

- All requirements from section above
- # of Audits Planned for Each Type identified in section above
- # of Audits Completed for Each Type identified section above
- Emerging Trends
- Investigator Assigned (if applicable)
- Findings
- Recommendations
- Action Taken

14.2.3.1 Audit Development

In developing the types of audits to include in the audit plan, the Contractor shall:

- Determine which risk areas will most likely affect the organization and prioritize the monitoring and audit strategy accordingly.
- Utilize statistical methods in:
  - Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
  - Determining appropriate sample size; and
  - Extrapolating audit findings to the full universe.
- Assess compliance with internal processes and procedures.
- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The Contractor shall also include in its plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and/or Program Integrity Lead and shall consist of, at a minimum, recovery of any identified overpayments.

The 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.

The Contractor shall develop as part of their work plan a strategy to monitor and audit subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.

The Contractor shall include routine and random auditing as part of its contractual agreement with subcontractors. The Contractor shall include in its work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and shall make it a priority to conduct a certain number of on-site audits.

The Contractor is encouraged to invest in data analysis software applications that provides the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

The Contractor shall cooperate with Department auditors on any Recovery Audit activity/findings.

14.2.3.2 Audit Report

The Contractor shall produce and provide to the Department upon conclusion of the investigation a standard audit report for each completed investigation. This report should utilize the *Completed Investigation Form* and 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 14.9 of this contract, final resolution should include, at a minimum, repayment of any identified overpayments.

14.3 COMPLIANCE OFFICER

The Contractor shall designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors. The Contractor shall also establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract. The Compliance Officer shall maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis. 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. The Contractor may identify different contacts for Member fraud, waste and abuse; network provider fraud, waste and abuse; subcontractor fraud, waste and abuse; and Contractor fraud, waste and abuse.

14.4 PROGRAM INTEGRITY LEAD

The Contractor shall designate a PI Lead who will represent the Contractor and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, and pre and post claim edits, PA/SA review, and any other fraud activities and outcomes. This individual must also be involved in the Department Program Integrity Collaborative. The Contractor must be aware and actively be involved with State, Federal, and CMS initiatives of Program Integrity.

14.5 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 in accordance with the Federal and State standards and requirements under this 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.

14.6 EFFECTIVE LINES OF COMMUNICATION BETWEEN CONTRACTOR STAFF

The Contractor shall establish effective lines of communication between the Compliance Officer, Program Integrity Lead, other Contractor staff, Members, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining

confidentiality. The Contractor shall also establish effective lines of communication with its Members.

Contractors shall establish a process to document and track reported concerns and issues, including the status of related investigations and corrective action.

The Contractor shall submit an organizational chart annually that outlines the CCC Plus Program Integrity division within its chart. The organizational chart should include all divisions that handle the CCC Plus program (operations, claims, Member services, outreach/marketing, health services, etc.).

14.7 ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines including but not limited to as described in 42 CFR §438.608.

14.8 DEVELOPMENT OF CORRECTIVE ACTION INITIATIVES

The Contractor's Program Integrity Plan shall include provisions for corrective action initiatives. The Contractor shall conduct appropriate corrective actions in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct but must, at a minimum, include repayment of any identified overpayments.

14.9 REPORTING AND INVESTIGATING SUSPECTED FRAUD, AND ABUSE TO THE DEPARTMENT

The Contractor is required to use the templates, formats, and methodologies specified by the Department in the CCC Plus Technical Manual and on the CCC Plus website, located at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). All confirmed or suspected provider 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 email at: CCCPlusReporting@dmas.virginia.gov. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

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. 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.

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.

Any claims that are not paid as a result of these reviews shall be reported by the Contractor through the quarterly fraud/waste/abuse report. If pre-payment review indicates a pattern of fraud, waste, or program abuse, the Contractor shall conduct a retrospective review of that provider to identify any prior overpayments.

The Contractor shall provide information and a procedure for Members, network providers and subcontractors to report incidents of potential or actual fraud, waste and abuse to the Contractor and to the Department.

The Contractor shall report to the Department all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

The Contractor shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

14.10 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 C.F.R. §§ 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.

14.11 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.

14.12 MEDICAID FRAUD CONTROL UNIT (MFCU)

Some program integrity activities may identify issues that constitute potential fraud. DMAS and the Contractor are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). The Contractor shall cooperate fully with any request for information or technical support made by the MFCU to support their investigations. MFCU investigations may verify that some of these referrals constitute a "credible allegation of fraud." In these instances, Contractors will be notified and shall suspend payments to those providers as set forth in 42 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.

14.13 MINIMUM AUDIT 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.

14.14 PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES

14.14.1 Fraud Referrals

When the Contractor identifies potential or actual fraud (as defined in 42 CFR § 455.2) by one of its providers or subcontractors, the allegation must be referred to the Department. Prior to submitting a referral to the Department, the Contractor shall have conducted a preliminary investigation of any allegation of FWA (including traditional referrals from internal and external sources, as well as leads generated through data mining). Once the Contractor has vetted the allegation and determined that it warrants a full investigation, it is at this point that the Attached *Notification of Provider Investigation* shall be sent to DMAS.

14.14.2 Formal Initiation of Recovery

The Contractor shall notify the Department upon formal initiation of a recovery from a solely conducted audit by the Contractor on its own network. 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.

14.14.3 Class Action & Qui Tam Ligation

The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

14.14.4 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.

14.14.5 Provider Network Audits

The Department, pursuant to 42 CFR § 455, et. seq. may conduct audits of the Contractor's provider network, and as a result of those audits, recover and retain identified overpayments. At the request of the Department, the Contractor will provide any information the Department deems necessary to conduct such investigations including, but not limited to fee schedules, provider contracts, and claim payment data.

14.14.6 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.

14.14.7 Payment Suspension

Pursuant to 42 CFR§ 455.23, the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. Upon notification from the Department that such a determination has been made, the Contractor must suspend payment as soon as possible and within 1 business day or in accordance with the timeframes communicated by DMAS in the notice. If the Contractor believes there is good cause, as defined in 42 CFR§ 455.23, to not suspend payments or to suspend payment only in part to such a provider, the Contractor must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider from payment suspension. The Department will evaluate the merit of the request for good cause exemption and notify the Contractor of the decision. Upon notification from the Department of the final determination to suspend payments, the Contractor shall suspend payments immediately in accordance with the timeframes communicated by DMAS in the notice of payment suspension

14.14.8 Required Reporting Procedures

Under 42 C.F.R. § 438.608(a), the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract:

- Implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
- Implement and maintain arrangements or procedures for prompt notification to the Department when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or death of the member.
- Implement and maintain arrangements or procedures for notification to the Department when it receives information about a change in the network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

SECTION 15.0 MEMBER AND PROVIDER GRIEVANCES AND APPEALS

15.1 GENERAL REQUIREMENTS

The Contractor shall have a system in place to respond to grievances, appeals, 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 (see Definitions) which 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. The Contractor shall provide to all network providers and subcontractors information about the grievance and appeals systems to the specifications described in 42 CFR §438.10(g)(2)(xi)(A)-(E) and at the initiation of all such contracts. In accordance with 42 CFR §438.10(g)(2)(xi)(A)-(E), the Contractor shall inform providers and subcontractors, at the time they enter into a contract, about the enrollee's right to file grievances and appeals and the requirements and timeframes for filing. The Contractor shall also include information on the Member's right to availability of assistance to the Member with filing grievances and appeals; the requirements and timeframes for filing a grievance or appeal; and, the right to request continuation of benefits during an appeal or State fair hearing although the Member may be liable for the cost of any continued benefits while the appeal or State fair hearing is pending if the final decision is averse to the Member. The Contractor shall not be responsible for handling of appeals related to carved out and excluded services.

15.2 GRIEVANCES

In accordance with 42 CFR §402(c)(2)(i), a Member may file a grievance with the Contractor or its network providers at any time by calling or writing to the Contractor or provider. Network providers may also file a grievance with the Contractor using the system described in this section. The Contractor shall be responsible for properly responding to all grievances. The DMAS Appeals Division does not handle grievances.

The Contractor shall have written policies and procedures that describe the grievance and appeals process and how it operates; and the process must be in compliance with MCHIP requirements, NCQA standards, and Federal requirements at 42 CFR § 438.400 et. seq., as amended. These written directives shall describe how the Contractor intends to receive, track, review, and report all Member inquiries, grievances and appeals. The Contractor shall make any changes to its Member grievance and appeal procedures that are required by the Department. The procedures and any changes to the procedures must be submitted to the Department prior to signing the original contract, at revision, and upon request, and as needed.

The Contractor shall provide grievance and appeal forms and/or written procedures to Members who wish to register written grievances or appeals. Additionally, the Contractor shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action.
The Contractor's grievance process must allow the Member, or the Member's authorized representative (provider, family Member, etc.) acting on behalf of the Member, to file a grievance at any time, either orally or in writing. The Contractor shall acknowledge receipt of

each grievance. (Grievances received orally can be acknowledged orally.) The Contractor shall also ensure that neither the individual nor a subordinate of any such individual who makes decisions on grievances were involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the Member's condition or disease. [42 CFR § 438.406(a)]

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the Member under the Contractor's grievance process.

The Contractor must have a system in place for addressing Member grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. The Contractor must maintain written records of all grievance activities, and notify DMAS of all internal grievances, through a reporting format approved by DMAS. The system must meet the following standards:

1) Timely acknowledgement of receipt of each Member grievance;
2) Timely review of each Member grievance;
3) Standard response, electronically or in writing, to each Member grievance within a reasonable time, but no later than thirty (30) calendar days after the Contractor receives the grievance. This timeframe may be extended in accordance with 42 CFR § 438.408(c); and,
4) Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance to each Member grievance whenever the Contractor extends the appeal timeframe or refuses to grant a request for an expedited appeal.

In accordance with 42 CFR §438.408(c) the Contractor may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the Member requests the extension, or, with the Department's permission, if the Contractor shows that there is a need for additional information and that the delay is in the Member's interest. If the Contractor extends the timeframe from a grievance not at the request of the Member, the Contractor must give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of their right to file a grievance if he/she disagrees with that decision.

The Contractor shall notify a Member of the resolution of a grievance using the Department's established methods outlined above and in a format and language that, at a minimum, meet the applicable notification standards per 42 CFR § 438.10.

15.3 GENERAL INTERNAL APPEAL REQUIREMENTS

In accordance with 42 CFR § 438.402(c)(2)(ii), a Member may file an internal appeal with the Contractor within sixty (60) calendar days from the date on the adverse benefit determination notice. The Contractor must maintain written records of all appeal activities, and notify DMAS of all internal appeals in the manner and format reflected in the CCC Plus Technical Manual. The Contractor is required to promptly respond (the same business day or within one business

day, depending on the urgency of the issue) to any requests made by DMAS pertaining to appeals.

In accordance with 42 CFR§ 438.406(b)(2)(iii), the Contractor shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

In accordance with 42 CFR § 438.404, the Contractor must give the Member written notice of any adverse benefit determination as defined in Section 23.1 of this Contract. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) calendar days in advance of the date of its action. For denial of payment, such notice shall be provided at the time of action. The Contractor is allowed to mail the notice of adverse benefit determination as few as five (5) days prior to the date of action if the Department has facts indicating that action should be taken because of probable fraud by the Member, and the facts have been verified, if possible, through secondary sources. For service authorization decisions not reached within the required time frames, such notice shall be provided no later than the date the time frames expire per Section 6.2.10 of this Contract. The form and content of the notice must be prior approved by DMAS; however, the notice must explain:

1) The adverse benefit determination the Contractor has taken or intends to take;

2) The reasons for the adverse benefit determination including the right of the 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 standard used in setting coverage limits;

3) The citation to the law or policy supporting such adverse benefit determination;

4) The Member's right to file an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal per 42 CFR § 438.402(b) and the right to request a State fair hearing consistent with 42 CFR § 438.402(c);

5) Procedures for exercising the right 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;

8) A list of titles and qualifications, including specialties, of individuals participating in the appeal review; and,

9) The Member's right to be represented by an attorney or other individual.

10) Information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services.

The written notice must be translated for the Members who speak prevalent languages. Additionally, written notices must include language explaining that oral interpretation is available for all languages and how to access it.

Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. Members must be informed that information is available in alternate formats and how to access those formats.

A Member may request continuation of services during the Contractor's internal appeal and during the DMAS State fair hearing. The Contractor shall provide for continuation of benefits in accordance with 42 CFR § 438.420 and the regulations governing the CCC Plus program. If the final resolution of the appeal upholds the Contractor's action and services to the Member were continued while the internal appeal of State fair hearing was pending, the Contractor may recover the cost of the continuation of services from the Member.

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, Freedom of Information Act ("FOIA") request, or any litigation involving the Contractor or the Department, including but not limited to, external appeals.

15.4 CONTRACTOR INTERNAL APPEALS

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. If an appeal is sent to DMAS by the Member or Member's representative and the internal plan appeal process has not been exhausted, the Contractor must notify DMAS within one (1) business day of notification of the appeal by DMAS that the plan's internal appeal process has not been exhausted.

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

1. Acknowledge receipt of each appeal;

2. Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making and were not a subordinate of any such individual;

3. An appeal may be submitted orally or in writing. The Contractor shall recognize oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal). If the Appellant does not request

an expedited appeal pursuant to 42 CFR § 438.410, the Contractor must require the Appellant to follow an oral appeal with a written, signed appeal;

4. Provide the Appellant a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The Contractor must inform the Appellant of the limited time available for this, especially in the case of expedited resolution;

5. Provide the Appellant and his or her representative opportunity, before and during the appeals process, to examine the Member's case file, including any medical records and any other documents and records considered during the appeals process; and,

6. 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. 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)(iii), if the Contractor has extends the timeframe for an appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the enrollee 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 provide oral notice and shall within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee 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 where either the Contractor or the Member's provider determines that the time expended in a standard internal resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports a Member's appeal. In instances where the Member's request for an internal expedited appeal is denied, the appeal must be transferred to the timeframe for standard internal resolution of appeals, the Member must be given prompt oral notice of the denial (make reasonable efforts) to treat it as an expedited internal appeal and a written notice within two (2) calendar days that also informs the Member of the right to file a grievance if he or she disagrees with that decision.

The Contractor shall issue decisions for expedited internal appeals as expeditiously as the Member's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the internal appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if the Contractor provides evidence satisfactory to the Department that there is need for additional information and that a delay in rendering the decision is in the Member's interest. Where the Contractor has extended the timeframe for an expedited appeal not at the request of the Member, the Contractor shall make

reasonable efforts to give the enrollee 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 extension not requested by the Member, the Contractor shall make reasonable efforts to provide oral notice and shall provide written notice to the Member of the reason for the delay that also informs the Member of the right to file a grievance if he or she disagrees with that decision. The Contractor shall make reasonable efforts to provide the Member with prompt verbal notice of any decisions that are not resolved wholly in favor of the Member and shall follow-up within two (2) calendar days with a written notice of action.

If the Contractor fails to adhere to the notice and timing requirements for resolving a standard or expedited internal appeal, the Member is deemed to have exhausted the Contractor's appeals process and may initiate a State fair hearing.

All Contractor decisions to internal appeals must 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. If an extension was granted and who made the request;

4. The date of the decision; and,

5. For appeals not resolved wholly in favor of the Member:
    a. The right to request an appeal to DMAS of the Contractor's final denial through the 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,
    b. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
    c. The right to request to receive benefits while the State fair hearing is pending and how to make the request, explaining that 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)];
    d. A list of titles and qualifications, including specialties, of individuals participating in the appeal review;
    e. The right to be represented by an attorney or other individual; and,
    f. Information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services.

6. If the Contractor reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for those services.

15.5 STATE FAIR HEARINGS

15.5.1 For Cause Disenrollment Determinations

In accordance with 42 CFR § 438.56(e)(2), Members who are dissatisfied with the Department's determination on the Member's for cause request to disenroll from one health plan to another shall have the right to appeal the Department's decision through the State fair hearing process. Also reference Section 3.2.15, *Cause for Enrollment Changes.*

15.5.2 Contractor Adverse Decisions

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

15.5.3 State Fair Hearing Process

DMAS Member appeals are conducted in accordance with 42 CFR § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include reductions in service, suspensions, terminations, and denials. 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 representative. Expedited appeals may be filed orally or in writing. The appeal may be filed at any time after the Contractor's appeal process is exhausted and extending through 120 calendar days after receipt of the Contractor's final adverse benefit determination. For appeals not filed within this timeline, an acceptable reason for delay, as determined by DMAS, must exist.

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

Upon receipt of notification by the Department of an appeal, the Contractor shall prepare and submit an appeal summary describing the basis of the adverse benefit determination to the DMAS Appeals Division and Member/Member's representative involved in the appeal in accordance with required time frames. In addition, the Contractor shall e-mail a complete copy of the case summary to the Department at CCCPlusAppeals@dmas.virginia.gov on the same day that the case summary is filed with the DMAS Appeals Division. r, The summary must be completed in accordance with 12 VAC 30-110-70, which describes notification requirements and also serves as a guideline for information necessary to include in both the notice and the

summary. The DMAS Appeals Division requests that the Contractor submit the appeal summary to the Department within twenty-one (21) calendar days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all cases, the summary must be received by the Department at least ten (10) calendar days prior to the scheduled hearing date and mailed to the Member on the date submitted to the DMAS Appeals Division. The appeal summary must include any and all justification that the Contractor wants considered as part of the State fair hearing, including but not limited to the policy and applicable regulations (not a summary thereof) upon which the Contractor's decision is based. For expedited appeals that meet the criteria set forth in 42 CFR § 438.410, the appeal summary must be faxed to the Department and faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than 4 business hours after the Department informs the Contractor of the expedited appeal.

The Contractor shall comply with all State and Federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division. 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 the CCC Plus contract.

Appeals to DMAS that do not qualify as expedited shall be resolved or a decision issued by DMAS within ninety (90) calendar days from the date the Member filed the internal appeal with the Contractor, not including the number of days the Member took to subsequently file for a State fair hearing. 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 the existing Federal court order in *Shifflett v. Kozlowski* (W.D.Va 1994), relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays (e.g., the hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant; the appellant or representative requests to reschedule/continue the hearing; the hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence).

For appeals filed with the DMAS Appeals Division, an enrollee may request continuation of services. DMAS will make a determination on continuation of services in accordance with the Commonwealth's existing appeals policy at 12 VAC 30-110-100, in accordance with 42 CFR § 438.420. If the final resolution of the appeal upholds the Contractor's action, and services to the enrollee were continued while the appeal or State fair hearing was pending, the Contractor may recover the cost of the continuation of services from the enrollee.

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 must authorize the disputed services promptly and as expeditiously as the Member's

health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

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

The Department's final administrative appeal decision may be appealed by the Member through the court system. However, the court review is limited to legal issues only. No new evidence is taken. During the court appeal process, DMAS and/or its counsel at the Office of the Attorney General ("OAG") may have a need to confer with the Contractor to gain further information about the appealed action. The Contractor must respond to inquiries from DMAS or the OAG within one (1) business day or sooner if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

15.6 PROVIDER RECONSIDERATIONS AND APPEALS

Network providers have the right to appeal adverse decisions to the Department. However, the Contractor's reconsideration process must be exhausted prior to filing an appeal with the DMAS Appeals Division. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor actions filed by providers.

15.6.1 Provider Reconsiderations

The Contractor shall have a reconsideration process in place comparable to those stated in Section 15.3 and 15.4 available to providers who wish to challenge adverse benefit determinations made by the Contractor. This process must assure that appropriate decisions are made as promptly as possible.

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

15.6.2 General Provider Appeal Requirements

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

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the DMAS

Appeals Division after 5:00 p.m. shall be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely. Upon receipt of notice that the Department has received an appeal from a provider involving services provided or being provided to the Contractor's Member, the Contractor must verify within one (1) business day that the provider has exhausted the Contractor's reconsideration process. Further the Contractor must verify, based upon the Contractor's records, that the appeal to the Department meets the DMAS timeliness requirements (i.e., within 30 calendar days of the Contractor's last date of denial).

Provider appeals to the Department will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.* There are two levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is before an Informal Appeals Agent employed by the Department. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and a Formal Appeals Agent employed by the Department helps present the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Department Director in issuing the Final Agency Decision. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor reconsideration decisions filed by providers.

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, 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.

The Contractor does not have the right to appeal DMAS' informal or formal appeal decisions.

15.6.3 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. The Contractor shall e-mail a complete copy of the case summary to the Department at CCCPlusAppeals@dmas.virginia.gov and mail to the provider on the same day that the case

summary is filed with the DMAS Appeals Division. For each adjustment, patient, and service date or other disputed matter identified by the provider in its notice of informal appeal, the case summary shall explain the factual basis upon which the Contractor relied in making its reconsideration decision and identify any authority or documentation upon which the Contractor relied in making its reconsideration decision. The Contractor shall comply with all state and federal laws, regulations, and policies regarding content and timeframes for case summaries. Failure to submit case summaries within the required timeframe and according to the applicable regulatory requirements contained within 12 VAC 30-20-540 shall result in the Contractor being liable for any costs that 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.

The DMAS Informal Appeals Agent 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 DMAS Informal Appeals Agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the DMAS Informal Appeals Agent shall specify the time within which the provider may file written submissions, not to exceed ninety (90) 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 Informal Appeals Agent. Only written submissions filed within the time specified by the Informal Appeals Agent shall be considered.

If an informal conference is conducted, the Contractor is required to attend and defend the Contractor's reconsideration decision at the informal conference with the provider before a DMAS Informal Appeals Agent. If the Contractor's reconsideration decision was based in whole or part upon a medical determination such as medical necessity or appropriateness, the Contractor shall provide sufficiently qualified medical personnel to attend the conference and defend the decision being appealed. Failure to attend or defend the Contractor's 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. The conference may be recorded at the discretion of the DMAS Informal Appeals Agent and solely for the convenience of the Informal Appeals Agent. Because the conference is not an adversarial or evidentiary proceeding, no other recordings or transcriptions shall be permitted. Any recordings made for the convenience of the Informal Appeals Agent shall not be released to DMAS, the Contractor, or the provider.

Upon completion of the conference, the DMAS Informal Appeals Agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed thirty (30) calendar days. Only documentation or information filed within the time specified by the DMAS Informal Appeals Agent shall be considered.

The informal appeal decision shall be issued within 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.

15.6.4 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 the Department's staff counsel in preparing the Department's evidence and acts as a witness at a hearing before a hearing officer appointed by the Virginia Supreme Court. The 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.

The Department and the provider shall file with the DMAS Appeals Division all documentary evidence on which the Department or the provider relies within twenty-one (21) 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. The Department 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, the Department, and the provider all mutually agree to extend the time for conducting the hearing. Notwithstanding the foregoing, the due date for the hearing officer to submit the recommended decision to the Department's Director, shall not be extended or otherwise changed.

If there has been an extension to the time for conducting the hearing, the hearing officer is authorized to alter the due dates for filing opening and reply briefs to permit the hearing officer to be in compliance with the due date for the submission of the recommended decision.

Within 30 calendar days of the completion of the hearing, the Department and the provider shall file their opening briefs with the DMAS Appeals Division. Any reply brief from the Department or the provider shall be filed within ten (10) 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.

Hearings shall be transcribed by a court reporter retained by the Department.

The hearing officer shall submit a recommended decision to the Department Director with a copy to the provider within 120 calendar days of the filing of the formal appeal notice. If the hearing officer does not submit a recommended decision within 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, the Department Director shall notify the Department and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed with the DMAS Appeals Division within fourteen (14) calendar days of receipt of the Department Director's letter. Only exceptions filed within fourteen (14) calendar days of receipt of the Department Director's letter shall be considered. The Department Director shall issue the Final Agency Decision within sixty (60) calendar days of receipt of the hearing officer's recommended decision.

The Department's Final Agency Decision may be appealed through the court system in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. However, the court review is limited to errors of law only. No new evidence is taken. During the court appeal process, the Department and/or its counsel at the Office of the Attorney General may have a need to confer with the contractor to gain further information about the appealed action. However, the Contractor is not a party to the lawsuit because the issue being contested is the Department' Final Agency Decision. The Contractor must respond to inquiries in a timely fashion. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

15.7 EVALUATION OF GRIEVANCES AND APPEALS

The Contractor shall, at a minimum, track trends in grievances and appeals. The Contractor's appeals and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards. The grievance and appeals process shall include the following:

- Procedures for registering and responding to grievances and appeals in a timely fashion.
- Documentation of the substance of the grievance or appeal and the actions taken;
- Procedures to ensure the resolution of the grievance;
- Aggregation and analysis of these data and use of the data for quality improvement.
- The Contractor must maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish CCC Plus program Members from commercial or other Medicaid Members if the Contractor does not have a separate system for the CCC Plus program.

15.8 GRIEVANCE AND APPEAL REPORTING

The Contractor shall submit to the Department by the fifteenth (15th) day of the month after the end of each month, a report of all Provider complaints and appeals and Member grievances and appeals as reflected in the CCC Plus Technical Manual.

Grievance categories identified shall be organized or grouped by the following general guidelines:

1) Transportation
2) Access to Services/Providers
3) Provider Care and Treatment
4) Care Coordination

5) MCO Customer Service
6) Payment and Reimbursement Issues
7) Administrative Issues

Appeal categories identified shall be organized or grouped by the following general guidelines:
1) Transportation
2) MCO Administrative Issues
3) Benefit Denial or Limitation
4) Provider Enrollment
The Contractor may use reports from its existing Member Services system if the system meets the Department's criteria.

15.8.1 Member Adverse Benefit Determination Decisions

The Contractor shall use the Department's RIGHTFAX system and fax a copy of any Member adverse denial decision at the time of issuance of the adverse benefit determination as adverse benefit determination is defined in this Contract. In addition, the Contractor shall report all adverse benefit determinations providing specific information for each (i.e., date filed, due date, extension (if any), closed, etc.). Refer to the CCC Plus Technical Manual for specifics on format and timeframe for submission.

15.9 RECORDKEEPING AND DOCUMENT PRESERVATION

15.9.1 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 the Department 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.

Also refer to Section 15.8 *Grievance and Appeal Reporting*.

15.9.2 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 the Department, including but not limited to, external Appeals.

SECTION 16.0 INFORMATION MANAGEMENT SYSTEMS

16.1 GENERAL REQUIREMENTS

The Contractor shall maintain Information Systems (Systems) that will enable the Contractor to meet all of the Department's and this Contract's requirements. The Contractor's Systems shall be able to support the current DMAS requirements, and any future IT architecture or program changes. Solutions shall be compliant with COV Information Technology Resource Management (ITRM) policies, standards, and guidelines, and may be updated from time to time. A complete list can be located: http://www.vita.virginia.gov/library/default.aspx?id=537.

The Contractor shall:

1) Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and the Department and any other entity deemed appropriate by the Department. Such files shall be transmitted to the Department through secure FTP, HTS, or a similar secure data exchange as determined by the Department;
2) Develop and maintain a website that is accurate, up-to-date, and designed in a user-friendly way that enables Members and providers to quickly and easily locate all relevant information. The Contractor shall establish appropriate links on the Contractor's website that direct users back to the Department's web portal;
3) Cooperate with the Department in its efforts to verify the accuracy of all Contractor data submissions to the Department; and,
4) Actively participate in any DMAS Systems workgroups, as directed by the Department.

16.2 DESIGN REQUIREMENTS

The Contractor shall comply with the Department's requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract. The Contractor's Systems shall interface with the Department's VaMMIS/MES system, the DMAS Virtual Gateway, and other DMAS IT architecture.

16.3 SYSTEM ACCESS MANAGEMENT AND INFORMATION ACCESSIBILITY REQUIREMENTS

In accordance with 42 CFR § 438.242(b)(3), the Contractor shall make all collected data available to the State and upon request to CMS. The Contractor shall make all systems and system information available to authorized DMAS and other agency staff to evaluate the quality and effectiveness of the Contractor's data and Systems.

The Contractor is prohibited from sharing or publishing DMAS data and information without prior written consent from the Department

16.4 SYSTEM AVAILABILITY AND PERFORMANCE REQUIREMENTS

The Contractor shall ensure that its Member and provider web portal functions and call centers are available to Members and providers twenty-four (24) hours a day, seven (7) days a week.

Prior to implementation, upon revision, or upon request, the Contractor shall draft an alternative plan that describes access to Member and provider information in the event of System failure and submit to the Department for approval. Such approved plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to the Department upon request. In the event of System failure or unavailability by the Contractor or one of its contracted vendors, the Contractor shall notify the Department upon discovery and implement the COOP immediately. The Contractor shall send the notification via email to the CCC Plus Operations Manager and to cccplusreporting@dmas.virginia.gov immediately upon discovery of the within one business hour of discovery of the issue.

The Contractor shall preserve the integrity of Member-sensitive data and be able to produce the data that resides in both a live and archived environment.

16.5 ELECTRONIC CARE COORDINATION SYSTEM

The Contractor shall utilize an electronic care coordination system that maximizes the opportunity to share and integrate data and information among the Contractor, its multiple service areas, helplines, providers, Members, and Care Coordinators quickly and efficiently. The system should allow staff (e.g., customer service, nurse helpline, medical management) who may be contacted by a Member regarding care coordination to have immediate access to the most recent case-specific information within the Contractor's electronic system. The data contained within the electronic system may include the following: administrative data, call center notes, helpline notes, provider service notes, a Member's care coordination notes, and any recent inpatient or emergency department utilization. The system must also have the capability to share or access relevant information (i.e., ICP, utilization reports, care treatment plans, etc.) with the Member, Member's provider(s), and Care Coordinators. The Contractor shall also be required to send and receive relevant data with subcontractors (i.e., to/from the Contractor's care coordination or other systems) to facilitate effective care coordination and transitions of care.

The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures of its electronic system and other tools Care Coordinators will use to integrate care for Members, including integrating Medicare for dual eligible individuals. The policies and procedures should place emphasis on how the system facilitates communication so that the Contractor, providers, helpline, Member, subcontractors and Care Coordinators can receive real time or near real time data (e.g., utilization management, claims data, experience with the Contractor, subcontractors, etc.) to better coordinate care, follow Members through episodes of care, and streamline care transitions to ensure positive health outcomes for Members. In the policies and procedures, the Contractor shall describe: (1) the types of data stored in the electronic care coordination system; (2) how information is fed into the system (e.g., real time, manual entry, etc.), how frequently (e.g., daily, weekly, etc.), and from what sources(s) (e.g., subcontractors); and, (3) which providers and staff have access to the data, how they access the data, and for what purposes; and (4) the Contractor's ability to capture (send/receive) relevant information to report to the Department for care coordination and monitoring purposes.

The Contractor agrees to interface with a single, statewide electronic care coordination system that may be designed by the Department to obtain data to address challenges with the coordination and integration of care and to provide transparency and data needed to move

Virginia to value-based payment. DMAS will work with the contractor to allow sufficient time toward this purpose. If requested, the Contractor shall participate in meetings to determine the functionality, the data elements that should be integrated into the system, and the frequency of data transmission. Contractors shall also share required data with DMAS on a real time or near real time basis, at no additional cost to the Department.

16.6 CENTRAL DATA REPOSITORY

The Department is expanding its data integration and analytics capabilities by developing a system that collects, integrates, and analyzes data from a variety of sources across the full continuum of care (primary, acute, behavioral, institutional, and community based). The Department will track health metrics for the Medicaid population across fee-for-service and all managed care programs. This data system will help the Department evaluate how well the CCC Plus program is serving individuals, while identifying best practices and opportunities for improvement. This comprehensive data mining approach will enable the Department to project risk, enhance care coordination, mitigate service gaps, and promote efficiencies.

The Contractor shall provide raw data, including data from subcontractors. The data shall be compliant with industry standards (e.g., National Information Exchange Model) and State companion guides. At a minimum, required data shall include:

1) Service authorizations;
2) Full provider networks;
3) Appeals and grievances;
4) Care coordination data;
5) Formulary data;
6) Financial management reports and transaction data for any off systems payments including, but not limited to:
    a. MLR reports, BOI data
    b. Lump sum payments to providers
    c. Incentive payments to providers
    d. Cost recovery transactions (e.g., third party liability explanation of benefits, fraud/waste investigations, and/or legal actions); and,
7) Encounter claims using the HIPAA Compliant Transactions and Code Sets and file formats following the Department's EDI requirements.

The Department will collect, analyze, and report data in a reliable and timely manner. The Contractor shall work collaboratively with the Department to develop solutions that align with the Department's data integration goals, based upon evidenced-based data standards which ensure the highest degree of data quality and integrity.

The Contractor shall submit the required data in the timeframe and required format(s). The Contractor shall be subject to liquidated damages and sanctions when data is submitted contrary to the Department's established standards of timeliness, completeness and accuracy, and where the method of submission is non-compliant with this Contract.

Beginning in the Fall 2018, the Department will begin working with the Contractor to develop a mechanism to collect service authorization (SA) data from all CCC Plus MCOs. The SA data will be collected as part of a phased implementation plan, beginning with pharmacy SA claims

data. The Contractor shall work closely with the Department to develop the technical requirements for providing the SA data as well as the mechanism for data transmission, including file formats and submission frequency. The SA data reporting implementation is expected to take place in 2019.

16.7 DATA INTERFACES SENT TO AND RECEIVED FROM DMAS

The Contractor shall have adequate resources to support the Department's interfaces and the care coordination technology system described herein. The Contractor shall be able to send and receive interface files. Interface files are explained in the CCC Plus Technical Manual and include, but are not limited to:

Inbound Interfaces

- EDI X12 5010 837I Facility Encounters
- EDI X12 5010 837P Professional Encounters
- EDI X12 5010 837D Dental Encounters (The Contractor shall hold these encounters for submission to the Department in the future with at least 60 days advance notice from DMAS).
- NCPDP 4.4 (Pharmacy Encounters)
- CCC Plus provider network files
- CCC Plus MTR (Service Authorization information)
- Clinical and care coordination related data

Outbound Interfaces

- EDI X12 5010 834 weekly files
- EDI X12 5010 820 monthly capitation payment file
- Medical Transition Report, including service authorizations and claims data
- DMAS provider network file

The Contractor shall use the file formats as described in the CCC Plus Technical Manual. The Contractor shall conform to HIPAA (X12 and NCPDP) compliant standards and all State and Federal standards for data management and information exchange and shall implement new versions as made available by HIPAA and NCPDP according to the Department's needs and guidance.

The Contractor shall demonstrate controls to maintain information integrity.

The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to the Department for reconciliation processes.

16.8 INTERFACE AND CONNECTIVITY TO THE VIRGINIA MEDICAID MANAGEMENT INFORMATION SYSTEM (VAMMIS) AND MEDICAID ENTERPRISE SYSTEM (MES)

The Contractor's interface with VaMMIS/MES shall include, but will not be limited to, receiving Medicaid participant enrollment information in HIPAA standard EDI X12 834 format; the submission of encounter data in the HIPAA standard X12, 837I, 837P, and the NCPDP D.0 formats; and receiving monthly capitation payments in the HIPAA standard X12 820 format. All

Contractor's staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of this Contract.

It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of this Contract. The Contractor will be granted access to the Department's EDI portal used for submission and receiving of X12 standard data files and other non-X12 data files. This access will be through the secured EDI portal maintained by the Department.

The Contractor will be granted access to VAMMIS through the web portal (https://www.virginiamedicaid.dmas.virginia.gov) with an ACF2 secure sign on. This will enable the Contractor to view eligibility and pertinent VAMMIS data as deemed necessary by the Department. The Contractor's Help Desk employees supporting this Contract shall have access to the Internet.

16.9 DATA QUALITY REQUIREMENTS

16.9.1 General Requirements

The Contractor shall meet all data requirements as defined by the Department. 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, CCC Plus Data Manual, CCC Plus 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 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 180 calendar days after the start of the contract. For newly required data, the Contractor shall have 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 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:

4) All encounter data;
5) Financial data and reports for payments to providers contracted to provide services to Members;
6) Service authorizations (approved, denied, and pending); and,

7) 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.

In accordance with 42 CFR §438.242(b), the Contractor shall screen all data received from providers for completeness, logic and consistency. All data submissions are required to be certified. Data certification forms shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall keep track of every record submitted to the Department or its designee and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification.

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

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

1) Collect and maintain 100% of the data required by the Department.
2) Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which shall include:
   a) Metrics that measure completeness, timeliness, and accuracy of the data;
   b) Benchmarks that describe whether the Contractor's performance is compliant with the Department's requirements;
   c) A description of how each measure is calculated by the Department;
3) Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation;
4) Participate in user acceptance testing with the Department in order to measure the level at which the test submissions meet data and data quality requirements before routine submissions from the Contractor begin;
5) Ensure that Contractor data can be individually linked to Department data at the record level (e.g. Contractor data on Members can be linked to the Department's unique Member identifier); and,
6) Provide any reports on required data as requested by the Department.

16.9.2 Data Reconciliation and Potential Audit Requirements

The Department may request a sample extract of previously submitted data from the Contractor that shall be compared to data received by the Department. At the discretion of the Department, the Contractor shall participate in site visits and other reviews and assessments by the Department, or its designee, for the purpose of evaluating the completeness of the Contractor's data inventory as disclosed to the Department, and to evaluate the collection and maintenance of data required by the Department. Upon request by the Department, or its designee and with thirty (30) calendar days' notice, the Contractor shall provide DMAS-specified Member records in order to permit the Department to conduct data validation assessments.

The Department, or its designee, may investigate suspected data quality issues including, but not limited to, deviations from expected data volume, or expected data corrections, voids or adjustments. Suspected data quality issues discovered by such investigations may result in the addition of metrics to the Data Quality Scorecard or the requirement that the Contractor replace data with suspected data quality issues at no cost to the Department. Any cost incurred by the Department to reprocess replacement data that the Department determines has data quality issues shall be passed through in its entirety to the Contractor. Costs for replacing such data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

16.9.3 Data Inventory and Data Quality Strategic Plan Requirement

At least twice yearly, or as otherwise requested by the Department, the Contractor shall submit to the Department a data inventory including, but not limited to:

1) the data's origin (*i.e*. what entity originally generated the data);
2) the business purpose of the data and reason for its existence;
3) a comprehensive description of all metadata elements, including:
    a. a list of all data fields
    b. a business description of the content of each field
    c. the field's format
    d. a list of valid values (where the data field is defined by a limited value set); and,
4) description of the format, schedule, and any other required details regarding how the data is transmitted to DMAS, if that source is required by the Department.

Should the Contractor possess a new data source with data on the Members, the Contractor shall inform the Department sixty (60) calendar days prior to that data source's acquisition or creation.

The Contractor shall provide the Department with an Annual Data Quality Strategic Plan in accordance to the specifications of the Department that addresses:

1) The Contractor's plan for ensuring high quality data that complies with the Department's standards for accuracy, timeliness, and completeness as described in the Data Quality Scorecard or other supporting documentation;
2) Plans and timelines for improving performance on the metrics in the Data Quality Scorecard, unless the Contractor is compliant on all measures;
3) What procedures and automated checks exist in the Contractor's systems to prevent transmission of non-compliant data; and,

4) The compliance actions and data quality standards expected of service providers, billing providers, sub-contractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

16.9.4 Data Requirements for Encounters, Financial Transactions, Service Authorizations and Provider Data

16.9.4.1 Encounters

The Contractor shall submit encounter data for Member services on which the Contractor incurred a financial liability, and shall include claims for provided services that were eligible to be processed, but where no financial liability was incurred. The Contractor shall submit encounters according to the Medicaid Enterprise System (MES) Encounters Processing Solution (EPS) CCC Plus Encounters Technical Manual as well as the Companion Guide. The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:

a. expected utilizations;
b. actual visits to expected visits;
c. service date lag time benchmarks;
d. expected EDI fail amounts; and,
e. average paid amount per service, by billing code.

2. The Contractor shall also:

a. Collect and maintain 100% of all encounter data for each covered service and supplemental benefit services provided to Members, including encounter data from any sub-capitated sources. Such data must be able to be linked to the Department's eligibility data;
b. Develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 USC 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program as directed in Section 4.8.8 (Drug Rebates) of this Contract; and,
c. Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) business days of the Contractor's payment date and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in its supporting documentation.
d. The Contractor's systems shall generate and transmit encounter data files according to the Department's requirements and any additional specifications as may be provided by the Department and updated from time to time.

In accordance with 42 CFR§ 438.602(e), the Contractor shall comply with any audit arranged for by DMAS to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by Contractor. The Contractor shall cooperate with the DMAS designated auditor(s) to ensure the audit is completed within the timeframe specified by the Department.

If the Department or the Contractor determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

1) Notify DMAS, prior to encounter data submission and within two (2) business days of discovery, that the data is not complete or accurate, and provide an action plan and timeline for resolution and approval.
2) Submit for 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-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.

16.9.4.2 Provider Network

The Contractor shall:

1. Collect and maintain 100% of all provider data for providers in that Contractor's or sub-contractor's network where the Contractor has incurred a financial liability or denied services for Members; and,

2. Submit complete, timely, reasonable, and accurate provider network data to the Department daily, prior to the Contractor's submission of encounters, and in the form and manner specified by the Department. The Department will use this provider file submission for CCC MCO assignments and encounter processing. The first submission shall be sent 60 days prior to the Department's program implementation. Standard formats, required data elements, and other submission requirements shall be detailed in the CCC Plus Technical Manual; and,

3. Submit to the Enrollment Broker a complete provider file in a Department approved electronic format thirty (30) calendar days prior to the effective date of the Contract. An updated file with all of the changes to the network shall be submitted to the Enrollment Broker weekly thereafter or more frequently, if needed, during any program expansions (e.g., upon adding additional populations to the CCC Plus program). Refer to the CCC Plus Technical Manual; and,

4. Submit to the Department a complete provider network file on a monthly basis at start-up for network analysis. The CCC Plus Network Requirements Submission Manual (NRSM) details the submission requirements, including frequency of submission (on-going) data elements, and file format.

16.9.4.3 Financial Transactions

The Contractor shall:

1. Collect and maintain 100% of all Health Care Claim Payment and Remittance Advice data for payments to providers contracted to provide services to Members; and,

2. Submit complete, timely, reasonable, and accurate financial data to the Department within two (2) business days of the Contractor's payment cycle and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

16.9.4.4 Service Authorizations

The Contractor shall:

a. Collect and maintain 100% of all service authorization data for services authorized, pending, or denied for Members.

b. Ensure that service authorization data includes utilization data for all claims associated with services provided pursuant to the specific authorization;

c. Submit complete, timely, reasonable, and accurate service authorization data to the Department no less than weekly, and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

16.9.5 Data Quality Penalties

Where DMAS determines that the Contractor has failed to comply with the Departments' data exchange requirements or is non-compliant with data quality benchmarks, DMAS may impose the sanctions set out below effective January 1, 2018. The process for the Department's imposition of sanctions shall comply with the requirements of 42 CFR §380, Subpart I.

The Department shall develop for the Contractor a Data Quality Scorecard, which shall be described in supporting documentation. The Data Quality Scorecard may include up to 40 data quality performance metrics, and performance by the Contractor on the scorecard shall be communicated monthly by the Department to the Contractor. If a new data quality metric is to be added to the Data Quality Scorecard, the Contractor shall have ninety (90) calendar days before data quality withholds may occur based on the Contractor's performance on that metric.

Where DMAS determines that the Contractor has failed to submit required data or meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department shall send a notice of non-compliance. The Department reserves the right to apply penalties for non-compliance.

A Notice of Non-Compliance by the Department to the Contractor shall include:

1. A description of the data quality issue and the Contractor's performance on any metrics that triggered the non-compliance notice;

2. The action that shall be taken by the Contractor in order to cure the performance failure; and,

3. Financial withhold or penalties as a result of non-compliance.

The Department may require the Contractor to replace any non-compliant data with compliant data at no cost to the Department. Any cost incurred by the Department to reprocess replacement data shall be passed through in its entirety to the Contractor. Costs for replacing non-compliant data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

16.9.6 Secure E-mail with the Department

1) The Contractor shall provide secure email access (TLS-encryption) between DMAS and the Contractor for correspondence containing sensitive private health information (PHI) or personal identifiable information (PII). The TLS technique is required for communications between DMAS and the contractor containing sensitive information.
2) Neither direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. DMAS will provide no special application server(s) for this purpose.
3) It is recommended that routing of emails between DMAS and the Contractor shall support Secure SMTP over Transport Layer Security (TLS) RFC 3207 (or latest) over the Internet. The vendor will coordinate TLS encryption set up with DMAS technical security staff as needed to establish TLS.
4) TLS email encryption shall be maintained through the mail gateway. Bidirectional TLS email encryption must be tested, documented and maintained between DMAS and the Contractor's SMTP server.
5) DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.
6) All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.

16.9.7 Compliance with VITA Standard

The Contractor shall comply with all State laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. These accessibility standards are state law (see § 2.2-3502 and § 2.2-3503 of the *Code of Virginia*). The Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor shall also keep abreast of any future changes to the Virginia Code as well as any subsequent revisions to the Virginia Information Technologies Standards.

The Contractor, at a minimum, shall comply with VITA standards, which may be found on the VITA website at http://www.vita.virginia.gov . The Department requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document the Contractor's compliance with the most stringent requirements listed below:

1) Section 1902 (a) (7) of the Social Security Act (SSA);
2) 45 CFR Parts 160, and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; Final, January 25, 2013
3) COV ITRM Policy SEC5519-00 (latest version);

4) COV ITRM Standard SEC501-07 (latest version).

The following specific security measures shall be included in the Risk Management and Security Plan Computer hardware controls that ensure acceptance of data from authorized networks only:

1) Manual procedures that provide secure access to the system with minimal risk.
2) Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;
3) All Contractor database software changes may be subject to the Department's approval prior to implementation; and,
4) System operation functions shall be segregated from systems development duties.

If requested, the Contractor agrees that the Plan will be made available to appropriate State and Federal agencies as deemed necessary by the Department. If any changes to the Plan occur during the contract period, the Contractor shall notify the Department within thirty (30) calendar days to the change occurring.

The Contractor shall modify its IT systems to accept Medicare enrollment data and to load the data in the Contractor's care coordination system for use by Care Coordinators, DM/Population Health and UM staff.

16.10 DATA SECURITY AND CONFIDENTIALITY OF RECORDS

The Contractor shall take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member names.

The Contractor shall put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 CFR § 164.530(c).

The Contractor shall meet the security standards, requirements, and implementation specifications as set forth in 45 CFR Part 164, subpart C, the HIPAA Security Rule.

16.10.1 Personal Data

The Contractor shall inform each of its employees of the laws and regulations related to confidentiality if the employee has any involvement with personal data or other confidential information (whether with regard to design, development, operation, or maintenance).

16.10.1.1 Return of Personal Data

The Contractor shall return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by the Department, will destroy such data or material.

16.10.1.2 Destruction of Personal Data

For any PHI received regarding an Eligible Beneficiary referred to Contractor by the Department, and who does not enroll in Contractor's plan, the Contractor shall destroy the PHI in accordance with standards set forth in *NIST Special Publication 800-88, Guidelines for Media Sanitizations*, and all applicable State and Federal privacy and security laws including HIPAA and its related implementing regulations, at 45 CFR Parts 160, 162, and 164, as may be amended from time to time.

16.10.2 Research Data

The Contractor shall seek and obtain prior written authorization from the Department for the use of any data pertaining to this Contract for research or any other purpose not directly related to the Contractor's performance under this Contract.

16.10.3 Information Sharing

During the course of an Member's enrollment or upon transfer or termination of enrollment, and subject to all applicable Federal and State laws, the Contractor shall arrange for the transfer, at no cost to the Department or the Member, of medical information regarding such Member to any subsequent provider of medical services to such Member, as may be requested by the Member or such provider or directed by the Department, the Member, regulatory agencies of Virginia, or the United States Government. With respect to Members who are in the custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Member, a copy of said Member's Medical Records in a timely manner.

16.10.4 HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the Contractor with this agreement or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the Contractor from the Department or from any other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

To the extent that the Contractor uses one or more providers and/or subcontractors to render services under this Contract, and such providers/subcontractors receive or have access to protected health information (PHI), each such provider/subcontractor shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers/subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agrees in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor under this Contract.

16.10.5 Use of Disclosure of Information

The use or disclosure of information concerning Contract services or Members obtained in connection with the performance of this Contract shall be in accordance with the Health

Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, and provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

The 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. The Contractor may disclose PHI for such purposes if the disclosure is required by law, or if the 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 of 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.

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, the 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:

1) Not use or further disclose PHI other than as permitted or required by the terms of this Contract or as required by law;
2) Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Contract;
3) Report to DMAS any use or disclosure of PHI not provided for by this Contract of which it becomes aware;
4) 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 DMAS 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;
5) 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;
6) Report to the Department any security incident of which it becomes aware;
7) 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;
8) 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.
9) Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the Department;

10) 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;
11) 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; and,
12) 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.

Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within 5 business days via email to the Department's Division of Integrated Care at CCCPlus@dmas.virginia.gov, as well as the Department's Office of Compliance and Security at HIPAAprivacy@dmas.virginia.gov.

16.10.6 Disclosure and Confidentiality

The Contractor shall have a confidentiality agreement in place with individuals of its workforce who have access to PHI. 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.

16.10.7 Disclosure to Workforce

The Contractor shall not disclose PHI to any individual in 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, shall 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.

16.10.8 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) calendar 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.

16.10.9 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.

16.10.10 Reporting Breach of Unsecured PHI

The Contractor shall report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware. Initial notification regarding any breach of unsecured PHI must be immediate or as soon as possible after discovery. Formal notification shall be delivered within 5 business days .from 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 via email to the Department's Division of Integrated Care at CCCPlus@dmas.virginia.gov, as well as the Department's Office of Compliance and Security at HIPAAprivacy@dmas.virginia.gov. 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.

16.10.11 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 DMAS, to an individual in order to meet the requirements of 45 CFR Part 164.

16.10.12 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.

16.10.13 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.

The Contractor shall 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, at revision or upon request to the Department.

The Contractor shall comply with the Department's Security Requirements for vendors.

16.10.14 Audits, Inspections, and Enforcement

With 30 days' notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA in such a manner that does not unreasonably interfere with normal business operations. The Contractor shall promptly remedy take reasonable action against 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.

SECTION 17.0 REPORTING REQUIREMENTS

17.1 GENERAL REQUIREMENTS

Consistent with Federal and State guidelines, the Contractor shall be responsible for robust and transparent reporting on critical elements of CCC Plus covered services and the Contractor's major systems. The Contractor shall have adequate resources to support CCC Plus program reporting needs as required by this Contract. Examples of data to be included in reports shall include, but are limited to, behavioral health, pharmacy, LTSS, claims service authorizations, provider networks, grievances and appeals, quality, program integrity, expenditures related to rebalancing efforts (institutional vs. community based), call center statistics (broken out by behavioral health including crisis calls and all other service categories), timeliness of assessments, individualized care plans and care plan revisions, participant health and functional status, marketing, outreach, and training, high-utilizer intervention activities, under-utilization analysis with reasons, appointment assistance activities, value based payment activities and related dashboards.

Within this and other sections of the Contract, certain reports are detailed. However, the majority of the required reports are reflected in the CCC Plus Technical Manual. The Contractor shall report detailed data in the areas listed above on a weekly, monthly, quarterly, and annual basis by program area, including separate reports for LTSS, behavioral health, and ART services. The Contractor shall also provide a monthly detailed business review report in a presentation style format that highlights the Contractor's overall system of care. The Contractor's detailed business report shall include a detailed review and trend analysis of the Contractor's on-going experience (i.e., utilization, activities, outcomes, etc.), as well as performance metrics for all program areas and major systems. The Contractor shall adhere to delivery of all reports established by the Department and noted within the CCC Plus Technical Manual and this Contract. The Contractor shall refer to the CCC Plus Technical Manual for the appropriate reporting formats, instructions, submission timetables, and technical assistance.

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.

The Contractor shall submit all reports to the Department according to the schedule below (if not specified elsewhere):

DELIVERABLES		DUE DATE
Daily Reports		Within two (2) business days
Weekly Reports		Wednesday of the following week
Monthly Reports		No later than the 15th of the following month

DELIVERABLES		DUE DATE
Quarterly Reports		Last day of month following the end of the quarter
Semi-Annual Reports		January 31st and July 31st
Annual Reports		No later than March 31st after the end of the calendar year.
On Request Reports		As required by the Department.

The Contractor shall submit all reports electronically and in the manner and format prescribed by this Contract and the CCC Plus Technical Manual. The Contractor shall ensure that all reports are complete and accurate or may be subject to liquidated damages as specified in the *Enforcement, Remedies and Compliance* section 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.

The Contractor shall transmit to and receive from the Department all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by the Department, so long as the Department's direction does not conflict with the law.

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.

17.2 ALL PAYERS CLAIM DATABASE

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia* for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contactor shall be responsible for the submission of paid claims data related to services provided under this contact. Such data submission, pursuant to §32.1-276.7:1 of the *Code of Virginia*, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the Social Security Act.

17.3 CRITICAL INCIDENT REPORTING AND MANAGEMENT

At initial Contract implementation, at revision, or upon request by the Department, the Contractor shall provide their policies and procedures for review and approval regarding the finding, reporting and management of critical incidents that Members experience while in nursing facilities, inpatient behavioral health or HCBS settings (e.g., an adult day care center, a Member's home or any other community-based setting), among other settings. 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 (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS) (if available); identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The Contractor shall require its staff and contracted CCC Plus 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.

As a part of Critical Incident Reporting and Management, the Contractor shall participate, when requested, in a Mortality Review Team. The Mortality Review Team will consist of individuals from the Department and other CCC Plus Contractors. The purpose of the team will be to review findings, cause, and prevention of critical incidents.

SECTION 18.0 ENFORCEMENT, REMEDIES, AND COMPLIANCE

18.1 CCC PLUS PROGRAM EVALUATION ACTIVITIES

The Department and its designated agents will conduct ongoing evaluations of the Contractor and the CCC Plus program from multiple perspectives using both quantitative and qualitative methods. The evaluations will be used for program improvement purposes and to assess the Contractor's and the program's overall impact on various outcomes including but not limited to, enrollment patterns, Member access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, behavioral health, home health, prescription drugs, nursing facility, waiver), integrated care strategies, care coordination, Department staff and provider experiences.

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

18.2 COMPLIANCE MONITORING PROCESS (CMP)

The Department shall be responsible for conducting an ongoing contract Compliance Monitoring Process (CMP). As part of this monitoring process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract. The Department may, at its sole discretion, conduct any or all of the following activities, as part of the contract monitoring process:

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.

The purpose of the CMP is to detect and respond to issues of noncompliance and remediate contractual violations when necessary. The CMP uses a tiered points system to achieve the Department's goal of Contract Compliance. Furthermore, the CMP is comprised of a six (6) level deficiency identification system described below.

18.2.1 CMP Point System

The Contractor incurs points due to issues of non-compliance. These points accumulate over a rolling 12-month schedule. The Department shall carry over all active points from the previous contract cycle, however, points more than twelve (12) months old expire and will no longer be counted. No points will be assigned for a violation the Contractor is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (i.e., natural disasters, a lightning strike disables a computer system, etc.).

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 points to the Contractor unless the Contractor can demonstrate, to the satisfaction of the Department (at its discretion), that:

1. The Contractor provided sufficient notification or education to providers of applicable program requirements and prohibited activities, and can document these actions to the Department's satisfaction; and
2. The Contractor took immediate and appropriate action to correct the problem and to ensure that it will not recur. The Department will review repeat and related incidents in order to determine whether the Contractor has a systemic problem. Systematic problems will not be waived. If the Department determines that a systemic problem exists, further sanctions or remedial actions may be assessed against the Contractor.

18.2.2 Sanctions Based on Accumulated Points

Sanctions will be based on the number of points accumulated at the time of the most recent compliance violation/incident. A compliance violation, unless otherwise defined, will be at the Department's discretion based on the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident. A Corrective Active Plan (CAP) or other sanctions may be imposed in addition to the fines listed below. The Department has a six (6) level compliance deficiency identification system within its CMP. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	0-15	--	None
2	16-25	CAP	$ 5,000
3	26-50	CAP	$10,000
4	51-70	CAP	$20,000
5	71-100	CAP	$30,000
6	> 100	Possible Termination	N/A

18.2.3 Compliance Violation Types

18.2.3.1 One (1) Point Violations

The Department may, at its discretion, assess one (1) point when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, impairs the Department's ability to properly oversee and/or analyze Contractor performance, including but not limited to reporting errors. Examples of one point violations include, but are not limited to, the following:

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 CCC Plus 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 CCC Plus Technical Manual.

18.2.3.2 Five (5) Point Violations

The Department may, at its discretion, assess five (5) points when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts: (1) impairs a Member's or potential Member's ability to obtain accurate information regarding the Contractor services; (2)

violates a care coordination process; impairs a Member's or potential Member's ability to obtain correct information regarding services; or, infringes on the rights of a Member or potential Member. Examples of five (5) point violations include, but are not limited to, the following:

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).
10. Failure to actively participate in quality improvement projects or performance improvement projects facilitated by the Department and/or the EQRO.
11. Failure to meet provider Access to Care & Network Standards.
12. Failure to comply with the Department's defined critical encounter submission requirements (e.g., timeliness, failed voids, rebate date, etc.).
13. Noncompliance with Claims Adjudication Requirements - 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 5 points per incident of noncompliance. If the Department has identified specific instances where a 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 5 points per incident of noncompliance.

18.2.3.3 Ten (10) Point Violations

The Department may assess ten (10) points when the Contractor fails to meet a program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts: (1) affects the 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. Examples of ten (10) point violations include, but are not limited to, the following:

1. 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).
2. Failure to assist a Member in accessing needed services in a timely manner after receiving a request from the Member.
3. Failure to provide medically-necessary Medicaid covered services to Members.

4. Failure to comply with the oversight requirements of Subcontractors.
5. Failure to comply with the Program Integrity Requirements set forth in this Contract.
6. Failure to participate in transition of care activities or discharge planning activities.
7. Failure to process prior authorization requests within the prescribed time frames.
8. Repeated failure to comply with a CAP (Corrective Action Plan).
9. 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.
10. The imposition of any copays on Native American Members.
11. Misrepresentation or falsification of information that the Contractor furnishes to the Department.
12. Misrepresentation or falsification of information that the Contractor furnishes to a Member, potential Member, or health care provider.
13. Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210.

18.3 OTHER – SPECIFIC PRE-DETERMINED SANCTIONS

18.3.1 Adequate network-minimum provider panel requirements

The Department may assess sanctions (e.g. CAPs, points, freeze enrollment, impose fines) if: (1) the Contractor violates any provider network requirements, or (2) a Contractor's Member has experienced problems accessing necessary services due to lack of an adequate provider network. This provision would not apply to ARTS as described in Section 8.2.6 *Behavioral Health (Including ARTS)*.

18.3.2 Submissions of Reporting Deliverables

All submissions, data and documentation submitted by the Contractor must be received by the Department as specified in this Contract. 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 CCC Plus Technical Manual), the Department may assess points on a "per report" basis, as outlined in the chart below, unless the Contractor requests and is granted an extension by the Department.

18.4 REMEDIAL ACTIONS

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth herein and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

These administrative procedures shall not supersede the administrative procedures set forth herein and those required by the Federal government.

The Department may pursue all remedial actions with the Contractor that are taken with Medicaid fee-for-service providers. The Department will work with the Contractor and the Contractor's network providers to change and correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner, as determined by the Department.

18.4.1 Remedies Not Exclusive

The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable, and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

18.4.2 Other Remedies

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

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

18.4.3 Federally-Prescribed Sanctions for Noncompliance

Pursuant to 42 CFR §.438.700, the Department shall establish intermediate sanctions for noncompliance, as specified in §438.702. The Department will base its determinations on findings from onsite surveys, Member or other complaints, financial status, or any other source.

In accordance with Section 1903(m)(5)(B)(ii) and 1932(e)(1)(A) of the Social Security Act (the Act) the Department will deny or withhold payments for Members when, and for so long as, payment for those Members is denied by CMS, based on the state's recommendation and the determinations specified below, including when the Contractor:

1. 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;
2. Imposes premiums or charges Members in excess of the premiums or charges permitted under Title XIX of the Act;
3. Acts to discriminate among Members on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll a Member, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible Members whose medical condition or history indicates a need for substantial future medical services;
4. Misrepresents or falsifies information that it furnishes to CMS or to the state;
5. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider;
6. Fails to comply with the requirements for physician incentive plans (PIPs), as set forth (for Medicare) in 42 CFR §422.208 and 42 CFR §422.210; or
7. Distributed directly, or through any agent or independent Contractor marketing materials that contain false or misleading information.

In addition, the Department will deny payments to the Contractor for new Members when, and for so long as, payment for those Members is denied by CMS. CMS may deny payment to the

Commonwealth for new Members if CMS' determination is not contested timely by the Contractor.

In accordance with Section 1932(e)(2)(A) of the Act, the State will impose the following civil money penalties, as follows:

1. For each determination that the Contractor fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of $25,000.
2. For each determination that the Contractor 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, Member, potential Member, or health care provider, a maximum of $100,000.
3. For each determination that the Contractor 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.
4. With respect to a determination that the Contractor 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.

Sections 1932(e)(2)(B) and 1903(m) of the Act specifies the conditions for appointment of temporary management. DMAS shall impose temporary management sanctions if the Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Act or as described in 42 CFR §438.706(b) - (d).

Section 1932(e)(3) of the Act specifies that if an Contractor 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 allow Members to disenroll without cause. The Department will not delay the imposition of temporary management to provide a hearing and will not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur.

Section 1932(e)(4) of the Act allows the State to terminate contracts of any MCO 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 MCO.

18.4.3.1 Sanction by CMS: Hearing Rules for MCOs

Title 42 CFR § 438.730 allows the Commonwealth to recommend that CMS impose the denial of payment sanction for new Members of the Contractors when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements set forth in 42 CFR § 438.730, as described in this Contract.

In accordance with 42 CFR §438.730 the Commonwealth must give the Contractor a hearing before termination occurs, and the Commonwealth must notify the Members enrolled with the Contractor of the hearing and allow the Members to disenroll if they choose without cause.

When the Commonwealth decides to recommend imposing the CMS sanction described in 42 CFR §438.730, this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within fifteen (15) days.

18.4.3.2 Notice of Sanction

If the Commonwealth's determination becomes CMS' determination per 42 CFR §438.730, the Commonwealth takes all of the following actions:

1) Gives the Contractor written notice of the nature and basis of the proposed sanction.

2) Allows the Contractor fifteen (15) days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction.

3) May extend the initial fifteen (15) day period for an additional fifteen (15) days, as follows:

   (i) The Contractor submits a written request that includes a credible explanation of why it needs additional time.

   (ii) The request is received by CMS before the end of the initial period.

   (iii) CMS has not determined that the Contractor's conduct poses a threat to a Member's health or safety.

18.4.3.3 Informal Reconsideration

1) If the Contractor submits a timely response to the notice of sanction, the Department will:

   (i) Conduct an informal reconsideration that includes review of the evidence by a Department official who did not participate in the original recommendation;

   (ii) Give the Contractor a concise written decision setting forth the factual and legal basis for the decision; and

   (iii) Forward the decision to CMS.

2) The Department's decision under 42 CFR §438.730 becomes CMS' decision unless CMS reverses or modifies the decision within fifteen (15) days from date of receipt by CMS.

3) If CMS reverses or modifies the Department's decision, the Department sends the Contractor a copy of CMS' decision.

18.4.3.4 Denial of Payment

CMS, based upon the recommendation of the Department, may deny payment to the Commonwealth for new Members of the Contractor under section 1903(m)(5)(B)(ii) of the Act in the following situations:

1) If a CMS determination that an Contractor has acted or failed to act, as described in paragraphs (b)(1) through (6) of §438.700, is affirmed on review under paragraph (d) of 42 CFR §438.730.

2) If the CMS determination is not timely contested by the Contractor under paragraph (c) of this 42 CFR §438.730.

Under §438.726(b), CMS' denial of payment for Members automatically results in a denial of payments by the Department to the Contractor for the same Members.

18.4.3.5 Effective Date of Sanction

If the Contractor does not seek reconsideration, a sanction is effective fifteen (15) days after the date the Contractor is notified under paragraph (c) of 42 CFR §438.730 of the decision to impose the sanction.

If the Contractor seeks reconsideration, the following rules apply:

1) Except as specified in 42 CFR §438.730 (d)(2), the sanction is effective on the date specified in CMS' reconsideration notice.

2) If CMS, in consultation with the Department, determines that the Contractor's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under 42 CFR §438.730 (d)(1)(ii).

18.4.3.6 CMS' Role

CMS retains the right to independently perform the functions assigned to the Commonwealth under paragraphs (a) through (d) of 42 CFR §438.730. At the same time that the Commonwealth sends notice to the Contractor under 42 CFR §438.730 (c)(1), CMS forwards a copy of the notice to the OIG. CMS conveys the determination described in 42 CFR §438.730(b) to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and 42 CFR§ 1003. In accordance with the provisions of 42 CFR§ 1003, the OIG may impose civil money penalties on the Contractor in addition to, or in place of, the sanctions that may be imposed under 42 CFR §438.730.

18.4.4 Other Specified Sanctions

In accordance with 42 CFR §438.702, In addition to Federally prescribed sanctions described above, the Department retains authority to impose additional sanctions under State statutes or State regulations to address areas of noncompliance. 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:

18.4.4.1 Suspensions of New Enrollment

The Department may suspend the Contractor's right to enroll new Medicaid Members (voluntary, automatically assigned, or both) under this Contract. The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option will notify the Contractor in writing of its intent to suspend new Medicaid enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid enrollment or disenroll Medicaid Members in anticipation of the Contractor not being able to comply with any requirement of this Contract or with Federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify Members of Contractor non-compliance and provide such Members an opportunity to enroll with another MCO without cause.

18.4.4.2 Department-Initiated Disenrollment

The Department may reduce the number of current Members by disenrolling the Contractor's Medicaid Members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

18.4.4.3 Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid Members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

18.4.4.4 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.

18.4.4.5 Other Financial Sanctions

The Department may impose financial sanctions/penalties upon the Contractor of at least the amount of payment required in the Contractor's contract with the disputing party.

18.4.4.6 Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department will 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:

1. 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.

2. 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.

18.4.4.7 Procedures For Withholding Capitation Payments

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.

18.4.4.8 Suspension of Medicaid Payments in Cases of Fraud

In accordance with 42 CFR § 455.23, Managed Care Organizations are subject to payment suspensions. The Department shall suspend payments to the Contractor based upon a pending investigation of a credible allegation of fraud. 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 act judiciously on a case-by-case basis. DMAS 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.

18.4.4.9 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.

18.5 CORRECTIVE ACTION PLAN

If, at any time, DMAS reasonably determines that the Contractor is deficient in the performance of its obligations under the Contract, DMAS may require the Contractor to develop and submit a corrective action plan (CAP) that is designed to correct such deficiency. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and State/Federal regulations. The Contractor's first step in preparing a CAP is to review the specific findings/observations noted in the communication received from the Department and determine the root cause of the deficiency. CAPs must always include the necessary information and be submitted in the method as required in the CCC Plus Technical Manual. If a CAP does not contain the necessary information, an additional sanction or violation point value may be assessed.

DMAS will approve, disapprove, or require modifications to the Corrective Action Plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the Corrective Action Plan as approved by DMAS. Failure to implement the Corrective Action Plan may subject the Contractor to termination of the Contract by DMAS or other intermediate sanctions as described in the *Enforcement, Remedies and Compliance* section.

18.6 INTERMEDIATE SANCTIONS AND CIVIL MONETARY PENALTIES

In addition to termination, DMAS will impose any or all of the sanctions noted in this Contract upon any of the events below provided, however, that DMAS will only impose those sanctions determined to be reasonable and appropriate for the specific violations identified. Sanctions will be imposed in accordance with regulations that are current at the time of the sanction. Sanctions will be imposed in accordance with this section if the Contractor:

1. Fails substantially to provide Covered Services required to be provided under this Contract to Members;
2. Imposes charges on Members in excess of any permitted under this Contract;
3. Discriminates among Members or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any

policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

4. Misrepresents or falsifies information provided to DMAS and its authorized representatives, Members, prospective Members, or its Provider Network;
5. Fails to comply with requirements regarding physician incentive plans;
6. Fails to comply with Federal or State statutory or regulatory requirements related to this Contract;
7. Violates restrictions or other requirements regarding marketing;
8. Fails to comply with quality management requirements;
9. Fails to comply with any corrective action plan required by DMAS;
10. Fails to comply with financial solvency requirements;
11. Fails to comply with reporting requirements; or
12. Fails to comply with any other requirements of this Contract.

Such sanctions may include:

1. Financial penalties consistent with 42 CFR § 438.704;
2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 USC § 1396 u-2(e)(2)(B);
3. Suspension of Enrollment (including assignment of Members);
4. Suspension of payment to the Contractor;
5. Disenrollment of Members;
6. Suspension of marketing; and
7. Denial of payment as set forth in 42 CFR § 438.730.

If DMAS has identified a deficiency in the performance of a subcontractor or provider and the Contractor has not successfully implemented an approved corrective action plan, DMAS may:

1. Require the Contractor to subcontract with a different Entity deemed satisfactory by DMAS; or
2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

Before imposing any intermediate sanctions, DMAS will give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DMAS elects to provide.

18.7 NOTICE OF SANCTION AND PRETERMINATION HEARING

18.7.1 Notice of Sanction

In accordance with 42 CFR §438.710, except as provided in §438.706(c), before imposing any of the intermediate sanctions specified in this Contract, the Department will give the affected entity timely written notice that explains the following:

(1) The basis and nature of the sanction.

(2) Any appeal rights available to the Contractor.

18.7.2 Pre-Termination Hearing

In accordance with 42 CFR §438.710, before imposing the intermediate sanction to terminate this Contract with the Contractor, the Department must provide the entity a pre-termination hearing, including all of the following procedures:

1) Give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.

2) After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination.

3) For an affirming decision, give Members of the Contractor notice of the termination and information, consistent with §438.10, on the individual's options for receiving Medicaid covered services following the effective date of termination.

SECTION 19.0 CONTRACTOR PAYMENT AND FINANCIAL PROVISIONS

The Contractor shall establish and maintain a financial management capability sufficient to ensure that the requirements of this Contract are met.

19.1 FINANCIAL STATEMENTS

19.1.1 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.

19.1.2 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 Contractor shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

19.1.3 Financial Report to the Department

The Contractor shall submit quarterly financial reports to the Department's Provider Reimbursement Division that details revenue, medical expenditures by category, total Member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, balance sheets, detailed information on related party transactions and all administrative expenses associated with the CCC Plus program using the format developed by the Department as specified in the CCC Plus Managed Care Technical Manual. The report shall be submitted on a quarterly basis to the Department following the same schedule as reports for the BOI, with the first report due for the quarter ending March 31, 2018 for any plan active in the quarter. This report is subject to audit and verification by the Department. For Contractors with multiple Medicaid lines of business in Virginia, the quarterly report should segregate and report data for each program (CCC Plus, Medallion, etc.) and reconcile to the annual BOI reports.

On an annual basis, each contractor shall submit supplemental information related to administrative expenses that (1) identify all non-allowable expenses for Medicaid reimbursement and (2) allocate its administrative expenses across major eligibility groups.

Non-allowable expenses for Medicaid reimbursement include but are not limited to:

- Related party management fees in excess of actual cost;
- Lobbying expenses, Contributions, State and Federal income taxes;
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs;
- Management fees relating to non-Virginia operations;

- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific MCO enrollees; and/or,
- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs, and Accruals for future losses.)

19.2 REPORTING OF REBATES

The Contractor shall report on a quarterly basis all rebates collected on drugs or devices dispensed to any Medicaid Member from pharmaceutical manufacturers, distributors or any other source. Refer to the CCC Plus Technical Manual for the format and requirements.

19.3 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 shall notify the Department at least thirty (30) calendar days prior to making any changes to its basis of accounting.

19.4 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.

19.5 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.

19.6 HEALTH INSURER FEE

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some CCC Plus health plans that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid line of business. DMAS will make an adjustment for the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes but the adjustment shall not exceed the Federal or State corporate income taxes reported on the plan's annual financial statement and allocated to the Virginia Medicaid line of business.

The Contractor shall furnish a copy of its Letter 5067C Final Fee Calculation from the IRS to DMAS for 2018 by September 15, 2019 if any such fee was payable. Along with a copy of the letter 5067C, each plan shall show the methodology for allocating the health insurer fee to each Virginia Medicaid line of business and certify the results. The Department will utilize this information to determine plan specific PMPM adjustments to the CY 2018 capitation rates. There will be separate components for the fee itself and the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes. A health insurance premium

adjustment will be determined after the amounts due are known in the fall. DMAS will make an aggregated retroactive adjustment by December 31, 2019.

The Contractor shall compare its final CY 2018 state and corporate income tax liability for the Medicaid line of business reported to the Bureau of Insurance and the capitation adjustment for the impact of non-deductibility of the health insurer fee and refund the difference, if any, between the capitation adjustment and the actual tax liability to the Department by April 30, 2019.

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

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

In accordance with 42 CFR §§438.8(k) and 438.8(n), the Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

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

The Contractor is required to report a MLR annually based on 42 CFR § 438.8. 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 calendar year.

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, 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 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)].

In accordance with 42 CFR §438.8(h), a credibility adjustment is added to the MLR calculation before calculating any remittances. A credibility adjustment to a calculated MLR may be added if the MLR reporting year is partially credible. The Contractor shall not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

In accordance with 42 CFR §438.8(k)(3), the Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

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 approportioned to the other entities.

The Contractor shall report to the Department the following information for each MLR reporting year based on data through September 30 of the following calendar year:

a. Total incurred claims;
b. Expenditures on quality improving activities;
c. Expenditures on activities related to program integrity compliance;
d. Non-claims costs;
e. Premium revenue;
f. Taxes, licensing and regulatory fees;
g. Methodology for allocation of expenditures;
h. Any credibility adjustment applied;
i. The calculated MLR;
j. Any remittance owed to the State;
k. A reconciliation of the information reported in this report with the audited financial report;
l. A description of the aggregation method by covered population; and,
m. The number of Member months.

If the Contractor is required to make a payment to the Department, the payment shall be due to the Department no later than twelve (12) months following the MLR reporting year.

The Contractor shall be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid premium income. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year developed in the same manner as the MLR (i.e. with data through September 30 of the following calendar 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 19.1.3. Second, the Health Insurer Fee shall be excluded from the non-claims costs and the reimbursement from DMAS under section 19.6 shall be excluded from revenue.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds 3.00% then the Contractor shall make payment to the Department equal to the sum of 50% of the excess of the percentage over 3.00% plus 50% of the excess of the percentage over 10.00% applied to the amount of Medicaid premium income attributable to the contract. Such amount will be remitted to DMAS as a refund of an overpayment. To illustrate, if the underwriting gain is 9% then the Contractor shall refund to the Department 3.0% of Medicaid premium income. If the underwriting gain is 11% then the Contractor shall refund to the Department 4.5% of Medicaid premium income. If the underwriting gain is 4.0% then the Contractor shall refund to the Department 0.5% of Medicaid premium income.

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

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 Member months during the calendar year. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than 12 months of experience in the program at the beginning of the calendar year.
If the Contractor is required to make a payment to the Department under this Contract provision, the payment shall be due to the Department no later than December 1 of the following calendar year.

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

19.8 REINSURANCE

19.8.1 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 $175,000 attachment point will be aggregated/pooled across all Contractors participating in the CCC Plus 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 Medicare/TPL payment. The Contractor shall notify the Department quarterly of all Members whose prescription drug costs

have exceeded the $175,000 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 CCC Plus program and incurs additional costs.

The Department will allocate the aggregate/pooled reinsurance claims to each MCO on the basis of premium income. 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. Contractors are required to submit documentation for pharmacy reinsurance claims within thirty (30) calendar days of each quarter end for the first three quarters of the contract year. The documentation must be submitted using the file format and guidelines in the CCC Plus Technical Manual. The quarterly periods end on March 31, June 30, September 30 and December 31 of the contract year. The deadline for final quarter, ending December 31st, will be due March 31st of the following year, to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will determine and report the allocated/pooled amount quarterly by Contractor within sixty (60) calendar days of receipt of such documentation from all Contractors 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.

19.8.2 ARTS Stop Loss

Contractors are responsible for Addiction and Recovery Treatment Services (ARTS) in Section 4.2.3 and Attachment 5 (Summary of Covered Services) of this contract. Given the uncertainty of the potential cost of these services, the Department will implement a stop loss arrangement across all managed care programs that the Contractor participates in with the Department. The stop loss time frame shall cover services with dates of service beginning April 1, 2017 through June 30, 2018. Under this arrangement, the Department shall reimburse the Contractor for one hundred percent (100%) of the costs for ARTS that exceed one hundred twenty percent (120%) of the capitation payment for ARTS. Only ARTS services in the table are eligible for stop loss. The table includes the documentation necessary to identify the services eligible for stop loss and the method that will be used to value eligible costs. The services must be furnished consistent with the requirements in this contract.

New Services	Bill Type	Claim Coding	Stop Loss Pricing	Per Unit
Inpatient Hospital Services	UB	Revenue code 1002: HCPCS H0011, H2036	MCO Paid Amount	Discharge/Day

Residential Treatment Services	UB	Revenue Code 1002: HCPCS H2036, H0010	MCO Paid Amount	Day
Residential Group Home (currently covered only for pregnant women)	CMS	H2034	$175.00	Day
Peer Support Services-individual (eff July 1, 2017)	CMS	T1012	$6.50	15 minutes
Peer Support Services-group (eff July 1, 2017)	CMS	S9445	$2.70	15 minutes
Medication Administration	CMS	H0020	Encounter	$8.00
Medication Costs in Clinics	CMS	S0109, J0571, J0572, J0573, J0574, J0575, J2315	See DMAS rate structure	See DMAS rate structure
Services with Higher Rates				
Substance Use Care Coordination	CMS	G9012	$243.00	month
Substance Use Case Management	CMS	H0006	$243.00	month
Intensive Outpatient	CMS	H0015	$250.00	day (min 3 hours)
Partial Hospitalization	UB	S0201 (CMS 1500 claim); Revenue Code 0913 (UB04 claim)	$500.00	day (min 6 hours)
Opioid Treatment Services-Individual	CMS	H0004	$24.00	15 minutes
Opioid Treatment Services-Group	CMS	H0005	$7.25	15 minutes

The amount of the capitation payment for CCC Plus shall be determined using the ARTS adjustment by eligibility group as described in the memo from PwC at the link http://www.dmas.virginia.gov/Content_atchs/pr/FY17%20and%20CY17%20ARTS%20Adjustment%20Eff%20April%202017%2002.03.2017%20w%20Exhibits.pdf for the period April 1, 2017 through December 31, 2017. The amount of the capitation rate for the period January 1, 2018 through June 30, 2018 will be available December 2017. The appropriate capitation rate times the number of member months for which capitation payments are made in the period April

1, 2017 through June 30, 2018 shall constitute the capitation payment for ARTS. These payments will be combined with other capitation payments for ARTS for other Medicaid programs in which the Contractor participates.

Stop loss reimbursements shall be made annually. Contractors are required to submit documentation for reimbursable claims minus any Medicare/TPL along with an invoice by September 30, 2018, ninety (90) calendar days after the end of the state fiscal year. The Department will make stop loss reimbursements within sixty (60) calendar days of receipt of the documentation and invoice or provide notice to the Contractor if additional information is required.

19.9 CAPITATION RATES

19.9.1 Payment to the Contractor

In accordance with 42 CFR§ 438.3(c)(2) capitation payments shall only be made by the Department, and shall only be retained by the Contractor, for Medicaid eligible Members enrolled with the Contractor. The Department shall issue capitation payments on behalf of Members at the rates established in this Contract and modified during the annual contract renewal process. Except for amounts covered by reinsurance in 19.9, the Contractor shall accept the established capitation rate paid monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for June enrollment will occur in July, July payment will be made in August, etc.). Capitation rates for the CCC Plus program will be consistent with payment and contracting requirements under 42 CFR § 438 Subpart A. DMAS will use either FFS claims data or MCO encounter data to calculate PMPM costs from a two-year base period, and adjust for any policy and program changes between the base period and the rate year and trend to the rate year. DMAS will include adjustments for managed care and administrative costs.

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 including in instances where the Member moves to another locality. If the Member moves to a locality where the Contractor is not approved to participate, the Member will be dropped from the plan's enrollment at the end of the month of change.

In accordance with 42 CFR §438.6, capitation rate cells are based on several factors (e.g., eligibility group, age, locality, level of care, primary payer, etc.) and is automatically generated by the system using the information in the system at the time of payment.

The rate cells are included on the rate pages attached to this contract. The Department will utilize a blended rate for populations that meet Nursing Facility Level of Care criteria and receive services either in a nursing home setting or in the community under the CCC Plus Waiver, at the standard benefit (formerly referred to as the EDCD Waiver). The blended rate will be based on target percentages for the mix of Member months in nursing homes and the CCC Plus Waiver standard benefit that are designed to keep improving the percentage of Members in the community under the CCC Plus Waiver, standard benefit.

The Department will develop a budget neutral risk adjustment methodology to be applied retroactively to capitation payments made for nursing facility and CCC Plus Waiver, standard benefit Member months during the first six months of 2018. The methodology was described in a memorandum provided to the prospective Contractors dated December 16, 2016. Thereafter, blended capitation rates for the remaining six (6) months will be determined prospectively based on each plan's Nursing Facility/CCC Plus Waiver standard benefit population mix determined as of April 1, 2018 and the target mix percentage developed by the region.

In addition, the Department will risk adjust the rates for the Non-Dual Community No LTSS (ABD without LTSS) population retroactively for the first six (6) months of 2018 and prospectively for the last six (6) months of 2018 based on the CDPS risk adjustment model and the Member enrollment by Contractor and region on April 1, 2018.

In accordance with 42 CFR§ 438.604(a)(2); 42 CFR § 438.606; 42 CFR 438.3; 42 CFR§ 438.5(c), the Contractor shall be required to submit data, including encounter data, on the basis of which the Department certifies the actuarial soundness of the capitation rates to the contracted health plans, including base data that is generated by the contracted health plans.

The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments using the EDI X12 820 standard. The 820 Capitation Payment file will list all of the Members for whom the Contractor is being reimbursed. The 820 is processed on the last Friday of the calendar month and is available to the Contractor on the following Monday. The file includes individual Member month detail with current and retroactive capitation payment adjustments.

19.9.2 Performance Incentive Program

As part of setting expectations and benchmarks for VBP, the Department intends to undertake a robust stakeholder input and feedback process. The feedback received during this process will be taken into account in establishing expectations. The Department plans to include flexibility and opportunities for ongoing feedback to evolve with lessons learned during the implementation of VBP.

The Contractor shall meet expectations and benchmarks set by the Department as it implements VBP strategies. As part of the DMAS VBP Roadmap (currently under development), the Department will establish parameters for the performance incentive program, to be updated during the annual Contract renewal period. Such parameters will include the designation of benchmarks for CCC Plus key performance indicators, population-based targets, and select VBP requirements.

The Department may modify the performance incentive program but any changes would be reflected in a modification to the CCC Plus Contract.

There will be no performance incentive provided during the initial five (5) months of CCC Plus implementation (August 2017 through December 2017). Phase-in of the performance incentive program will begin in CY 2018, with a one percent (1%) quality withhold tied to sufficient reporting of core quality measures in two phases:

1) Phase 1: January 1, 2018 through June 30, 2018 - Contractors will be accountable for reporting all core quality measures for the LTSS population; and,
2) Phase 2: July 1, 2018 through December 31, 2018 - Contractors must report core quality measures for all CCC Plus populations.

Contractors that sufficiently report data for all core quality measures will earn back the entire one percent (1%) of the withhold percentage.

Contractors that fail to report data necessary to evaluate the core quality measures (i.e. do not sufficiently report core quality measures) will forfeit the entire one percent (1%) quality withhold for CY 2018.

The Department will notify Contractors of the process for submitting the core quality measures through separate guidance. This guidance shall include frequency that measures shall be reported and a process for communication with the Contractor should corrections be needed to data submissions. In the event the Contractor ultimately does not correct or resubmit sufficient data as outlined in this process, the Contractor will lose the one percent (1%) quality withhold for CY 2018.

Beginning CY 2019, the Department will modify the performance incentive program to account for Contractor performance, including achievement of designated VBP and population-based targets. Ongoing performance incentive program design will remain consistent with the goals outlined in the DMAS Quality Strategy and Value-Based Payment Roadmap (currently under development).

19.9.3 Modifications to Capitation Rates

DMAS 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 CCC Plus Contract.

Rates will be updated using a similar process for each calendar year. Mid-year rate changes may be implemented effective July 1, 2018 if the changes as a whole are material. Mid-year rate changes would be considered for budget changes effective July 1 that affect one or more adjustments to the capitation rates, any changes to contracts that are used as the basis for adjustments to the capitation rates, other policy changes or more current information necessary to calculate accurate payment rates for the Contract. Changes would be considered material if it exceeds 0.5 percent for any eligibility category. Changes will be applied, if necessary on a retrospective basis, to effectuate accurate payments for each month.

19.9.4 American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions of the American Recovery and Reinvestment Act of 2009.

19.9.5 Suspension of Payments

DMAS may suspend payments to Contractor in accordance with 42 CFR § 455.23 as determined necessary or appropriate by DMAS.

19.9.6 Rating Category Changes

The Capitation Rates will be updated following a change in a Member's status relative to the rate cell. As part of Capitation Payment processing, the rating category of each Member will be determined based on their status on the first day of the month.

19.9.7 Medicaid Capitation Reconciliation

DMAS will implement a process to reconcile Enrollment and Capitation Payments for the Contractor that will take into consideration the following circumstances:

- Transitions between rate categories;
- Retroactive changes in eligibility, rate categories, or Member contribution amounts, level of care, Member FIPS; and,
- Changes through new Enrollment, disenrollment, or death.

The reconciliation may identify underpayments or overpayments to the Contractor.

Retroactive adjustments to enrollment and payment 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 timelines of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment updates/corrections. DMAS shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

DMAS will reconcile payments related to the MEMA adjustment on a periodic basis.

19.9.8 Recoupment/Reconciliation

The Department shall recoup a Member's capitation payment for a given month in cases in which a Member's exclusion or disenrollment was effective retroactively. The Department shall not recoup a Member's capitation payment for a given month in cases in which a Member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to, death of a Member, cessation of Medicaid eligibility, or transfer to an excluded CCC Plus program Medicaid category, change in level of care status, and Member FIPS.

The Department shall recoup capitation payments made in error by the Department. The Contractor may recover any payments made for services provided to impacted Members from providers in accordance with the MCO's Contract with the Provider.

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 retroactive 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 payments on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter. The reconciliation payment adjustments will be reflected in the capitation payment process. See the CCC Plus Technical Manual for detailed information.

19.9.9 Audits/Monitoring

DMAS will conduct periodic audits to validate rate category assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by DMAS.

19.9.10 Payment in Full

The Contractor shall accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

Notwithstanding any contractual provision or legal right to the contrary, the parties to this Contract agree there shall be no redress against the other party, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Department, the Contractor shall rely on its own resource to project likely experience under the Contract.

19.10 CERTIFICATION (NON-ENCOUNTERS)

Any payment information from the Contractor that is used for rate setting purposes which has not been submitted through the Encounter Processing System of the Medicaid Enterprise System or any payment related data required by the State shall 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 shall use the *Certification of Data* form (attached), 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.

SECTION 20.0 APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in 42 CFR § 438.700 (a) the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 42 CFR §§ 438.700 through 724 allowing the Department to impose the sanctions provided therein.

The Contractor shall have all the appeal rights provided for in 42 CFR § 438.710.

20.1 CONTRACTOR RIGHT TO APPEAL

The Contractor shall have the right to appeal any adverse action taken by the Department. The Contractor may not submit to the Department for resolution under this section disputes relating to Medicaid eligibility requirements or covered services.

20.2 DISPUTES ARISING OUT OF THE CONTRACT

As provided for in *Code of Virginia* §2.2-4363, as amended, disputes arising out of this Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

20.3 INFORMAL RESOLUTION OF CONTRACT DISPUTES

For any dispute arising out of this Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

20.4 PRESENTATION OF DOCUMENTED EVIDENCE

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

SECTION 21.0 RENEWAL/TERMINATION OF CONTRACT

21.1 CONTRACT RENEWAL

The initial term of this Contract is August 1, 2017 through December 31, 2017 with automatic renewal thereafter for a period of five (5) calendar years, with the potential for up to five (5) 12-month extensions. The Contract is automatically renewed annually beginning the first day of each calendar year. The Contractor may elect not to renew its Contract with the Department at the end of the term of the Contract for any reason, provided it meets the timeframe for doing so set forth in the paragraph below in this section.

The Contractor may opt out of automatic renewal clause if it provides notice to the Department in writing at least six (6) full calendar months prior to the renewal. If the Contractor fails to notify the Department of the non-renewal on or before this date, the Contract will be automatically renewed.

At the Department's sole discretion and for good cause shown, a nonrenewal notice with less than six (6) full calendar months' notice may be accepted from the Contractor. The notice shall include an explanation of the Contractor's grounds for non-renewal and acceptance, if any, must be in writing from the Department. For it to be effective, the Contractor must receive from the Department a written acceptance of a nonrenewal of less than (6) six months.

21.2 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 CCC Plus 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.

21.3 TERMS OF CONTRACT TERMINATION

This Contract may be terminated in whole or in part:

1. By the Contractor, for convenience, with not less than one hundred eighty (180) calendar days advance written notice;
2. By the Department, for convenience, with not less than ninety (90) calendar days advance written notice;
3. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
4. By the Department, as specified below, if the Department determines that the instability of the Contractor's financial condition threatens delivery of MLTSS services and continued performance of the Contractor's responsibilities; or
5. By the Department, as specified below, if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

If at any time the CCC Plus contract is terminated by either the Contractor or the Department, the Contractor's D-SNP contract with the Department shall also be terminated.

Each of the conditions for Contract termination is described in the following paragraphs.

21.3.1 Termination for Convenience

The Contractor may terminate this Contract, with or without cause, upon one hundred eighty (180) calendar days advance written notice.

The Department may terminate this Contract, without cause, upon ninety (90) calendar days advance written notice.

21.3.2 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.

21.3.3 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 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.

21.3.4 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.

In the event that the Department determines that the Contractor's failure to perform its duties and responsibilities under this Contract results in a substantial risk to the health and safety of its Members, the Department may immediately terminate this Contract prior to providing notice to the Contractor.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure 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.

21.4 TERMINATION PROCEDURES

21.4.1 Continued Obligations of the Parties

In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Virginia Medicaid program, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Member at the time of such termination or withdrawal until the Member has been disenrolled from the Contractor's health plan. DMAS will disenroll the Member by the end of the month that termination, expiration, or non-renewal of this contract is effective.

21.4.2 Continuity of Services

The Contractor recognizes that the services under this contract are vital to DMAS and must be continued without interruption and that, upon contract termination, a successor, either DMAS or another Contractor, may continue them. The Contractor agrees:

1. To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
2. To make all DMAS owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and,
3. That DMAS shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.

The Contractor shall, upon written notice from DMAS, furnish phase-in/phase-out services for up to ninety (90) calendar days after this contract expires and shall negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the DMAS' approval.

The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the DMAS in writing prior to commencement of said work.

21.4.3 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.

21.4.4 Notification of Members

If DMAS elects to terminate or not renew the Contract, DMAS will notify all Members covered under this Contract of the date of termination and the process by which those Members will continue to receive care. In all cases of termination, the Contractor shall be responsible for notifying Members about the termination. All notifications from the health plan must be approved in advance. 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 DMAS issued notifications. The Contractor shall conduct these notification activities within a time frame established by the Department.

21.4.5 Transition of Membership

Upon cancelation of the contract in any region of the Commonwealth, the Department will:

1. Reassign individuals to the remaining health plans in the region if there are at least two (2) health plans still participating;
2. Within the first five (5) years of the CCC Plus Contract, offer participation to a qualifying health plan that responded to the Request for Proposal (RFP).

21.4.6 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 by the Department 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.

21.4.7 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.

SECTION 22.0 GENERAL TERMS AND CONDITIONS

22.1 NOTIFICATION OF ADMINISTRATIVE CHANGES

The Contractor shall notify DMAS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor shall notify DMAS in no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Members.

22.2 ASSIGNMENT

The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of DMAS.

22.3 INDEPENDENT CONTRACTORS

The Contractor, its employees, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the Department or its authorized agents.

22.4 BUSINESS TRANSACTION REPORTING

22.4.1 Proposed Acquisition or Purchase/Sale of Virginia Medicaid 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 Department requires the Contractor to provide with its written notice, and the following additional items to include from the potential purchaser within 180 days or upon reasonable certainty of, the proposed acquisition date, but in no case less than ninety (90) days of the proposed acquisition taking effect:

- A letter of intent which describes the purpose and manner of the sale;
- The letter must include the acquisition plan, method and terms (e.g. stock or asset transfer); a proposed effective date, copies of BOI and VDH approval, and NCQA certification;
- A detailed description of the parent/acquiring company to include health insurance history and experience, Medicaid managed care experience (including state Medicaid recommendations and sanctions, if any);
- A project plan including completion of any network development, information technology changes and requirements, and communications;
- An organizational chart indicating the retention of 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;
- A Member and provider education and outreach plan; and,
- A transition plan detailing (i) how the acquisition will or will not impact the Contractor's current processes, certifications and programs, including NCQA accreditation (ii) a list of subcontractors impacted or not impacted, and (iii) a communication plan for notifying the subcontractor(s) of changes (a detailed operational transition plan).

The Department reserves the right to request additional information concerning a proposed acquisition of an existing Medicaid health plan. Pursuant to 42 CFR § 438.66(d) the Department reserves the right to conduct a readiness review upon receipt of change of ownership notification when deemed necessary. The Department shall review the proposed acquisition when it has verified that all of the requested information is submitted and shall make every effort to issue a written response within ninety (90) days of the commencement of its review. Additionally, the Contractor shall notify the Department of business transactions associated with the Contractor's change of ownership.

22.4.2 Organizational Business Change

The Contractor shall advise the Department, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid business in Virginia or other states. Business transactions to be disclosed include, but are not limited to:

1) Any sale, exchange, or lease of any property between the Contractor and a party in interest;
2) Any lending of money or other extension of credit between the Contractor and a party in interest; and,
3) Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a party in interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

22.5 LOSS OF LICENSURE

If, at any time during the term of this Contract, the Contractor or any of its Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary Federal or State approvals, the Contractor shall report such loss to DMAS. Such loss may be grounds for termination of this Contract.

22.6 INDEMNIFICATION

The Contractor shall indemnify and hold harmless the Commonwealth of Virginia, and DMAS from and against any and all liability, loss, damage, costs, or expenses which DMAS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its subcontractors provided that:

1. The Contractor is notified of any claims within a reasonable time from when CMS and DMAS become aware of the claim; and,
2. The Contractor is afforded an opportunity to participate in the defense of such claims.

22.7 CONFLICT OF INTEREST

For the duration of this Contract, neither the Contractor nor its subcontractors may have any interest that will conflict, as determined by DMAS with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, DMAS requires that neither the Contractor nor its subcontractor have any financial, legal, contractual, or other business interest in any entity performing CCC Plus program enrollment functions for DMAS or Related Entity(ies), if any.

22.8 INSURANCE FOR CONTRACTOR'S EMPLOYEES

The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide DMAS with certification of same upon request. The Contractor, and its professional personnel providing services to Members, shall obtain and maintain appropriate professional liability insurance coverage. The Contractor shall, at the request of DMAS, provide certification of professional liability insurance coverage.

22.9 IMMIGRATION AND CONTROL ACT OF 1986

By signing this Contract the Contractor certifies that they do not and shall not during the performance of this Contract employ illegal alien workers or otherwise violate the provisions of the Federal Immigration Reform and Control Act of 1986.

22.10 SEVERABILITY

Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. The Department and the Contractor further agree that in the event any provision is deemed invalid, they shall immediately begin negotiations for a suitable replacement provision.

22.11 ANTI-BOYCOTT COVENANT

During the time this Contract is in effect, neither the Contractor nor any affiliated company shall participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by the *Code of Virginia* § 38.2-505 . Without limiting such other rights as it may have, DMAS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51) percent of the ownership interests of the Contractor.

22.12 RECORD RETENTION, INSPECTION, AND AUDITS

Consistent with Federal managed care regulations at 42 CFR 438.3(u), the Contractor shall maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years.

In accordance with 12VAC30-120-1730, for Members who are children under age 21 and enrolled in the Tech program, the Contractor shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years <u>after</u> the minor has reached 21 years of age.

Consistent with Federal managed care regulations 42 CFR § 438.3(h), the Contractor shall make the records maintained by the Contractor and its Provider Network, as required by the Department and other regulatory agencies, available to the Department and its agents, designees or contractors or any other authorized representatives of the Commonwealth of Virginia or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and

the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its subcontractors that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or, determinations of amounts payable.

The Contractor shall make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Members, and any additional relevant information that the Department may require, in a manner that meets the Department's record maintenance requirements.

The Contractor shall comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

22.13 OPERATION OF OTHER CONTRACTS

Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder. However, the Contractor shall provide the Department with a complete list of such plans and services, upon request. The Department will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law.

Nothing in this Contract may be construed to prevent DMAS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

22.14 PREVAILING CONTRACT

This Contract supersedes all prior agreements, representations, negotiations, and undertakings not set forth the Contract or incorporated herein. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

22.15 NO THIRD-PARTY RIGHTS OR ENFORCEMENT

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

22.16 EFFECT OF INVALIDITY OF CLAUSES

If any clause or provision of this Contract is in conflict with any Federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

22.17 APPLICABLE LAW

The term "applicable law," as used in this Contract, means, without limitation, all Federal and State law, and the regulations, policies, procedures, and instructions of CMS and DMAS all as existing now or during the term of this Contract.

22.18 SOVEREIGN IMMUNITY

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Virginia of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

22.19 WAIVER OF RIGHTS

The Contractor or DMAS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor or DMAS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by the Department of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

22.20 INSPECTION

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

22.21 DEBARMENT STATUS

By signing this Contract the Contractor certifies that they are not currently debarred by the Commonwealth of Virginia or any other Federal, State or local government from entering into contracts for the type of services covered herein, nor are they an agent of any person or entity that is currently so debarred.

22.22 ANTITRUST

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said Contract.

22.23 DRUG-FREE WORKPLACE

For the purposes of this section, “drug-free workplace” means a site for the performance of work done in connection with this Contract, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the Contract. During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor’s employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Business Associate maintains a drug-free workplace; and, (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Vendor.

SECTION 23.0 DEFINITIONS AND ACRONYMS

Listed below are the Definitions and Acronyms used in this CCC Plus Contract. These terms utilize the meaning used in the CCC Plus program rules and 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. In the event of a conflict in language between these Definitions, Attachments, and other sections of this Contract, the specific language in the Contract shall govern.

23.1 DEFINITIONS

Abuse – Either: (1) Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid program; or, (2) the suspected or known physical or mental mistreatment of a Member which must be reported immediately upon discovery.

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

Activities of Daily Living (ADLs) - Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs. Also see Instrumental Activities of Daily Living (IADLs).

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

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

Administrative Dismissal – A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings. Administrative dismissal also means the dismissal of a Member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse benefit determination from the MCO.

Adult Day Health Care (ADHC) – Long term maintenance or supportive services offered by a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those individuals enrolled in the CCC Plus Waiver who are older adults or who have a disability and who are at risk of placement in a Nursing Facility (NF). The program shall be licensed by the Virginia Department of Social Services

(VDSS) as an adult day care center (ADCC). The services offered by the ADCC shall be required by the individual receiving the CCC Plus Waiver in order to permit the individual to remain in his/her home rather than entering a NF.

Adverse Benefit Determination – Pursuant to 42 CFR § 438.400, means any of the following: (i) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) for a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Agency-Directed Services - A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

Agency Provider - A public or private organization or entity that holds a Medicaid provider agreement and furnishes services to individuals using its own employees or subcontractors.

Alzheimer's Assisted Living (AAL) Waiver - CMS-approved home and community-based services (HCBS) waiver that covers a range of community support services offered to individuals who have a diagnosis of Alzheimer's or related dementia (without a diagnosis of intellectual disability or serious mental illness), are over age 55, who meet Nursing Facility level of care, and are receiving an Auxiliary Grant. The AAL waiver participants are not eligible for the CCC Plus program. The AAL Waiver will discontinue on June 30, 2018. At that time, individuals who were enrolled in the AAL Waiver may become enrolled in the CCC Plus program if they meet the eligibility requirements of the program.

Appeal – In accordance with 42 CFR § 438.400, a Member appeal is defined as a request for review of a Contractor's internal appeal decision to uphold the Contractor's adverse benefit determination. For Members, an appeal may only be requested after exhaustion of the Contractor's one step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 CFR § 431 Subpart E, 42 CFR §438 Subpart F, and 12 VAC 30-110-10 through 12 VAC 30-110-370. For providers, a provider appeal is a request made by a Contractor's 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) 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.).

Assess - To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the

individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

Assessment - Processes used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the person-centered Individualized Care Plan (ICP) and the determination of whether an individual requires HCBS waiver services.

Assistive Technology - Specialized medical equipment and supplies including those devices, controls, or appliances specified in the ICP, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs/IADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual's assessed needs.

Attendant - An individual who provides consumer-directed personal assistance, respite or companion services through a consumer-directed model.

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

Authorized Representative - A person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

Behavioral Health Home – A team based services delivery model that provides comprehensive and continuous care to patients, including care coordination, with the goal of maximizing health outcomes. For this Contract, Health Homes will not need to meet the standards set forth in §2703 of the Patient Protection and Affordable Care Act.

Behavioral Health Inpatient Services – Acute psychiatric services provided to Members in a secured facility setting.

Behavioral Health Outpatient Services – Non-acute psychiatric services that are provided to Members in a variety of non-facility based settings including community settings.

Behavioral Health Services - An array of therapeutic services provided in inpatient and outpatient psychiatric and community mental health settings. Services are designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Behavioral Health Services Administrator (BHSA) - An entity that is contracted to manage or direct a behavioral health benefits program. The BHSA is responsible for administering the Department's behavioral health benefits, including care coordination, provider management, and reimbursement of such behavioral health services.

Birth Injury Fund - Virginia Birth-Related Neurological Injury Compensation Fund is commonly known as the Birth Injury Fund. More information can be found at: https://www.vabirthinjury.com/why-the-birth-injury-program .

Building Independence (BI) Waiver – The CMS-approved HCBS § 1915 (c) waiver whose purpose is to provide support in the community for individuals 18 years of age or older who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by DMAS and DBHDS.

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

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

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

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

Caregiver - A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends, or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

Care Coordination (also known as Care Management) – The Contractor's responsibility of assessing and planning of services; linking the Member to services and supports identified in the individualized care plan (ICP); 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; making collateral contacts to promote the implementation of the ICP and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling that guides the Member and develops a supportive relationship that promotes the ICP (also see *Targeted Case Management*).

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

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

Certified Community Behavioral Health Clinics (CCBHCs) – An opportunity for states to improve the behavioral health of their citizens by: providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improving access to high quality care. See http://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf for additional information.

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

Claim – An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500 or UB-92.

Clean Claim - 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.

Clinical Laboratory Improvement Amendments (CLIA) – A laboratory testing program regulated by the Centers for Medicare & Medicaid Services and implemented by the Division of Laboratory Services under the Center for Clinical Standards and Quality. CLIA covers approximately 254,000 laboratory entities. CLIA defines a clinical laboratory as any facility which performs laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention, or treatment of disease or impairment.

Cold Call Marketing – Any unsolicited personal contact by the Contractor with a potential Member for the purpose marketing.

Common Core –Refers to the subset of the Contractor's formulary that includes all the preferred drugs from the Department's Preferred Drug List (PDL).

Commonwealth Coordinated Care (CCC) Program – The Department's capitated, managed care, financial alignment demonstration model, administered under the Center for Medicare & Medicaid Innovation authority. Virginia operates the CCC program with CMS under a

Memorandum of Understanding (MOU) and a three-way contract between DMAS, CMS and contracted Medicare-Medicaid Plans (MMPs). The CCC program will end on December 31, 2017. Additional information is available at: http://www.dmas.virginia.gov/Content_pgs/valtc.aspx.

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 four (4) of the Department's five (5) home and community-based services (HCBS) 1915(c) waivers (the Alzheimer's Assisted Living (AAL) Waiver individuals are not eligible for the CCC Plus program).

Commonwealth Coordinated Care Plus (CCC Plus) Waiver – The Department's Home and Community Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two benefit plans: the standard benefit plan (formerly known as EDCD Waiver) and the tech assisted benefit plan (formerly known as the Technology Assisted Waiver). Individuals who are enrolled in the tech assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the CCC Plus program.

Community-Based Organizations (CBOs) – Organizations such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) that have historically formed the backbone of the HCBS delivery system for seniors and adults with physical disabilities. CBOs provide long-term services and supports (LTSS), care planning, and care coordination using a variety of funding sources including Federal funds and State appropriations, and frequently local funds.

Community-Based Team (or CBT): Community based screening team. A nurse, social worker or other assessors designated by DMAS and a physician who are employees of, or contracted with, VDH or the LDSS. CBTs conduct screenings for adults and children who live in the community and are not currently inpatients.

Community Living (CL) Waiver – The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to 6 years of age who are at developmental risk and individuals age 6 and older who have Developmental Disability (DD) and meet the ICF/IID level of care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver.

Community Service Board (CSB)/Behavioral Health Authority (BHA) - A citizens' board established pursuant to Virginia Code §37.2-500 (http://leg1.state.va.us/cgi-

bin/legp504.exe?000+cod+37.2-500) and §37.2-600 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-600) that provides mental health, developmental disability and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases, the term CSB also includes Behavioral Health Authority (BHA).

Complaint – a complaint means an expression of dissatisfaction by a member, family member, care giver, provider, etc., about any matter other than an "adverse benefit determination."

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

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

Consumer-Directed (CD) Services – HCBS (personal care and respite services) for which the CCC Plus Waiver individual or his or her representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) - The Medicaid enrolled provider who is responsible for supporting the CCC Plus Waiver Member or his or her representative, as appropriate, by ensuring the development and monitoring of the ICP, providing employee management training, and completing ongoing review activities as required by DMAS for CCC Plus Waiver Members who are consumer-directing.

Contract - This signed and executed CCC Plus program document resulting from the RFP, issued and awarded, including all attachments or documents incorporated by reference.

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

Contractor - A managed care health plan selected by the Department and contracted by execution of this Contract to participate in the CCC Plus program in accordance with the RFP award.

Cost Sharing – Coinsurance and deductibles. Also see definition for "Patient Pay."

Covered Services – Services as outlined in this Contract that the Contractor shall cover for its enrolled Members.

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

Critical Incident - 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 incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member.

Crisis Intervention Services – Immediate mental health care, available 24 hours per day, seven (7) days per week, to assist Members who are experiencing acute psychiatric dysfunction requiring immediate clinical attention.

Crisis Stabilization Services – Direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature 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 Members in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Cultural Competence – Understanding those values, beliefs, and needs that are associated with the Member's age, gender identity, sexual orientation, and/or racial, ethnic, or religious background. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for the Member and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

Days – Business days, unless otherwise specified.

Day Support Services - Training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level. This is different from Adult Day Health Care (ADHC).

Day Treatment/Partial Hospitalization – Time limited interventions that are more intensive than outpatient services and are required to stabilize a Member's psychiatric condition. The services are delivered when a Member is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for Members with serious mental health disorders.

Delivery System Reform Incentive Payment (DSRIP) - DSRIP provides financial incentives to states, based off of the achievement of agreed upon metrics and measures. DSRIP is intended to dramatically improve health care quality, contain costs, and maximize the value of health care investments, particularly for Medicaid populations. DSRIP financing is to help Medicaid programs achieve delivery system transformation through infrastructure development and

support, serving as provider-based building blocks for other broader health care transformation efforts.

Department of Behavioral Health and Developmental Services (DBHDS) – DBHDS is the state agency responsible for coordination of behavioral health, developmental disabilities, and substance use services through the local community services boards (CSBs). This agency has responsibility for the day-to-day operations of the Community Living Waiver, Family and Individual Supports Waiver, and the Building Independence Waiver. DBHDS also serves as the state Lead Agency for Virginia's early intervention system and is responsible for certification of early intervention providers and service coordinators/case managers.

Department of Health Professions (DHP) – 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.

Developmental Disability (DD) Waivers – The CMS-approved HCBS §1915(c) waivers for individuals with developmental disabilities. The individuals are enrolled in either the Building Independence (BI), Community Living (CL), or the Family and Individual Supports (FIS) Waivers.

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

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

Drug Efficacy Study Implementation (DESI) – 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.

Dual Eligible Individuals – A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as Specified Low-Income Medicare Member (SLMBs), Qualified Medicare Member (QMBs), Qualified Disabled and Working Individuals (QDWIs), or Qualifying Individuals (QIs)) are not included in the CCC Plus program.

Dual Eligible Special Needs Plan (D-SNP) - A type of Medicare Advantage (MA) plan that enrolls only dual eligible individuals in Medicare and Medicaid.

Durable Medical Equipment (DME) - Medical equipment, supplies, and appliances consistent with 42 CFR § 440.70(b)(3).

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under 21 years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

Early Intervention (EI) - Early Intervention (EI) services are provided through Part C 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 to age three years 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. 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.

Electronic Visit Verification (EVV) - Home visit tracking systems that verify service visits occurring in the home or in the community and document the precise time the provision of service begins and ends.

Emergency Custody Order (ECO) – Judicial intervention to order law enforcement personnel to take into custody and transport for needed mental health evaluation and care or medical evaluation and care a person who is unwilling or unable to volunteer for such care pursuant to 42 CFR § 441.150 and *Code of Virginia*, § 16.1- 335 et seq, § 37.2-808, § 16.1-340 (Juvenile), § 37.2-1103 (Medical), and § 16-1.340 (Court). A magistrate is authorized to order such custody

on an emergency basis for short periods. Different emergency custody statutes apply to adults than to juveniles.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services - Those health care services that are rendered by participating or non-participating providers qualified to furnish these services, 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: (1) placing the Member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior, and these services are needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR § 438.114.

Emerging High Risk Subpopulation– Individuals who have no current medical, behavioral health, or long-term services and supports (LTSS) needs but may have needs in the future. Refer to *Model of Care, Element #1.o.*

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

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

Encounter Data – Data collected by the Contractor that documents all of the health care and related services provided to a Member. These services include, but are not limited to, professional services, medical supplies or equipment, and medications. Encounter data is collected on an individual Member level and includes the person's Medicaid ID number. It is also specific in terms of the provider, the medical procedure, and the date the service was provided. DMAS and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring managed care plan's performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

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

Enhanced Benefits - Benefits that the Contractor may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor's capitation rate.

Enrollment (CCC Plus Program) - Assignment of an individual to a health plan by the Department in accordance with the terms of this Contract. This does not include attaining eligibility for the Medicaid program.

Enrollment (Waiver) - The process whereby an individual has been determined to meet the eligibility requirements (financial and functional and medical/nursing) for a service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a HCBS waiver, effective the first day a waiver service is rendered. This does not include attaining eligibility for the Medicaid program.

Enrollment Broker - An independent entity that is the beneficiary support system used to enroll individuals in the Contractor's health plan and is responsible for the operation and documentation of a toll-free helpline. The responsibilities of the Enrollment Broker include, but are not limited to, education and enrollment, assistance with and tracking of individuals' grievance resolutions, and may include marketing and outreach.

Enrollment Period – The period of time that a Member is enrolled with a health plan.

Electronic Pre-Admission Screening (ePAS) – DMAS web portal that streamlines submission and payment for screening activities. The ePAS system has the capacity to upload fillable UAI and other screening forms. Screening teams may access ePAS via the Internet and enter the information directly into the system while the screening is being conducted. Reference the DMAS Screening Manual available on the Virginia Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov.

Excluded Entity – Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined by Federal requirements set forth in 42 CFR § 438.610.

Expedited Appeal – The accelerated process by which the Contractor must respond to an appeal by a Member if a denial of care decision by the Contractor may jeopardize life, health or ability to attain, maintain or regain maximum function.

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

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

Family and Individual Supports (FIS) Waiver – The CMS-approved home and community-based §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to 6 years of age who are at developmental risk and

individuals age 6 and older who have a Developmental Disability (DD) and meet the ICF/IID level of care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

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

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

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

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

First Tier, Down Stream, and Related Entities - Any party that enters into a written arrangement, acceptable to DMAS, with the Contractor to provide administrative services or health care services to a CCC Plus program Member; or any party that enters into a written arrangement, acceptable to DMAS, with persons or entities involved with providing CCC Plus benefits, below the level of a first tier entity; or, a related entity by ownership and control. A sub-contractor relationship or related entity that could impact the Contractor's ability to comply with the requirements of this Contract.

Fiscal/Employer Agent (F/EA) - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 that has a separate Federal Employer Identification Number used for the sole purpose of filing Federal employment tax forms and payments on behalf of program individuals who are receiving CD services.

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).

Formal Support – Services provided by professional, trained employees, typically paid for their work, such as the personal care attendant who helps with bathing.

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

Former Foster Care and Fostering Futures – For the purposes of this Contract, these individuals are enrolled in Aid Category 70. Depending on which group (Title IV-E or Non IV-

E), their eligibility ranges from age 18 to 26. These individuals were formerly covered under a Foster Care designation. Refer to Section 3.2.6.

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 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.

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

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

Health and Acute Care Program (HAP) – One of the Department's managed care programs that provides acute and primary medical services to individuals enrolled in the HCBS waivers. Waiver services are paid as carved out services. HAP individuals other than individuals in the Alzheimer's Assisted Living (AAL) Waiver will transition to the CCC Plus program during the CCC Plus regional launch.

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

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

Health Risk Assessment - A comprehensive assessment of a Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, long-term services and supports (LTSS), and social needs.

Home and Community-Based Services (HCBS) Waivers - A variety of home and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive one or more of these services either

solely or in combination, based on the documented need for the service or services to avoid institutional (Nursing Facility) placement. The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid program. States can offer a variety of services under a HCBS waiver. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Hospice – As defined § 32.1-162.1 of the *Code of Virginia*, a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. Children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. A hospice utilizes a medically directed interdisciplinary team. A hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care shall be available twenty-four hours a day, seven days a week.

Hospital Team – Hospital screening team. Persons designated by an acute care hospital, rehabilitation hospital, or a rehabilitation unit in an acute care hospital who are responsible for conducting and submitting the screening for individuals that are inpatients to DMAS' automated system (electronic Pre-Admission Screening; ePAS) or other approved system. Hospital teams conduct screening for adults and children who are inpatients.

Indian Health Care Provider (IHCP) – Includes providers from Indian Health Services (IHS) or an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U). Also refer to definition of Native American.

Individualized (Person-Centered) Care Plan (ICP) – The Contractor's comprehensive written document developed with a Member that specifies the Member's services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the Member's strengths, skills, needs, preferences, and goals. The ICP includes all aspects of an individual's care needs including, but not limited to, medical, behavioral, social, and long term services and supports, as appropriate.

Individualized Education Program (IEP) – A written statement for a child with a disability 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.

Informal Support – The support provided by a Member's social network and community, such as family, friends, faith-based organizations, etc., and is typically unpaid.

Infant and Toddler Online Tracking System (ITOTS) – Data system that collects early intervention eligibility information from the 40 local lead agencies; meets Section 618 Federal reporting requirements for Part C of the Individuals with Disabilities Education Act (IDEA).

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

Instrumental Activities of Daily Living (IADLs) - Activities such as meal preparation, shopping, housekeeping, laundry, and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of level of care and service needs. Also see Activities of Daily Living (ADLs).

Intensive Community Treatment Services – An array of mental health services for Members with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Services are designed to be provided through a designated multi-disciplinary team of mental health professionals. Services are available either directly or on call 24 hours per day, seven days per week and 365 days per year.

Intensive In-Home Services (IIH) for Children/Adolescents Under Age 21 – Time-limited interventions provided in the Member's residence and when clinically necessary in community settings. IIH services are designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of a Member who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the Member.

Intensive Outpatient (IOP) Substance Use Disorder Services – Services shall include the major psychiatric, psychological and psycho-educational modalities: individual and group counseling; family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the Member; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for Members are provided in a non-residential setting.

Interdisciplinary Care Team (ICT) - A team of professionals that collaborate, either in person or through other means, to develop and implement a person-centered Individualized Care Plan (ICP) built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and

meets the medical, behavioral, LTSS, early intervention, and social needs of Members. ICTs include the MCO Care Coordinator and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, early intervention Care Coordinators/providers, social workers and other appropriate entities for the individual's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – A facility licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to 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 Members toward the achievement of a more independent level of functioning.

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

Investigation – As used in this Contract related to program integrity activities, an investigation is a review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. The Department reserves the right to expand upon any investigation.

Laboratory - A place performing tests for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 CFR § 493.3, as amended.

Level of Care (LOC) – The specification of the minimum amount of assistance that an individual requires in order to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive CCC Plus Waiver services.

Level of Care Review – The periodic, but at least annual, review of a Member's condition and service needs to determine whether the Member continues to need a level of care specified by a waiver. Also referred to as Level of Care Review Instrument (LOCERI). Also see the definition for nursing facility annual reassessment. For more information about LOCERI, including the Level of Care User Guide and Tutorial, is available on the Virginia Medicaid Web Portal, Provider Resources tab, at: https://www.virginiamedicaid.dmas.virginia.gov.

List of Excluded Individuals and Entities (LEIE) - When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs, information about the provider is entered into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type,

and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Local Lead Agency - An entity that, under contract with the DBHDS, administers a local early intervention system. The DBHDS contracts with forty (40) local lead agencies to facilitate implementation of local early intervention services statewide.

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

Long Term Acute Care Hospitals (LTAC) – A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in treating patients with serious and often complex medical conditions. DMAS recognizes these facilities as acute care facilities and are covered under this Contract.

Long Term Services and Supports (LTSS) – Includes hospice, nursing facility, and CCC Plus Waiver covered services.

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

Managed Long Term Services and Supports (MLTSS) Manuals – Documents developed by the Department that provide the specifications for the submission of provider networks, encounters, and other contract deliverables, including monthly, quarterly, annual, and other required reports. In addition, the Manuals provide information on enrollment files, payment files, and DMAS-generated files.

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 – In accordance with 42 CFR § 438.104 means any communication, from an MCO to a Medicaid Member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the Member to enroll in that particular MCO's Medicaid product, or either to not enroll in or to disenroll from another MCO's Medicaid product.

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

Marketing, Outreach, and Member Communications – Any informational materials targeted to Members that are consistent with the definition of marketing materials at 42 CFR § 438.104.

Medallion 3.0 – The Department's statewide mandatory Medicaid program which operates under a CMS §1915(b) waiver and utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. Medallion 3.0 serves over 600,000 individuals: children, care taker parents, and pregnant women. Individuals classified as Aged, Blind or Disabled (ABD) or in HAP (except those in the Alzheimer's Waiver) and have been enrolled in Medallion 3.0 will transition to the CCC Plus program no later than January 1, 2018.

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

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

Medicaid Enterprise System (MES) – The Department's modernized technology system which will replace the current Medicaid Management Information System (MMIS).

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

Medicaid Management Information System (MMIS) – The medical assistance and payment information system of the Department. This system will be replaced with the MES upon completion of the redesign.

Medicaid Works Program - A voluntary Medicaid plan option that enables workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid.

Medically Necessary or Medical Necessity – Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee's condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21), and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Medication Monitoring - An electronic device only available in conjunction with Personal Emergency Response Systems (PERS) that enables certain waiver individuals who are at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

Medicare – Title XVIII of the Social Security Act, the Federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment (DME), and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare Member with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Medicare Advantage - (Medicare "Part C") - Sometimes referred to as "MA Plans," includes all of an individual's Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Medicare Part A – Insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Medicare Part B – Insurance that helps cover medically-necessary services like doctors' services, outpatient care, durable medical equipment (DME), home health services, and other medical services. Part B also covers some preventive services.

Medicare Part D – Medicare prescription drug coverage.

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

Member Handbook – Document required by the Contract to be provided by the Contractor to the Member prior to the first day of the month in which their enrollment starts. Refer to *Member Outreach and Marketing* for more information.

Member Medical Record – Documentation containing medical history, including information relevant to maintaining and promoting each Member's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

Mental Health Skill-Building Services – Goal directed training to enable Members to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services shall include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the Member's health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Minimum Data Set (MDS) - Part of the federally-mandated process for assessing individuals receiving care in Certified Nursing Facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for Nursing Facility residents to return to community settings. All Medicare and Medicaid certified nursing facilities were required to use the MDS 3.0.

Model of Care – A comprehensive plan that describes the Contractor's population; identifies measurable goals for providing high quality care and improving the health of the enrolled population; describes the Contractor's staff structure and care coordination roles; describes the interdisciplinary care team; system of disseminating the Model to Contractor staff and network providers; and, provides other information designed to ensure that the Contractor provides services that meet the needs of Members.

Money Follows the Person (MFP) - Demonstration project designed to create a system of long term services and supports that better enable individuals to transition from certain institutions into the community. To participate in MFP, individuals must: 1) have lived for at least 90 consecutive days in a Nursing Facility, an intermediate care facility for persons with intellectual disabilities (ICF/ID), a long-stay hospital licensed in Virginia, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof; and, 2) move to a qualified community-based residence. The MFP program will cease new enrollments effective December 31, 2017. Individuals enrolled in MFP are not eligible for the CCC Plus program.

Monitoring - The ongoing oversight to determine that services are administered according to the individual's ICP and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include, but are not limited to, telephone contact; observation; interviewing the Member and/or the Member's family, as appropriate, in person or by telephone; and/or interviewing service providers.

Monthly – For the purpose of Contract reporting requirements, monthly 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 monthly reports are due by March 15th, etc.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

National Practitioner Data Bank (NPDB) – The NPDB, maintained by the U.S. Health Resources and Services Administration (HRSA), is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. Although the NPDB includes unique identifiers, to protect sensitive information, it is available only to registered users whose identities have been verified. The NPDB will also include information that is in the Healthcare Integrity and Protection Data Bank (HIPDB) when the two data banks are consolidated. The HIPDB is also a source of exclusion information.

National Provider Identifier (NPI) - NPI is a national health identifier for all health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in CCC Plus program will be required to have and use an NPI.

Native American – For the purposes of this Contract, this terminology is used interchangeably with the population referenced in 42 CFR § 438.14, and who is recognized as an Indian (as that term is defined in Section 4(c) of the Indian Health Care Improvement Act of 1976 (25 USC 1603(c)).

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

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

Nursing Facility (NF)/"Certified Nursing Facility" - Any skilled nursing facility, skilled care facility, intermediate care facility, nursing 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.

Nursing Facility Annual Reassessments - Annual reassessments (functional and medical/nursing needs) for continued Nursing Facility placement, including the incorporation of all MDS guidelines.

Ombudsman – The independent State entity that will provide advocacy and problem-resolution support for CCC Plus program 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). To coincide with Medicare open enrollment, for CCC Plus Members, open enrollment will occur during October, November and December for a January 1st effective date. Within sixty (60) calendar days prior to the open enrollment begin date, the Department will inform Members of the opportunity to remain with the current plan or change to another plan without cause. Those Members who do not choose a new health plan during the open enrollment period shall remain in his or her current health plan selection until their next open enrollment period.

Out-of-Network – Coverage provided outside of the established MCO network. Medical care rendered to a Member by a provider not affiliated with the Contractor or its subcontractors.

Patient Pay - When an individual's income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals residing in a NF (skilled or custodial) and for those enrolled in waivers. Patient pay is required to be calculated for every individual (including Native Americans) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be the responsibility of the Contractor and shall be outlined in the Contractor's provider agreement.

Person with Ownership or Control Interest – In accordance with 42 CFR §455 Subpart B, 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. See *Prohibited Affiliations* section of this Contract for more information.

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

Personal Care Provider – A provider that renders personal care services to an eligible Member in order to prevent or reduce institutional care.

Personal Care Services - A range of support services necessary to enable the waiver individual to remain at or return home rather than enter a nursing facility and includes assistance with ADLs, IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care services shall be provided by personal care aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model or by consumer directed attendants under the CD model of service delivery.

Personal Emergency Response System (PERS) - An electronic device and monitoring service that enables certain individuals at risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS Provider - An entity that meets the standards and requirements set forth by DMAS to provide PERS equipment, direct services, and PERS monitoring. PERS providers may also provide medication monitoring.

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

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

Post Stabilization Services – Covered services related to the Member's underlying condition that are provided after a Member's Emergency Medical Condition has been stabilized and/or under the circumstances described in 42 CFR § 438.114(e).

Potential Member – A Medicaid Member who is subject to mandatory enrollment (42 CFR § 438.10(a))

Pre-Payment Review - A type of program integrity activity that requires a provider to submit additional documentation to support a billed claim before that claim is processed for payment. Pre-payment review is often focused on a claim type, a provider type, or a specific provider based on an indication that additional scrutiny is needed. It may be used after identifying an area/provider that presents a program integrity risk, or prior to evidence of risk, in order to mitigate potential issues.

Prevalent Language – When five (5) percent or more of the Contractor's enrolled population in any participating region is non-English speaking and speaks a common language other than English.

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

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

Primary Caregiver - The primary person who consistently assumes the role of providing direct care and support of the Member to live successfully in the community without compensation for providing such care.

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 of All-inclusive Care for the Elderly (PACE) - PACE provides the entire spectrum of medical (preventive, primary, acute) and long term services and supports to their enrollees without limit as to duration or dollars. PACE participants are excluded from the CCC Plus program.

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

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

Provider Network – A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance use providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. Also see Network Provider.

Provider Preventable Condition – (also called Provider Preventable Event) - A condition that (1) meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 CFR § 447.26(b); and/or (2) a hospital acquired condition or a condition occurring in any health care setting that has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the beneficiary, and is auditable. The Department's policy regarding Provider Preventable Conditions is set out in 12 VAC 30-70-201 and 12 VAC 30-70-221.

Psychosocial Rehabilitation Services – A treatment program of two or more consecutive hours per day provided to groups of adults in a non-residential setting. Members must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the Member about mental illness, substance use disorders (SUD), and appropriate medication to avoid complication and relapse and opportunities to learn and use independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Qualifying CCC Plus Waiver Services – Qualifying Services can be authorized as *stand-alone* services. Qualifying services include: ADHC, personal care, respite, and private duty nursing services. The following CCC Plus Waiver services are not qualifying waiver services: AT, EM, and PERS, and must be authorized in conjunction with at least one *qualifying* CCC Plus Waiver service.

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

Quality Incentive – The portion of a Contractor's capitation payments at-risk in a given Contract period based on performance on quality metrics, population-based performance targets and VBP requirements as designated by the Department.

Quality Management Review (QMR) – An on-site visit and/or desk review of the Contractor conducted by the Department to assure the health and safety of waiver participants and compliance with Federal waiver assurances.

Quarterly – For the purpose of Contract reporting requirements, quarterly shall be defined as within thirty (30) calendar days after the end of each calendar quarter. Calendar quarters begin on January 1, April 1, July 1, and October 1 of each year.

Reassessment – For Members enrolled in a waiver or a Nursing Facility, the periodic (in accordance with waiver requirements), face-to-face review of a Member's condition and service needs.

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

Residential Services (Community Based) for Children and Adolescents Under 21 (Level A) – A combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the Member's person-centered individualized care plan (ICP). The Member must also receive at least weekly individual psychotherapy services in addition to the therapeutic residential services.

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

Resource Utilization Groups (RUGS) – Based on information acquired from the Nursing Minimum Data Set, the RUGS score is developed. RUGS reflects the exclusive categories of a Nursing Facility resident's level of resource need (based on their functional and cognitive status) which are used to facilitate payment. For the purposes of this contract, RUGS refers to the version in use by the Department on the date of service.

Respite Care Provider - Agency provider that renders respite services designed to provide periodic or routine relief for unpaid primary caregivers under the CCC Plus Waiver.

Respite Services - Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care. Respite services may refer to skilled nursing respite or unskilled respite.

Rural Area - DMAS will follow the CMS MA HSD reference guide, available at: https://www.cms.gov/Medicare/Medicare Advantage/MedicareAdvantageApps/index.html. DMAS defines rural as micro, rural, and CEAC areas. DMAS will post a table that identifies VA rural and urban localities at: http://www.dmas.virginia.gov/Content_pgs/mltssihp.aspx.

Rural Exception - A rural area, as defined within this Contract (see Rural Area definition), and 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.

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

Screening - The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for screening for certain long term services requiring Nursing Facility eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual's needs; and, (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet Nursing Facility level of care.

Screening Team - The entity contracted with DMAS that is responsible for performing screenings for Nursing Facilities or, if qualified, waiver services pursuant to the *Code of Virginia* § 32.1-330. Screening teams include: (1) "Community-based team" (CBT) means a nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, the Virginia Department of Health or the local Department of Social Services; (2) "Hospital Team" means persons designated by the hospital who are responsible for conducting and submitting the screenings for inpatients to DMAS automated system; and, (3) "DMAS designee" means the public or private entity with an agreement with the Department to complete screenings.

Serious and Persistent Mental Illness (SMI) – Used to refer to individuals ages 18 and older, who have serious mental illness diagnosed under the DSM in the following major diagnostic categories: schizophrenias and other psychotic disorders, bipolar disorders, and major depressive disorders.

Serious Emotional Disturbance – Used to refer to children from birth through seventeen (17), who have had a serious mental health problem diagnosed under the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one year's time, problems that are significantly disabling based upon the social functioning of most children of the child's age, problems that have become more disabling over time, and service needs that require significant intervention by one or more agency (see http://www.dbhds.virginia.gov for additional information).

Service Authorization (SA)/Prior Authorization (PA) - A type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that service is performed and the 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 a Member.

Service Facilitator (SF) - Entity responsible for supporting the individual, individual's family/caregiver, or Employer of Record, as appropriate, by ensuring the development and monitoring of the CD services Plans of Care, providing employee management training, and completing ongoing review activities as required by the Department for CD personal care and respite services.

Significant Change - A change (decline or improvement) in a Member's status that: 1) will not normally resolve itself without intervention or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only); 2) impacts more than one area of the individual's health status; and, 3) requires interdisciplinary review and/or revision of the ICP.

Skilled Private Duty Nursing Services (Skilled PDN) – Skilled in-home nursing services listed in the person-centered Individualized Care Plan that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the *Code of Virginia*, respectively); and (iv) provided by a licensed RN, or by an LPN

under the supervision of an RN, to CCC Plus Waiver Members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on Member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

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

Specialist - A doctor who specializes in treating certain diseases, health problems, or conditions. For the purposes of this contract, not a primary care or pediatric doctor.

Spend Down –When a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a "medically needy" calculation which compares the individual's income to a medically needy income limit for a specific period of time referred to as the "budget period" (not to exceed 6 months). When a Medicaid applicant's incurred medical expenses are equal to the spend down amount, the individual is eligible for full benefit Medicaid for the remainder of the spend down budget period. Individuals with short-term and retroactive coverage only, including certain medically needy (spend down) individuals, will not be eligible to participate in the CCC Plus program.

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

State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures, and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-325, as amended.

State Plan Substituted Services (In Lieu of Services) – Alternative services or services in a setting that are not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). However, the Contractor shall not require a Member to use a state plan substituted service/"in lieu of" arrangement as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner. For individuals 21 through 64 years of age, an Institution for Mental Disease (IMD) may be an "in lieu of" service;

however, shall be limited to **no more than** fifteen (15) calendar days in any calendar month. Reference 42 CFR §§438.3 and 438.6(e).

Store and Forward – Used in Telehealth, when pre-recorded images, such as X-rays, video clips and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include tele-dermatology where digital pictures of a skin problem are transmitted and assessed by a dermatologist; tele-radiology where x-ray images are sent to and read by a radiologist; and, tele-retinal imaging where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

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

Substance Abuse Case Management – Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs for the individuals assessed to have a substance-related disorder as defined in the current DSM. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Crisis Intervention – Immediate mental health care, available 24 hours a day, seven days a week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service's objective is to prevent exacerbation of a condition, to prevent injury to the Member or others, and to provide treatment in the context of the least restrictive setting. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Day Treatment – Services of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Day Treatment for Pregnant Women – Comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Intensive Outpatient Services – Services two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours. This service should be provided to those Members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Residential Treatment for Pregnant Women – Comprehensive and intensive services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. May also be referenced as a Substance Use Disorder Service.

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

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

Targeted Case Management (TCM) – Services that will assist individuals with specific conditions in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist social, educational, vocational, housing, and other services. TCM services include: ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high risk prenatal and infant case management services. Refer to the *CCC Plus Coverage Chart*.

Telehealth – The use of electronic information and telecommunications to support remote or long-distance health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services. Telehealth refers to all remote health care services which may include non-clinical services, such as provider training, administrative public health sessions, and continuing medical education. Telehealth incorporates a vast array of telecommunications technologies (e.g., telephone, fax, email, Internet, video monitoring, and interactive videos) to remove time and distance barriers for the delivery care. In contrast, telemedicine only refers to clinical remote technologies for the purpose of medical diagnosis and treatment.

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

Temporary Detention Order (TDO) – An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or

medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 CFR § 441.150 and *Code of Virginia* § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults than for juveniles.

Therapeutic Behavioral Services (Level B) – A combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals. The Member must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services.

Therapeutic Day Treatment (TDT) for Children and Adolescents – A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in treatment programs of two or more hours per day.

Third-Party Liability (TPL) - Any entity (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for injury, disease, or disability of a Medicaid Member.

Transition Services - Services that are "set-up" expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. For the purposes of transition services, an institution means a NF, or a specialized care facility/hospital as defined at 42 CFR § 435.1009. Transition services do not apply to an acute care admission to a hospital.

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

Transportation Network Companies (TNC) - Provides prearranged rides for compensation using a digital platform that connects passengers with drivers using a personal vehicle. TNC drivers are referred to as TNC partners; reference additional information at https://www.dmv.virginia.gov/commercial/tnc/intro.asp.

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 - DMAS will follow the CMS MA HSD reference guide, available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html.

DMAS defines urban as metro and large metro. DMAS will post a table that identifies VA rural and urban localities at: http://www.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx.

Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical/behavioral health condition, but that are the result of an unforeseen illness, injury, or condition for which medical/behavioral health services are immediately required. Urgent care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

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

Value-Based Purchasing (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 Uniform Assessment Instrument (UAI) - The standardized multidimensional assessment instrument that is completed by the Screening Team that assesses an individual's physical health, mental health, psychosocial and functional abilities to determine if an individual meets the Nursing Facility level of care.

Vulnerable Subpopulations – Populations identified in *Items a-m in Element #1 of the Model of Care.*

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.

23.2 ACRONYMS

AA -- Adoption Assistance
AAA -- Area Agencies on Aging
AAL -- Alzheimer's Assisted Living Waiver
ABD -- Aged, Blind, and Disabled Population
ACA -- Patient Protection and Affordable Care Act
ACIP -- Advisory Committee on Immunization Practice
ADCC -- Adult Day Care Center
ADHC -- Adult Day Health Care
ADHD -- Attention-Deficit/Hyperactivity Disorder
ADL -- Activities of Daily Living
AHRQ -- Agency for Healthcare Research and Quality
ALS -- Amyotrophic Lateral Sclerosis
ANSI -- American National Standards Institute
APIN -- Administrative Provider Identification Number
APM -- Alternate Payment Model
ARTS -- Addiction and Recovery Treatment Services
ASAM -- American Society of Addiction Medicine
ASP -- Application Service Provider
BAA -- Business Associate Agreement
BBA -- Balanced Budget Act of 1997
BHA – Behavioral Health Authority
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
CBO -- Community-Based Organizations
CCBHC -- Certified Community Behavioral Health Clinic
CCC -- Commonwealth Coordinated Care
CCM -- Chronic Care Management
CD -- Consumer-Directed
CDSMP – Chronic Disease Self-Management Program
CFR -- Code of Federal Regulations
CHF -- Congestive Heart Failure
CHIPRA -- Children's Health Insurance Program Reauthorization Act
CIL -- Center for Independent Living
CLIA – Clinical Laboratory Improvement Amendments
CMR -- Comprehensive Medication Review
CMS -- Centers for Medicare and Medicaid Services
CMS 1500 -- Standard Professional Paper Claim Form
CMHRS -- Community Mental Health Rehabilitative Services
CON -- Certificate of Need
COPD -- Chronic Obstructive Pulmonary Disease
CORFs -- Comprehensive Outpatient Rehabilitation Facilities

CPT -- Current Procedural Terminology
CQI -- Continuous Quality Improvement
CSB -- Community Service Board
CY -- Calendar Year
CYSHCN -- Children and Youth with Special Health Care Needs
DARS -- Virginia Department of Aging and Rehabilitative Services
DBA -- Dental Benefits Administrator
DBHDS -- Department of Behavioral Health and Developmental Services
DD -- Developmental Disability
DESI -- Drug Efficacy Study Implementation
DHHS -- Department of Health and Human Services
DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DOB -- Date of Birth
DOD -- Date of Death
DRG -- Diagnosis Relative Grouping
DSM -- Diagnostic and Statistical Manual of Mental Disorders
D-SNP -- Dual Eligible Special Needs Plan
DSP -- Data Security Plan
DSRIP -- Delivery System Reform Incentive Payment
DSS -- Department of Social Services
ECO -- Emergency Custody Order
EDI – Electronic Data Interchange
EI -- Early Intervention
EMR -- Emergency Medical Record
EN -- Enteral Nutrition
EOL -- End-of-Life
EOM -- End of Month
EOR -- Employer of Record
EPA -- Environmental Protection Agency
ePAS -- Electronic Pre-Admission Screening
EPSDT -- Early and Periodic Screening, Diagnostic, and Treatment
EQR -- External Quality Review
EQRO -- External Quality Review Organization
ER -- Emergency Room
ESRD -- End Stage Renal Disease
EVV -- Electronic Visit Verification
FAMIS -- Family Access to Medical Insurance Security
FC -- Foster Care
F/EA -- Fiscal/Employer Agent
FFS -- Fee-for-Service
FIPS -- Federal Information Processing Standards
FOIA -- Freedom of Information Act
FQHC -- Federally Qualified Health Centers
FTE -- Full-Time Equivalent
FTP -- File Transfer Protocol
FY-- Fiscal Year

GAAP -- Generally Accepted Accounting Principles
HAP -- Health and Acute Care Program
HCBS -- Home and Community-Based Care Services
HCPCS -- Healthcare Common Procedure Coding System
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
HPMS -- Health Plan Management System
HRA -- Health Risk Assessment
HRR -- Hospital Referral Region
IADL -- Instrumental Activities of Daily Living
IBNR -- Incurred But Not Reported
ICF/ID -- Intermediate Care Facility/Individuals with Intellectual Disabilities
ICP -- Individualized Care Plan
ICT -- Interdisciplinary Care Team
ID -- Identification
ID -- Intellectual Disability
IDEA -- Individuals with Disabilities Education Act.
IDEA-EIS -- Individuals with Disabilities Education Act - Early Intervention Services
IEP -- Individual Education Plan
IFSP -- Individual Family Service Plan
IHCP -- Indian Health Care Provider
IHS -- Indian Health Services
IOP -- Intensive Outpatient
I/T/U -- Indian Tribe, Tribal Organization, or Urban Indian Organization
IMD -- Institution for Mental Disease
ITOTS—Infant and Toddler Online Tracking System (Early Intervention tracking system)
LARC -- Long Acting Reversible Contraceptive
LCSW -- Licensed Clinical Social Worker
LDSS -- Local Department of Social Services
LEIE -- Listing of Excluded Individuals and Entities
LIFC -- Low Income Families and Children
LOC -- Level of Care
LOCERI -- Level of Care Review Instrument
LSH -- Long-Stay Hospital
LTAC -- Long Term Acute Care
LTSS -- Long Term Services & Supports
MA -- Medicare Advantage
MAO -- Medicare Advantage Organization
MATE -- Medical Assistance to Employment
MCHIP -- Managed Care Health Insurance Plans
MCO -- Managed Care Organization
MDS -- Minimum Data Set
MES -- Medicaid Enterprise System
MFCU -- Medicaid Fraud Control Unit
MFP -- Money Follows the Person
MLTSS -- Managed Long Term Services and Supports

MMIS -- Medicaid Management Information System (also known as VAMMIS)
MMP -- Medicare-Medicaid Plan
MOC -- Model of Care
MOU -- Memorandum of Understanding
MTM -- Medication Therapy Management
MTR -- Medical Transition Reports
NCPDP -- National Council for Prescription Drug Programs
NCQA -- National Committee for Quality Assurance
NDC -- National Drug Code
NEMT -- Non-Emergency Medical Transportation
NF -- Nursing Facility
NIST -- National Institute of Standards and Technology
NPDB -- National Practitioner Data Bank
NPI -- National Provider Identifier
NRSM -- Network Requirements Submission Manual
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
PCP -- Primary Care Provider
PHI -- Protected Health Information
PIP -- Physician Incentive Plan
PIRS -- Patient Intensity Rating Survey
PDSA -- Plan Do Study Act
PMV -- Performance Measure Validation
POC -- Plan of Care
PPE -- Provider Preventable Event (refer to Provider Preventable Condition)
PSA -- Prostate Specific Antigen
PT -- Physical Therapy
PUMS -- Patient Utilization Management & Safety Program
QI -- Quality Improvement
QIP -- Quality Improvement Program
RFP -- Request for Proposal
RHC -- Rural Health Clinics
RN -- Registered Nurse
RTF -- Residential Treatment Facility
RUGS -- Resource Utilization Groups
SA -- Service Authorization (formally known as Prior Authorization)
SAMHSA -- Substance Abuse and Mental Health Services Administration
SED -- Serious Emotional Disturbance
SLP -- Speech-Language Pathology
SMI -- Serious Mental Illness
SPO -- State Plan Options
SSI -- Social Security Income
SSN -- Social Security Number

SUD -- Substance Use Disorder
TB -- Tuberculosis
TBI -- Traumatic Brain Injury
TDO -- Temporary Detention Order
TFCCM -- Treatment Foster Care Case Management
TMJ -- Temporomandibular Joint (disorder)
TPL -- Third-Party Liability
TPN -- Total Parenteral Nutrition
TTY/TDD -- Teletype/Telecommunication Device for the Deaf
UAI -- Uniform Assessment Instrument
UB-92 -- Universal Billing 1992 claim form
UM -- Utilization Management
USC -- United States Code
VAC -- Virginia Administrative Code
VAMMIS -- Virginia Medicaid Management Information System
VAN --Value Added Network
VBP -- Value Based Payment
VICAP -- Virginia Independent Clinical Assessment Process
VPN -- Virtual Private Network
VVFC -- Virginia Vaccines for Children Program
XYZ -- Any Named Entity

ATTACHMENTS

ATTACHMENT 1 - CCC PLUS CONTRACTOR SPECIFIC CONTRACT TERMS

Effective Dates: January 1, 2018 – December 31, 2018

Contract Name: Commonwealth Coordinated Care Plus

Issued By: Commonwealth of Virginia
Department of Medical Assistance Services

Contractor: <Health Plan>

This Contract is effective January 1, 2018 and shall continue through December 31, 2018.

1. The Contractor shall accept the established capitation rates, effective January 1, 2018 (see Exhibit A) paid monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for January enrollment will occur in February, February payment will be made in March, etc.) as further explained in Section 19 of the CCC Plus Contract.

2. By signature of this Contract, the Contractor agrees to adhere to all CCC Plus MCO Contract provisions, including network adequacy. The Contractor shall operate in all six (6) regions of the Commonwealth and in accordance with the Department's standards for network sufficiency as detailed in this Contract. The Department reserves the right to delay or deny the Contractor's receipt of enrollment for any region or locality within a region, contingent on the Contractor's ability to meet the network adequacy standards set forth and described in this Contract.

3. Maximum enrollment level: A limit of 70% of enrolled lives within an operational region may be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an operational region exceed 70%, the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at 70% or below. The enrollment cap may be exceeded due to Member-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary. Operational regions consist of the areas reflected in the CCC Plus contract, Attachment 7, *CCC Plus Program Regions and Localities* chart.

4. This contract is contingent upon receipt of final approval from the Centers for Medicare and Medicaid Services (CMS), including all provisions of the Federal regulations in 42 CFR § 438. Any revisions needed shall be completed through a subsequent contract Amendment.

5. By signature of this Contract, the Contractor agrees to adhere to all CCC Plus program 2018 Contract provisions, including compliance with Federal conflict of interest provisions and compliance with requirements in 42 CFR § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

CCC PLUS CONTRACTOR SIGNATURE PAGE
(Continued)

6. With signature of this Contract, the Contractor shall attach all of the following documentation:

    a. A copy of its valid license issued with "Health Maintenance Organization" Lines of Authority by the State Corporation Commission (see Section 2.3 of the Contract); and,
    b. A copy of its MCHIP certification issued by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection (see Section 2.4 of the Contract); and,
    c. The required information reflected in the Disclosure of Ownership and Control Interest Statement (CMS 1513).

7. The Contractor agrees to submit claims (encounter) data, along with the Contractor's subcontractor data, to the Department or its designated Consultant(s) in accordance with the terms specified in this Contract and the CCC Plus Encounter Technical Manual. These data will be used to ensure services were administered to the Contractor's Members as well as to support future Contract rate calculations.

IN WITNESS HEREOF, the parties have caused this Contract Amendment to be duly executed intending to be bound thereby.

CONTRACTOR: <Health Plan Name>	COMMONWEALTH OF VIRGINIA Department of Medical Assistance Services
BY: _____	BY: _____
NAME: _____	NAME: Cynthia B. Jones
TITLE: _____	TITLE: Director
DATE: _____	DATE: _____

ATTACHMENT 2 - BUSINESS ASSOCIATE AGREEMENT

THIS ATTACHMENT supplements and is made a part of the Business Associate Agreement (herein referred to as "Agreement") by and between the Department of Medical Assistance Services (herein referred to as "Covered Entity") and [name Business Associate] (herein referred to as "Business Associate").

General Conditions

This BAA ("Agreement" or "BAA") is made as of December 1, 2016 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:

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
   CCCPlus@dmas.virginia.gov

2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:

   Contact: DMAS Division of Integrated Care
   Department of Medical Assistance Services
   600 East Broad Street
   Richmond, Virginia 23219
   CCCPlus@dmas.virginia.gov

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. Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use,

disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.

i. Shall comply with 45 CFR § 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall
   a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the HITECH Act.
   b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.
   c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.
   d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 CFR § 164.312(e).
   e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall
   a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
      i. the date made,
      ii. the name of the person or organization receiving the PHI,
      iii. the recipient's (Member) address, if known,
      iv. a description of the PHI disclosed, and the reason for the disclosure.
   b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

4. Sanctions - Business Associate shall
   a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
   b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:
   a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer.
      i. Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within 5 business days from 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.

(To be completed by Business Associate)

Department of Medical Assistance Services/Contractor Name

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.

   Contact: DMAS Integrated Care Division Director
   Department of Medical Assistance Services
   600 East Broad Street
   Richmond, Virginia 23219
   Phone Number : (804) 371-7983
   Email Address: CCCPlus@dmas.virginia.gov

   Contractor Contact:
   Address:
   Phone Number:
   Email Address:

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 3 - BHSA/CCC PLUS MCO COORDINATION AGREEMENT

This Mutual Cooperation and Coordination Agreement (the "Agreement") is entered into this __ day of June, 2017, by and between Magellan of Virginia (Magellan), and-
_____("MCO").

WHEREAS, Magellan has entered into a contract with the Department to provide behavioral health services to beneficiaries ("Members") of the Medicaid Program (the "Program"); and

WHEREAS, <MCO> intends to Contract with the Department to provide coverage for primary, acute, long term services and supports, pharmacy, and behavioral health services, except for the subset of behavioral health services known as community mental health rehab services to Members covered under the CCC Plus Program; and

WHEREAS, Magellan and MCO are required by the terms of their respective contracts with the Department to cooperate with each other and to coordinate care provided to Members, including, but not limited to, (i) support service delivery approaches that integrate behavioral health and primary care services, (ii) address and attempt to resolve coordination of care issues concerning behavioral health care and physical health care, and (iii) share data for purposes of coordinating care for Members; and

WHEREAS, Magellan and MCO, at the direction of the Department, desire to formalize the understanding they have reached with respect to such cooperation and coordination, as set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants contained herein, BHSA and CCC Plus MCO agree as follows:

Magellan and MCO shall cooperate to coordinate care in a manner that meets the requirements of their respective contracts with the Department, subject to any restrictions relating to confidentiality of patient information, and further subject to the written approval of the Department.

With respect to the sharing of patient information, Magellan and MCO shall adhere to the following:

a) All collaborative activities shall adhere to state and federal confidentiality laws and regulations; including, without limitation the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated there under, 45 CFR Parts 160 – 164 (the "Regulations").

b) Magellan and MCO may share among each other clinically relevant information, such as periodic treatment updates, subject to all state and federal confidentiality laws and regulations, including but not limited to HIPAA and the Regulations. The parties hereto acknowledge their individual obligations, as covered entities, to comply with HIPAA and the Regulations. Each party shall employ reasonable efforts to implement HIPAA privacy requirements in a manner that allows for the effective exchange of clinical information for treatment, payment and healthcare operations purposes, as described in 45 CFR § 164.506(c), while complying with applicable confidentiality requirements. The parties agree that, upon request, their respective notices of privacy practices shall be exchanged to facilitate such treatment, payment and healthcare operations purposes. The parties acknowledge that certain federal or state laws may take precedence over HIPAA

General

a) Magellan and MCO shall work together to coordinate and collaborate in the referral, diagnostic assessment and treatment, prescribing practices, the provision of emergency services and other treatment issues necessary for the prevention of disease and achieving optimal health of each Member.
b) All parties agree to meet on an as needed basis, as directed by the Department, and will identify a contact within each organization to facilitate communication throughout the term of the Agreement.

Contact for Magellan:
CEO, Magellan Behavioral Health of _____, Inc.
COO, Magellan Behavioral Health of_____, Inc.
Director of System Transformation, Magellan Behavioral Health of_____, Inc.
Clinical Director, Magellan Behavioral Health of _____, Inc.

Contacts for MCO:
Plan President
Medical Director
Director of Care Management
Director of Quality

c) Coordination of care by Magellan and MCO will include interaction, cooperation, problem identification, and problem resolution in order to reduce barriers or boundaries that impede appropriate health care delivery to Members.

Term. This Agreement shall become effective as of the day and date first written above. Either party may terminate this Agreement at any time upon thirty (30) days prior written notice to the other party, with approval by the Department.

Miscellaneous Provisions.

a) Amendment. This Agreement may be amended only in writing and the amendment must be signed by both parties.

b) Entire Agreement. This Agreement and amendments thereto constitute the entire understanding and agreement of the parties hereto and supersedes any prior written or oral agreement pertaining to the subject matter hereof, except for such written agreements which antedate this Agreement

c) Compliance with Terms. Failure to insist upon strict compliance with any of the terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

d) Severability. If any portions of this Agreement shall, for any reason, be invalid or unenforceable, such portions shall be ineffective only to the extent of any such invalidity or unenforceability, and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect; provided however, that if the invalid provision is material to the overall purpose and operation of this Agreement, then this Agreement shall terminate upon the severance of such provision.

e) Independent Contractors. None of the provisions of this Agreement is intended to create, nor shall it be deemed or construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement.

f) Assignment. No party may assign this Agreement without the prior written consent of the other parties.

g) Governing Law. This Agreement shall be construed in accordance with the laws of the State of Virginia.

h) Counterparts. This Agreement may be signed in counterparts which, when taken together, shall be treated as a single document.

i) Headings. The headings and captions of the Sections of this Agreement are for the convenience of reference only and do not in any way modify, interpret or construe the intention of the parties or affect the provisions of the Agreement.

j) Notices. All notices, requests, demands and other communications regarding this Agreement shall be in writing and shall be deemed to have been duly given (a) on the date of delivery if delivered personally, or (b) on the date of receipt if sent by overnight national courier service or (c) on the date of receipt when mailed (registered or certified mail, postage prepaid, return receipt requested) addressed to a party at the address give above.

IN WITNESS WHEREOF, the forgoing Mutual Cooperation and Coordination Agreement has been duly executed by the parties hereto as of the day and date first written above.

BY: _____	BY: _____
NAME: _____	NAME: _____
TITLE: _____	TITLE: _____
DATE: _____	DATE: _____

ATTACHMENT 4 - SAMPLE CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Name of patient)

_____
(Name or general designation of program making disclosure)

to disclose to _____the
(Name of person or organization to which disclosure is to be made)

following information: _____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to: _____
(Specific purpose of disclosure)

_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

_____

Dated: _____
Signature of patient

_____
Signature of parent, guardian or authorized

representative when required

_____

Source: This sample form is set forth in CSAT/SAMHSA's TAP 13, Page 17; TIP 7, Page 41

ATTACHMENT 5 - CCC PLUS COVERAGE CHART

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 CCC Plus 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 Federal EPSDT requirements.

The CCC Plus Coverage Chart provides detailed information for covered benefits and includes information on how the Contractor can assist its CCC Plus Members in accessing services that are carved-out of this Contract and covered through fee-for-service or other DMAS Contractor. Services are presented in the chart in the following order: Part 1- Medical Benefits, Part 2A-Inpatient and Outpatient Mental Health Services, Part 2B – Community Mental Health Rehabilitation Services (CMHRS), Part 2C – Addiction and Recovery Treatment (ARTS), Part 3A – EPSDT Services, Part 3B – Early Intervention Services, Part 4A - Long Term Care Facility Based Services, Part 4 B- Long Term Services and Supports- Community Based, Part 4C- Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver Services.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40 Also See Hospital Manual Chapter IV, Exhibits for required forms.	Yes, limited	Yes, limited	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.
Assisted Suicide	Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.)	No	No	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.
Behavioral Health	See Part 2 of this Attachment			
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. *The Contractor is not required to cover this service except as medically necessary in accordance with EPSDT criteria.*
Christian Science Sanatoria Facilities and Nurses	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from CCC Plus program participation when admitted to a Christian Science Sanatoria and services shall be covered under the fee-for-service program with DMAS established criteria and guidelines. Christian Science Nursing Services are not covered.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor shall cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Community Intellectual Disability Case Management (T1017)	12 VAC 30-50-440	Yes	No	The Contractor shall provide information and referrals as appropriate to assist Members in accessing these services through the individual's local community services board.
Court Ordered Services	*Code of Virginia* 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 See Dental Manual	Yes	Limited coverage	DMAS' contracted dental benefits administrator (DBA) will cover routine dental services for children under 21 and for adult pregnant women; therefore, these services are carved out of CCC Plus 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 also cover medically necessary anesthesia and hospitalization services for its Members when determined to be medically necessary by the Department's Dental Benefits Administrator.
Developmental Disability Support Coordination (T2023)	12 VAC 30-50-490	Yes	No	These services will be covered through Medicaid fee-for-service until completion of the Community Living and Family and Individual Supports system redesign.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Dietary Counseling Medicaid Works (Also see EPSDT and Pregnancy related services)	12VAC30-60-200	Yes	Limited Coverage	The Contractor shall cover medically necessary Dietary Counseling Services, for Medicaid Works enrolled Members. For example, if they have hyperlipidemia (high cholesterol) and/or other known risk factors for cardiovascular and diet-related chronic disease (for example, heart disease, diabetes, kidney disease, obesity). DMAS FFS reimburses for Dietary Counseling services for Medicaid Works individuals (aid category 59) as follows: 1. Medical Nutrition Therapy; Initial Assessment CPT code 97802: $28.10 per unit for inpatient and $29.93 per unit for outpatient with a maximum of four (4) units per day in either setting; and 2. Medical Nutrition Therapy; Re-Assessment and Intervention, CPT code 97803: $23.82 per unit for inpatient and $25.96 per unit for outpatient with a maximum of two (2) units per day in either setting.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services - See Part 3A of this Attachment				
Early Intervention Services - See Part 3B of this Attachment				
Emergency Services	42 CFR § 438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	The Contractor shall cover all emergency services without service authorization. The Contractor shall also cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a Member's choice of provider for emergency services.
Emergency Services - Post Stabilization Care	42 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.
End Stage Renal Disease (ESRD)	12 VAC 30-50-270 and 12 VAC 30-60-130	Yes	Yes	Individuals diagnosed with ESRD at time of enrollment will be auto-enrolled in CCC Plus but may request to be disenrolled within the first 90 days of CCC Plus enrollment and remain in FFS. CCC Plus Members who are diagnosed with ESRD after enrollment will remain in CCC Plus program for ESRD services.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Enhanced Services	CCC Plus Contract	No	Yes	Enhanced benefits are services offered by the Contractor to Members in excess of CCC Plus 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 CCC Plus 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. *For those Members <21, clinical trials are not always considered to be experimental or investigational and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.*
Family Planning Services	12 VAC 30-50-130	Yes	Yes	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 CCC Plus program participation.
HIV Testing and Treatment Counseling	*Code of Virginia* Section 54.1-2403.01 12 VAC 30-50-510 Chapter IV of the Physician Manual	Yes	Yes	The Contractor shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The Contractor shall ensure that, as a routine component of prenatal care, every pregnant Member shall be advised of the value of testing for HIV infection. Any pregnant Member shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the Member's Medical Record.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
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. Medicaid home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services for Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving State and/or Federal assistance for those home health services. For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting. 0550 Skilled Nursing Assessment 0551 Skilled Nursing Care, Follow-Up Care 0559 Skilled Nursing Care, Comprehensive Visit 0571 Home Health Aide Visit 0424 Physical Therapy, Home Health Assessment 0421 Physical Therapy, Home Health Follow-Up Visit 0434 Occupational Therapy, Home Health Assessment 0431 Occupational Therapy, Home Health Follow-Up Visit 0444 Speech-Language Services, Home Health Assessment 0441 Speech Language Services, Home Health Follow-Up Visit 0542 Non-Emergency Transportation, Per Mile *Additional information can be found in the Home Health provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov*

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Hospice Services - See Part 4 (LTSS) of this Attachment.				
Hysterectomies	42 CFR Part 441 Subpart F as amended See Hospital Manual Chapter IV, Exhibits For required forms.	Yes, limited.	Yes, limited.	The Contractor may not impose a 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 reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or upon request.
ID/DD/DS Waivers (known Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver) See Part 4C of this Attachment.				
Immunizations	12 VAC 30-50-130	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 to work with the Department to achieve its goal related to increased immunization rates. Also see EPSDT in part 3B for immunizations for children.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 12 VAC 30-50-225 12 VAC 30-60-20 12 VAC 30-60-120 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	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 in maternity cases where the Member is discharged earlier than 48 hours after the day of delivery. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325(a)(1) through § 32.1-325(a)25 of the *Code of Virginia*.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private. - See Part 4 of this Attachment.				
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. In accordance with 42 CFR§§ 493.1 and 493.3, all laboratory testing sites providing services under this Contract are required to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)	12VAC30-50-220	Yes	Yes	Screenings will be covered for Members who meet all of the following criteria: 55-80 years of age; asymptomatic (no signs or symptoms of lung cancer); tobacco smoking history of at least one pack per day for 30 or more years; current smoker or former smoker who has quit smoking within the last 15 years; and, receive a written order furnished by a licensed provider or a qualified non-physician practitioner for lung cancer screening with LDCT that meets the requirements described above. Prior authorization may be required. Providers use G0297 for billing. Diagnosis codes Z87.891, F17.210, F17.211, F17.213, F17.218, or F17.219
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer. Screening mammograms for age 40 and over shall be covered consistent with the guidelines published by the American Cancer Society.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
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's DME benefits shall be limited based upon medical necessity. There are no maximum benefit limits on DME. 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. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the Member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the Member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Contractor must use the valid preauthorization begin date as the invoice date. 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 The MCOs shall work with the Member to receive/replace DME supplies that have been lost or destroyed, or the current DME provider is not available, as a result of a disaster or emergency in accordance with *Code of Virginia* § 44.146.16.
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 30-50-540 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 for all eligible persons as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. Contractor shall cover necessary procurement/donor related services. Transplant services shall be covered for children (under 21 years of age) per EPSDT guidelines.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
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.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor shall cover annual pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care; EPSDT	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 Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Personal care coverage is also available for Members through HCBS waiver programs. See Section 4 of this coverage chart.
Personal Care Medicaid Works See CCC Plus Waiver services in Section 4b.	12VAC30-60-200 12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide coverage for personal care services for Medicaid works individuals using the same coverage criteria as the personal care coverage criteria under the CCC Plus HCBS waiver, however, Medicaid Works individuals are not required to have a preadmission screening. In order to receive personal care services, Medicaid Works individuals who meet coverage criteria must be enrolled with the Medicaid Works (MW) exception indicator. Medicaid Works individuals also have no patient pay responsibility for the personal care services. Criteria information regarding personal care can be found in the EDCD Waiver Provider Manual, Chapter IV, beginning on page 10. The manual is available on the web portal at www.virginiamedicaid.dmas.virginia.gov under the Provider Resources; Provider Manuals link.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150	Yes	Yes	The Contractor 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. There are no maximum benefit limits on PT, OT, SLP, and audiology services. These services are covered regardless of where they are provided, The plan shall also cover all Medically Necessary, intensive physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130 42 CFR §438.206	Yes	Yes	The Contractor shall cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT. The Contractor shall permit any female Member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the *Code of Virginia*, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists. The Contractor shall provide for a second opinion from a network provider, or arrange for the Member to obtain one outside the network, at no cost to the Member.
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.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
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 post-partum services for sixty (60) days after pregnancy ends for the Contractor's enrolled Members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department's criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements.
Prescription Drugs	12 VAC 30-50-210 Chapter IV of the Pharmacy Manual	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. Refer to the Contract Section on Pharmacy Services. Also see Section 4.8 of this Contract.
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 under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Program in Part 4 of this Attachment) Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. PDN Coverage is also available for Members in the Technology Assisted Program.
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male Members for prostate cancer.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual	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 is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor 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.
School Health Services	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. Private duty nursing and personal care services provided through EPSDT, Technology Assisted Program, Community Living Waiver, or Family and Individual Supports Waiver are not considered school health services, including when provided in the school setting or provided before or after school.
Skilled Nursing Facility Care - See Part 4A (LTC Facility Services) of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Sterilizations	42 CFR§ 441, Subpart F, as amended *Code of Virginia* § 54.1-2974	Yes, limited.	Yes, limited.	The Contractor shall not perform sterilization for a Member under age twenty-one (21). The Contractor shall comply with State and Federal requirements and shall comply with the thirty (30) calendar day waiting period requirement as specified in *Code of Virginia* § 54.1-2974. The Contractor shall ensure that the consent form DMAS-3004 of 42 CFR § 441.258 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the Member being informed, the 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 reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or upon request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Provider Manual)	Yes	Yes	The plan shall provide coverage for 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. The Department recognizes physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and state laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 CFR §440.170(a) Chapter IV of the Transportation Manual	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 Medicare or another third party payer and to services provided by subcontractors. 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, and taxicabs. 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). The Contractor shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The Contractor shall cover transportation to and from Medicaid covered community mental health rehabilitation services. Community Living, Family and Individual Supports, and Building Independence Waiver Members shall receive acute and primary medical services via the Contractor and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program.
Vision Services	12 VAC 30-50-210 Chapter IV of the Vision Services Manual	Yes	Yes	The Contractor shall cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. The Contractor shall also 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.
Waiver Services (Home and Community Based) - See Part 4 B (LTSS) of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
INPATIENT MENTAL HEALTH TREATMENT SERVICES				
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 Manual-Psychiatric Services Chapter 4 Final Rule: 42 CFR Part 438.6 page 27861 and pages 27557 and 27558	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 (Institute of Mental Disease) for no more than 15 days in a calendar month, consistent with the Federal regulations described in 42 CFR § 438.6 and section 4.12 *State Plan Substituted (In Lieu Of) Services* of this contract.
Inpatient Psychiatric Hospitalization in General Hospital	12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 Manual-Psychiatric Services, Chapter 4	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.
State Geriatric Hospital Placements (Piedmont, Catawba, Hiram Davis, and Hancock)		Yes	No	Individuals in Piedmont, Catawba, Hiram Davis, and Hancock state geriatric facilities are excluded from CCC Plus program participation.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO)	*Code of Virginia* § 16.1-340 and 340.1 and §§ 37.2-808 through 810	Yes	Yes	Pursuant to 42 CFR § 441.150 and the *Code of Virginia*, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor 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. The

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
(Revenue Codes for TDOs and Service Code 0405 for ECOs)	Appendix B of the Hospital Manual			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 *Code of Virginia*, as follows: For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the *Code of Virginia*, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the 96-hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services. For Adults age 18 and over – Pursuant to § 37.2-809.H of the *Code of Virginia*, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.
OUTPATIENT MENTAL HEALTH SERVICES – Psychiatric Services Manual for All				

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
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 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary pharmacological management services. (CPT 90863)
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140 Psychiatric Services Manual	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. Psychiatric Diagnostic Evaluation ; with Medical Service (CPT 90792 alone or GT)
Psychological/ Neuropsychological Testing	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law. Psychological Testing administered by Computer (CPT: computer: 96103) Neurobehavioral Status Exam (CPT: 96116) Neuropsychological Testing Administered by Psychologist/Physician (CPT: 96118) Neuropsychological Testing Administered by Technician (CPT: 96119) Neuropsychological Testing Administered by Computer(CPT: 96120)

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
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 children and adolescents. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when medically necessary for individuals under age 21.
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Use the most up-to-date version of the CPT codes

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018. *Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.* ***Exceptions are noted below.***				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Behavioral Therapy Services under EPSDT	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000 EPSDT Manual	Yes	Effective 1/1/2018	The Contractor is required to provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130, 12 VAC 30-130-2000, and the DMAS EPSDT Behavioral Therapy Provider Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal. Also see Section 3A EPSDT. Multisystemic Therapy (ABA) (Service Code: H2033)

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
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Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
				Multisystemic Therapy (ABA) Assessment (Service Code: H0032-UA)
Crisis Intervention Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 12 VAC 30-60-5 Community Mental-Health Rehabilitation Services Manual - CMHRS Chapters 2, 4 & 6	Yes	Effective 1/1/2018	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 Enrollees who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as Enrollees 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 Enrollee, providing access to further immediate assessment and follow-up, and linking the Enrollee and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. Service Code: H0036 alone or GT; or H0036 GT alone or 32
Crisis Stabilization Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary crisis stabilization services. Includes services provided to non-hospitalized Enrollees 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. Service Code: H2019

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) *
*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018.

Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. ***Exceptions are noted below.***

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Day Treatment/Partial Hospitalization	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary day treatment/partial hospitalization assessment and treatment services. Includes sessions of two (2) or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for Enrollees with serious behavioral disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for Enrollees with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital. Assessment Service Code: H0032-U7 Treatment Service Code: H0035HB
Intensive Community Treatment Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary Intensive Community Treatment Assessment and Treatment services. Includes an array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Intensive Community Treatment is provided through a designated multi-disciplinary team of behavioral health professionals. It is available twenty-four (24) hours per day. Assessment Service Code: H0032-U9 Treatment Service Code: H0039
Intensive In-Home Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-130-2000	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary Intensive In-Home Assessment and Treatment services. Assessment Service Code: H0031

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018. *Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.* ***Exceptions are noted below.***				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6			Treatment Service Code: H2012
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143 12 VAC 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	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 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary Mental Health Skill-building Assessment and Treatment Services. 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 30-60-5 12 VAC 30-130-2000 12 VAC 30-60-143 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	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

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018. *Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.* ***Exceptions are noted below.***				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
				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. Assessment Service Code: H0032-U6. Treatment Service Code: H2017
Therapeutic Group Home Children and Adolescents under 21 – Group Home (Formerly known as Levels A&B)	ER: 12 VAC 30-50-130 and 12 VAC 30-60-61 http://townhall.virginia.gov/L/ViewXML.cfm?textid=11341 12 VAC 30-60-5 12 VAC 30-130-2000 Residential Treatment Services Manual	Yes	**Not at this time**.	The Contractor shall cover medically necessary Residential Services (Community-Based) for children and Adolescents under 21 – Therapeutic Group Home (formerly Levels A&B). Level A Service Code: H2022 HW or HK (Level A will cease to be reimbursed on 5/1/2018) TGH Service Code: H2020 HW or HK ***TGH will not transition to the Contractor on 1/1/2018. TGH will transition later than the other CMHRS.***
Psychiatric Residential Treatment Facility – (PRTF) for children under age 21 years – (Formerly known as Level C)	ER: 12 VAC 30-10-54012 VAC 30-60-61 12 VAC 30-50-130 12 VAC 30-60-50 http://townhall.virginia.gov/L/ViewXML.cfm?textid=11341	Yes	**No**	The Contractor is not responsible for covering Psychiatric Residential Treatment Facility (PRTF) services. DMAS authorization into a PRTF program will result in disenrollment of the Member from the CCC Plus program. The PRTF provider must contact the DMAS BHSA for authorization and payment through the fee-for-service program. The Contractor must 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.

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018. *Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.* ***Exceptions are noted below.***				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	Residential Treatment Services, Manual			Revenue codes and Service code 1001 ***PRTFC ~~may~~ will not transition to the Contractor on 1/1/2018. PRTFC ~~may~~ will transition later than the ~~other~~ CMHRS.***
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 30-130-2000 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. Assessment Service Code: H0032 Service Code: H0035 HA Modifiers: School Based TDT must be billed as H0035HA After School TDT must be billed as H0035HA-UG Summer TDT must be billed as H0035HA-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 Psychiatric Services Manual Chapters 2, 4 & 6	Yes	**Not at this time**.	The Contractor shall cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years. Service Code T1016.
MH Peer Support Services	Fast Track Regulations:	Yes	Effective 1/1/2018	The Contractor shall cover medically necessary MH Peer Support Services for adults and MH Family Support Partners for youth under 21.

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
CMHRS services were carved-out of the CCC Plus Contract prior to January 1, 2018. The Department's BHSA provided these services for CCC Plus Members through the fee-for-service program prior to January 1, 2018. *Effective January 1, 2018, the Contractor shall provide coverage for CMHRS within the Department's coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.* ***Exceptions are noted below.***				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160 through 12 VAC 30-130-5210 12 VAC 30-130-2000 http://townhall.virginia.gov/L/ViewXML.cfm?textid=1172 Manual: CMHRS - Peer Services Manual Supplement			Service Code H0024 (Individual) H0025 (Group)

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - The Contractor shall provide coverage in IMD settings as appropriate based on the ASAM Criteria for adults who are 21 through 64 years of age.				
Medically Managed Intensive Inpatient	ASAM Level 4.0	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed High Intensity Residential Services	ASAM Level 3.5	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier TG
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2034
OUTPATIENT WITHDRAWAL MANAGEMENT				
ARTS Partial Hospitalization	ASAM Level 2.5	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes S0201 Rev 0913 and S0201
ARTS Intensive Outpatient	ASAM Level 2.1	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0015 Rev 0906 and H0015
Ambulatory Withdrawal Management With	ASAM Level 2WM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities	
Extended On- Site Monitoring					
Ambulatory Withdrawal Management Without Extended On- Site Monitoring	ASAM Level 1 WM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes	
Medication Assisted Treatment (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Medication Administration Care Coordination Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance	H0004 – individual and family counseling H0005 - group counseling S0109 Methadone 5 mg oral billed by provider H0020 G9012 Substance Use Care Coordination H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Care Coordination	H0004 – individual and family counseling H0005 - group counseling J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider G9012 Substance Use Care Coordination

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
				Physician Visit – Induction Day 1 — H0014 Urine Drug Screen — 80305 to 80307 and G0480- G0483 Labs — CPT codes Physician Visit – Maintenance — Use CPT E&M Established patient
Buprenorphine/Naloxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	ASAM Office Based Opioid Treatment	Yes	Yes	Counseling and Medication Oversight — H0004 – individual and family counseling H0005 - group counseling Care Coordination — G9012 Substance Use Care Coordination Physician Visit – Induction Day 1 — H0014 Drug Screen — 80305 to 80307 and G0480- G0483 Labs — CPT codes Physician Visit – Maintenance — Use CPT E&M Established patient
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER SUPPORT SERVICES				
Substance Use Case Management	12 VAC 30-60-185 12 VAC 30-50-491	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)
ARTS Peer Services	Fast Track Regulations: 12VAC30-50-226 12VAC30-50-130	Yes	Yes	The Contractor shall cover ARTS Peer Support Services for Adults and ARTS Family Support Partners for youth under 21. Group – S9445 Individual – T1012

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)* *Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001) See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	12VAC30-130-5160 through 12VAC30-130-5210 http://townhall.virginia.gov/L/ViewXML.cfm?textid=11723To Be Determined; New Service Manual: ARTS - Peer Services Manual Supplement			
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-50-180	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria (99408/99409)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
EPSDT Benefit Global Coverage Guidelines	12 VAC 30-50-130 42 CFR § 440.40(b)(2) and 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	Yes	Yes	EPSDT includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under 21 years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. For individuals under 21 years of age EPSDT services will be provided before Technology Assisted Program services are offered. 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 See CMHRS Services Part 2B of this Coverage Chart	Same as EPSDT Global Coverage Guidelines			

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
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 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.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.
Immunizations	Same as EPSDT Global Coverage Guidelines	Yes	Yes	According to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines, immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Coverage shall also be within CDC guidelines. The Contractor shall coordinate coverage within the Virginia Vaccines for Children (VVFC) program. See the EPSDT Supplement Manual and the VVFC website at: http://www.vdh.virginia.gov/imunization/vvfc
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary: o hemoglobin/hematocrit o tuberculin test (for high-risk groups) o blood lead testing (see below section on Lead Testing)
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. Environmental investigations are coordinated by local health departments.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the Member's local health department to see if a Member qualifies for a risk assessment. More information is available at http://www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for-public-health/elevated-blood-lead-levels-in-children Payments for environmental investigations shall be limited to no more than two visits per residence.
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	All Medicaid children are required to receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. Testing may be performed by venipuncture or capillary. Filter paper methods are also acceptable and can be performed at the provider's office. Tests of venous blood are considered confirmatory. The providers need to use the code 83655 for Lead blood testing and one of the following: • 36416 for the collection of capillary blood specimen (finger, heel, ear stick) • 36415 for the collection of venous blood by venipuncture. A blood lead test result equal to or greater than 5 ug/dL (or consistent with the most current CDC guidelines) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing 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.
Private Duty Nursing	42 CFR §§ 441.50, 440.80, Social Security Act §1905(a) and 1905(r) I.	Yes	Yes	The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement. The Contractor shall use the Department's criteria, as described in the DMAS EPSDT Nursing Supplement when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument, if desired, which must be

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				approved by the Department. However, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit. Skilled PDN is also covered for Members who are enrolled in Technology Assisted Program who require continuous nursing that cannot be met through home health. Technology Assisted Program uses form 108& 109 to determine the hours of service needed. Under EPSDT or Skilled PDN, the Member's condition warrants continuous nursing care including but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT and Skilled PDN differ from home health nursing which provides for short-term intermittent care where the emphasis is on Member or caregiver teaching. Examples of Members that may qualify for PDN coverage include but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention. Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT or Skilled Private Duty Nursing 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.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				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.
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. CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf NHelp - http://www.healthlaw.org/ State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.gov The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov , under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Early Intervention Services	20USC § 1471 34 CFR§ 303.12 *Code of Virginia* § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor shall provide coverage for Early Intervention services as defined in 12 VAC 30-50-131, 12 VAC 30-50-415, and 12VAC35-225 et. seq., and within the Department's coverage criteria and guidelines. The DMAS Early Intervention billing codes, reimbursement methodology, and coverage criteria shall be used and are described in the Department's Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Medical necessity for 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. The Contractor shall also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate. For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for: 1) Those services federally required to be provided at public expense as is the case for a) assessment/EI evaluation, b) development or review of the Individual Family Service Plan (IFSP); and, c) targeted case management/service coordination; 2) Developmental services; and, 3) Any covered early intervention services where the family has declined access to their private health/medical insurance; See Section 12.4.12.3 *Comprehensive Health Coverage*

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.gov The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov , under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
Early Intervention Targeted Case Management/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	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.		
				Billing Code	**Description**	**Limits**
				T2022	Service Coordination	1 charge/child/month
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 is required to provide coverage for Early Intervention initial and subsequent assessments for service planning in the child's natural environment or in a center based program.		
				Billing Code	**Description**	**Limits**
				T1023 (RC 2) T1023 U1(RC 1)	Initial assessment, development of initial IFSP, Annual IFSP	24 units/day and 36 units/year
IFSP Team Treatment Activities (more than one professional	12VAC30-50-131 12 VAC 35-225-120 – 12VAC35-225-160	Yes	Yes	The Contractor is required to 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.		
				Billing Code	**Description**	**Limits**

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.gov The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov , under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
providing services during same session for an individual child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning				T1024* (RC 2) T1024 U1* (RC 1)	•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 after the initial Assessment for Service Planning	The maximum daily units/per child/ per (service) code/ per individual practitioner is **6 units** with a maximum of **18 units** per day per child for all agency/providers combined. Applies to all codes in this section with "*".
Developmental Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention developmental services for an individual child or for more than one child, in a group (congregate) in the child's natural environment.		
				Billing Code	**Description**	**Limits**
				T1027* (RC 2)	Developmental Services and other early intervention services provided for more than one child, in a group (congregate).	RC 2 only. See above for limits *.
				Billing Code	**Description**	**Limits**
				T1027 U1* (RC 2)	Developmental Services and other early intervention services provided for one child	RC 2 only. See above for limits *.
Center-Based Early Intervention Services;	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention center-based individual and group (congregate) services.		
				Billing Code	**Description**	**Limits**

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.gov The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov , under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
individual and/or group				T1026* (RC 1)	Center-based group (congregate) early intervention services	See above for limits*.
				T1026 U1* (RC 2)	Center-based individual early intervention services	
				T1015* (RC 1)	Center-based group (congregate) early intervention services	
				T1015 U1* (RC 2)	Center-based individual early intervention services	
Early Intervention Physical Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child's natural environment.		
				Billing Code	**Description**	**Limits**
				G0151* (RC 1)	Group (congregate) PT	See above for limits*.
				G0151 U1* (RC 1)	Individual PT	
Early Intervention Occupational Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child's natural environment.		
				Billing Code	**Description**	**Limits**
				G0152* (RC 1)	Group (congregate) OT	See above for limits*.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

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. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.gov The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov , under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				G0152 U1* (RC 1)	Individual OT	
Early Intervention Speech Language Pathology; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child's natural environment.		
				Billing Code	**Description**	**Limits**
				G0153 (RC 1)	Group (congregate) SLP	See above for limits*.
				G0153 U1 (RC 1)	Individual SLP	
Developmental Nursing; individual and/or group	12VAC30-50-13112 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention individual and group (congregate) Nursing Services or Developmental Services provided by a nurse, in the child's natural environment.		
				Billing Code	**Description**	**Limits**
				G0495* (RC 1)	Group (congregate) RN Training and Education Services;	See above for limits*.
				G0495 U1* (RC 1)	RN Individual Training and Education Services.	

SUMMARY OF COVERED SERVICES - PART 4A – LONG TERM SERVICES AND SUPPORTS (LTSS) FACILITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor shall cover this service. The Contractor shall also be responsible for non-nursing facility services and shall work with the NF on discharge planning if appropriate. The Contractor shall establish strong relationships with NFs to ensure that Members in NFs receive high quality care, maintain good health, and to reduce avoidable hospital admissions among NF residents. Contractors shall help facilitate Members returning to community settings when possible and desired by the Member. The Contractor may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired by Members.
Long Stay Hospital State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist Members in accessing services. The Contractor shall cover all services associated with the provision of long stay hospital services. Long Stay Hospital services are a state plan only service which covers individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services. The Contractor shall make provisions for the collection and distribution of the individual Member's monthly patient pay for long stay hospital services. Hospitals recognized as LSH are Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).
Specialized Care State Plan Only Service	12 VAC 30-60-40; 12 VAC 30-60-320 (ADULTS)	Yes	Yes	The Contractor shall cover all services associated with the provision of specialized care services for adults and children. Specialized care services are a state plan only service which covers complex trach and ventilator dependent nursing facility residents at a higher reimbursement rate. The Contractor shall make provisions for the collection and

SUMMARY OF COVERED SERVICES - PART 4A – LONG TERM SERVICES AND SUPPORTS (LTSS) FACILITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	12 VAC 30-60-340 (CHILDREN) Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			distribution of the individual Member's monthly patient pay for specialized care services. Transition services are covered for those individuals seeking services in the community through the Contractor or through the Money Follows the Person program.
Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)	http://www.dbhds.virginia.gov/library/developmental%20services/ods-voluntaryadmission2011.pdf http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/training-centers	Yes	No	The Contractor is not required to cover ICF-IID services. Individuals receiving services in an ICF-ID will be excluded from MLTSS participation.

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Alzheimer's Assisted Living Waiver (AAL) AAL Waiver Services	12 VAC 30-120-1600 through 12 VAC 30-120-1680 Additional information can be found in the AAL Waiver provider manual available on the DMAS web portal at www.virginiamedicaid.dmas.virginia.gov	Yes	No	The Contractor is not responsible for coverage Individuals in the AAL Waiver services will be excluded from CCC Plus program participation and will be covered under the DMAS fee-for-service program in accordance with DMAS established coverage criteria and guidelines. (See the AAL Provider Manual for additional information). However, individuals with Alzheimer's disease and persons with dementia will be included if they meet other eligibility requirements and are not enrolled in the Alzheimer's Assisted Living Waiver. Refer to Model of Care section 5.1.1.1 for more information. NOTE: The AAL Waiver will discontinue on June 30, 2018. At that time, individuals who were enrolled in the AAL Waiver may become enrolled in the CCC Plus program if they meet the eligibility requirements of the program. AAL Waiver services require service authorization through the appropriate DMAS contractor. Through person-centered care planning, the Contractor shall ensure that Members are aware of other community based treatment options available through the Contractor designed to serve Members in the settings of their choice. Assisted living services include personal care services, homemaker, chore, attendant care, and companion services. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. AAL Waiver services shall also include: 1. Medication administration: Medications shall be administered only by a provider employee who is currently licensed or registered to administer medications (physician, physician assistant, pharmacist, nurse practitioner, RN, LPN, other licensed health care professional (LHCP), or registered medication aide), by meeting the regulatory requirements as set forth by the DSS and the appropriate regulatory or licensing board of the Department of Health Professions in the Commonwealth. 2. Individual summaries: The LHCP must complete an admissions summary of each individual upon admission to the facility and when a significant change in health status or behavior occurs in one of the following areas: weight loss, elopements, behavioral symptoms, or adverse reactions to prescribed medication. A LHCP shall identify individual care problem areas and formulate interventions, to the extent permitted by his/her license, to address those problems and

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				to evaluate, to the extent permitted by his/her license, if the planned interventions were successful. 3. Skilled nursing services: Skilled nursing services are nursing services that are used to complete individual summaries and administer medications, and provide training, consultation, and oversight of direct support staff. Skilled nursing services must be provided by a LHCP who is licensed to practice in the state and provided in accordance and within the scope of practice specified by state law. 4. Therapeutic social and recreational programming: An activity program must be designed to meet the specific needs of each waiver individual and to provide daily activities appropriate to individuals with Alzheimer's or Alzheimer's related dementia. • This program shall be individualized and properly implemented, followed, and reviewed as changes are needed. • Waiver individuals who wander shall have an activity program to prevent this. • Consistent with 22VAC40-72-1100, there shall be structured group activities each week, not to include activities of daily living. • There shall be at least one hour of one-on-one activity per week, not to include activities of daily living. Such one-on-one activities may be rendered by such licensed or volunteer staff as determined appropriate by the provider. • Group activities must be provided by staff assigned responsibility for the activities. AAL Services Code T2031 (billed as a per diem)
CCC Plus HCBS Waiver *(formerly Elderly or Disabled with Consumer Directed Services EDCD and Technology Assisted Waivers)* General Requirements	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal	Yes	Yes	The Contractor shall provide care coordination, information and referrals as appropriate to assist Members in accessing these services. The Contractor shall cover personal care, respite care, adult day health care, personal emergency response systems, skilled private duty nursing, assistive technology, environmental modifications, services facilitation, transition services. The Contractor shall cover both agency directed and consumer directed services as a service delivery model for personal care and respite care services. Personal emergency response systems may include medication monitoring as well. Transition services are covered for those individuals seeking services in the community after transition from a qualified institution. The Contractor shall make provisions for the collection and distribution of the Member's monthly patient pay for Program

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	at: www.virginiamedicaid.dmas.virginia.gov			services (if appropriate). The Contactor shall cover transportation services for the CCC Plus Waiver program Members. Rates for all CCC Plus Waiver services have both a Northern Virginia and Rest of State rate structure with the exceptions of Assistive Technology and Environmental Modifications. Rates are paid based upon the Member FIPS except for Adult Day Health Care. (See additional details below for specifics regarding AT and EM.)
CCC Plus Waiver Personal Care	Same as General Requirements	Yes	Yes	Agency-or consumer-directed personal care services shall be offered to persons who meet the screening criteria, described at12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within ***at least*** equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Personal Care** A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized. Personal care shall not be a replacement for private duty nursing services performed by a RN. Service Codes AD = T1019 CD = S5126 Services are billed as hourly.
CCC Plus Waiver Respite Care	Same as General Requirements	Yes	Yes	Respite is for the relief of the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the Member.

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				Agency- or consumer-directed respite care services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. Respite coverage in children's residential facilities. A. Individuals with special needs who are enrolled in the CCC Plus Waiver and who have a diagnosis of developmental disability (DD) shall be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with DD. B. These respite services shall be covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery. **Service Definition - Respite Care** Respite services are unskilled services (agency-directed or consumer-directed) or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual. **Skilled Private Duty Nursing Respite Care (Agency-Directed Only)** Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services. **Congregate Private Duty Nursing Respite Care (Agency-Directed Only)** Congregate respite nursing provided to three or fewer Program individuals who reside in the same primary residence. Service Codes AD = T1005 CD = S5150

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				PDN RN Respite Services = S9125 TD PDN LPN Respite Services = S9125 TE Congregate Respite RN Nursing Services = T1030 TD Congregate Respite LPN Nursing Services = T1031 TE Services are billed as hourly Respite is limited to 480 hours per fiscal year – regardless of the number of providers or whether the individual receives agency and consumer directed respite services.
CCC Plus Waiver Adult Day Health Care ADHC	Same as General Requirements	Yes	Yes	Adult Day Health Care (ADHC) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Adult Day Health Care** Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who are elderly or who have a disability and who are at risk of placement in a NF. The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). ADHC may be offered either as the sole home- and community-based care service or in conjunction with other CCC Plus Waiver services. ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.
CCC Plus Waiver	Same as General Requirements	Yes	Yes	Personal Emergency Response Systems (PERS) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Personal Emergency Response System (PERS) PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.				under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Personal Emergency Response System (PERS)** Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual's safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual's home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices. PERS is not a stand-alone service. It must be authorized in conjunction with at least one qualifying CCC Plus Waiver service. Service Codes PERS nursing = H2021 TD (RN) PERS nursing = H2021 TE (LPN) PERS installation = S5160 Person installation + medication monitoring = S5160 U1 PERS monitoring = S5161 PERS medication monitoring = S5185 PERS nursing services are billed in 30 minute increments. PERS installation (w/ or w/out medication monitoring) is billed as per visit.
CCC Plus Waiver Services Facilitation	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be	Yes	Yes	Services Facilitation shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	found in the CCC Plus Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			**Service Definition – Services Facilitation** During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. The SF is responsible for completion of the following tasks related to service facilitation: • Service Facilitation Comprehensive Visit: • Consumer (Individual) Training: • Management Training • Routine On-site Visits • Reassessment Visit Service Codes SF Initial Comprehensive Visit = H2000 (billed as visit). SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit). SF Routine Visit = 99509 (billed as visit). SF Reassessment Visit = T1028 (billed as a visit).
CCC Plus Waiver Transition Services	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver provider manual available on the	Yes	Yes	Transition Services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. **Service Definition – Transition Services** Services that are "set-up" expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. Transition services do not apply to an acute care admission to a hospital. Transition Services Code T2038 (limited with a total cost regardless of the number of items to $5,000.00 per lifetime
CCC Plus Waiver Assistive Technology and Assistive Technology Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized as a standalone service. Assistive technology devices, as defined in 12VAC30-120-924, shall be portable and shall be authorized per fiscal year. AT = T1999 (limited to per item with a set limit of $5,000.00 per year) AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per year) AT and AT maintenance combined costs cannot exceed the $5,000.00 limit.
CCC Plus Waiver Environmental Modifications and Environmental Modification Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at:	Yes	Yes	Service Definition – Environmental Modifications (EMs) Physical adaptations to an individual's primary residence or primary vehicle which are necessary to ensure the individual's health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization. EM = S5165 (limited to per item with a set limit of $5,000.00 per year) EM Maintenance = 99199 U4 (limited to per item with a set limit of $5,000.00 per year) EM and EM maintenance combined costs cannot exceed the $5,000.00 limit

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	www.virginiamedicaid.dmas.virginia.gov			
CCC Plus Waiver Skilled Private Duty Nursing	Same as General Requirements	Yes	Yes	Private Duty Nursing (PDN) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Services shall be provided within *at least* equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720. **Service Definition – Skilled Private Duty Nursing (Skilled PDN)** In-home nursing services provided for individuals enrolled in the CCC Plus Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. **Service Definition – Congregate Skilled PDN** Skilled nursing provided to three or fewer CCC Plus Waiver individuals who reside in the same primary residence. Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances where individuals attend school or must be out of the home for part of the authorized PDN hours. Congregate skilled PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form. Coverage Limits – Up to 16 hours a day; 112 hours per week Service Codes PDN RN Nursing Services = T1002 (billed hourly) PDN LPN Nursing Services = T1003 (billed hourly) Congregate RN Nursing Services = T1000 U1 (billed hourly). Congregate LPN Nursing Services = T1001 U1 (billed hourly).

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Hospice Services	12 VAC 30-50-270 and 12 VAC 30-60-130 Additional information can be found in the Hospice provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes*	*Individuals receiving Hospice at time of enrollment will be excluded from CCC Plus program participation and will not be auto-enrolled. CCC Plus program enrolled Members who elect hospice will remain CCC Plus program enrolled. A Member may be in a waiver and also be receiving hospice services. The Contractor shall provide information and referrals as appropriate to assist Members in accessing services. The Contractor shall cover all services associated with the provision of hospice services. The Contractor shall ensure that children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. Categories of Care: 0651- Routine Home Care: In-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016 a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter. 0652 - Continuous Home Care: In-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour) 0655 - Inpatient Respite Care: Short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate. 0656 - General Inpatient Care: May be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day) 0658 - Nursing Facility: A resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Under FFS, hospice providers are reimbursed 95% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care. MCOs have the discretion to negotiate an alternative payment method with hospice providers for nursing home room and board services. 0551 - Skilled Nursing Visit – Used when submitting charges representative of a visit by a Registered Nurse within the Member's last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment. 0561 - Medical Social Service Visit – Used to be used when submitting charges representative of a visit by a Clinical Social Worker within the Member's last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.
Money Follows the Person (MFP)	12 VAC 30-120-2000; 12 VAC 30-120-935; 12 VAC 30-120-935; and 12 VAC 30-120-2010 Additional information can be found in the Waiver provider manuals (as Appendix E)	Yes	No	Individuals in MFP will be excluded from CCC Plus program participation. MFP demonstration services include: transition coordination up to two months prior to and 12 months following discharge from an institution (only for individuals who are participants in MFP and transition to the CCC Plus Waiver); assistive technology for individuals who are participants in the MFP and the CCC Plus Waiver, for up to 12 months after discharge from an institution; environmental modifications for individuals who are enrolled in MFP and the CCC Plus Waiver, for up to 12 months after discharge from an institution; and transition services up to nine months, two of which can be prior to discharge from an institution. Individuals participating in MFP will be excluded from CCC Plus program. CCC Plus program Members will no longer have the option to move from a NF to the community through the MFP program after 12/31/2017. Members will have the option to transition to the community within the CCC Plus program model. Plans will need to

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov			ensure that enrollees in NFs who wish to move to the community get referred to the screening teams as appropriate.
Money Follows the Person (MFP) Assistive Technology and Assistive Tech. Maintenance AT = T1999 (limited to per item with a set limit of $5,000.00 per year) AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per year) AT and AT maintenance combined costs cannot exceed the $5,000.00 limit.	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the EDCD Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	No	Individuals in MFP will be excluded from CCC Plus program participation. For these individuals, Assistive Technology services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized as a standalone service. Assistive technology devices, as defined in 12VAC30-120-924, shall be portable and shall be authorized per fiscal year.
Money Follows the Person (MFP) Assistive Technology and Assistive Technology Maintenance AT = T1999 (limited to per item with a set limit of $5,000.00 per year)	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the EDCD Program provider manual available on the DMAS web	Yes	No	Individuals in MFP will be excluded from CCC Plus program participation. For these individuals, Assistive Technology services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-307. Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized as a standalone service.

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per year) AT and AT maintenance combined costs cannot exceed the $5,000.00 limit.	portal at: www.virginiamedicaid.dmas.virginia.gov			Assistive technology devices, as defined in 12VAC30-120-924, shall be portable and shall be authorized per fiscal year.
Program of All-Inclusive Care for the Elderly (PACE)	12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_atchs/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf	Yes	No	Individuals in PACE will be excluded from CCC Plus program participation. Individuals in CCC Plus program have the right to transition from CCC Plus program to PACE, including outside of their annual open enrollment. The Contractor shall ensure that Members are aware of PACE. PACE provides qualifying Members a fully integrated community alternative to nursing home care, and provides care/services covered by Medicare/Medicaid, and may include enhanced services not covered by Medicare/Medicaid. PACE coverage includes prescription medications, doctor care, transportation, home care, hospital visits, adult day services, respite care, restorative therapies, and nursing home stays, when necessary. In order to qualify for PACE, an individual must be 55+ years of age, live within a PACE service area, and be able to reside safely within the community at the time of enrollment. When a Member requests additional information about PACE, the contractor shall assist the Member with obtaining information and related referrals. This includes checking to see if there is a PACE site in the Member's service area. This information is available via the DMAS website: http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx (based upon the member's zip code). The Contractor shall refer Members interested in enrolling in PACE to their Local Department of Social Services (LDSS) to request a UAI screening. Meeting the functional criteria for nursing home level of care is a requirement for PACE enrollment and screening must be coordinated through the Member's LDSS.

SUMMARY OF COVERED SERVICES - PART 4C – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED DD SERVICES				
Waiver Services for Individuals in the 3 Developmental Disabilities (DD) Waivers The Contractor is not required to cover DD Waiver Services **(including when covered under EPSDT)**, DD targeted case management (T1017 & T2023), or transportation to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Coverage Details
Building Independence Waiver formerly Day Support (DS) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Day Support Waiver** will become the **Building Independence Waiver** which will include supports for adults (18+) who live independently in their own homes. Services may be complemented by non-waiver funded rent subsidies and/or other types of support.
Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Individual and Family Developmental Disabilities Support (DD) Waiver** will become the **Family and Individual Supports Waiver** which will include supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.
Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver	Regulations and Manual are currently in process.	Yes	No	The **Intellectual Disability (ID) Waiver** will become the **Community Living Waiver**, which will include residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs.
A description of all waiver services and a comparison of the services covered under each DD Waiver is available below				

Services Available Under the DD Waivers *(Carved out of this contract and covered through fee-for-service.)*

Shared Living = T1020 (billed as either full month or partial month)

This is a new service and is available under all 3 DD waivers.

An individual would live in an apartment, condominium, townhome, or other home in the community with a roommate of the Member's choice. The roommate acts as the individual's live-in companion. Individuals must be 18 years old or older and must be directly responsible for the residence (i.e., the individual must either rent or own it).

Individuals will be responsible for all expense associated with their housing, utilities and food as well as those for the live-in companion. Those expenses incurred by the individual and determined to be usual, reasonable and within the location's maximum reimbursement amount will be reimbursed by Medicaid consistent with the service authorization. These expenses may be covered when the live-in companion provides companionship supports, including fellowship

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
and enhanced feelings of security, and may include limited Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) supports as long as these account for no more than 20% of the anticipated companionship time on a weekly basis. The individual is responsible for his own living expenses. Designated Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive payment for administering this service. After retention of an allowable amount for administrative expenses, the provider will distribute payments to the individual to reimburse for expenses incurred per the service authorization. Tiers do not apply to this service. Size does not apply to this service.
Community Engagement = T2021 (billed as hourly) This service applies to all 3 of the DD the waiver(s): This is a new service that provides the individual with a wide variety of opportunities to build relationships and natural support systems, while utilizing the community as a learning environment. It supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). These services are provided to the individual at no more than a 1:3 staff to individual ratio. Tiers 1-4 do apply to this service. Size does not apply to this service.
Community Coaching = 97532 (billed as hourly) This service applies to all 3 of the DD waivers This is a new service designed to engage the individual in the community and to help the individual be supported to minimize a barrier from participating in activities of community engagement. This is a one-on-one service that occurs in a community setting. Tiers do not apply to this service. Size does not apply to this service.
Group Day Services = 97150 (billed as hourly) This service applies to all 3 of the DD waivers This includes skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, enhancement of social networks and assurance of an individual's health

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
and safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services are delivered in a group setting of no more than 1:7 staff to individual ratio. Tiers 1-4 do apply to this service and are stand-alone tiers. Size does not apply to this service.
Individual Supported Employment = H2023 (billed as hourly) This service applies to all 3 of the DD waivers: This is a service that is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment. Tiers do not apply to this service. Size does not apply to this service.
Group Supported Employment = H2024 (billed as hourly using the modifier related to the size.) This service applies to all 3 of the DD waivers This is a service that provides continuous staff support in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group Supported Employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. These supports enable an individual to obtain and maintain a job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Tiers do not apply to this service. Size applies to this service. Size is defined as: • 2 or Fewer Individuals/Staff = Size 1 = UA • 2+ TO 4 Individuals/Staff = Size 2 = U2 • 4+ Individuals/Staff = Size 3 = U3
Electronic-Based Home Supports = A9279 (limited to $5K per year) This service applies to all 3 of the DD waiver

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
This is a new service designed to give individuals support to gain more independence and freedom at home by using electronic equipment. Electronic devices can be purchased and installed in the individual's home to help monitor and support greater autonomy. To qualify for reimbursement, purchases must substitute for other Medicaid services, promote integration into the community and increase the individual's safety in the home. Providers that bill and receive payment for this service are responsible for providing emergency assistance 24 hours a day and 365 or 366 days a year as well as furnishing, installing, maintaining, testing and providing user training of the services. Members receiving per diem residential services will not qualify to receive this service. Tiers do not apply to this service. Size does not apply to this service.
Assistive Technology (AT) = T1999 (limited to per item with a set limit of $5,000.00 per year) AT Maintenance = T1999 U5 (limited to per item with a set limit of $5,000.00 per year) This service applies to all 3 of the DD waivers. AT and AT maintenance costs cannot exceed the $5,000.00 limit. This means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment. Tiers do not apply to this service. Size does not apply to this service.
Environmental Modifications (EM) = S5165 limited to per item with a set limit of $5,000.00 per year) EM Maintenance = 99199 U4 (limited to per item with a set limit of $5,000.00 per year) This service applies to all 3 of the DD waiver. EM and EM maintenance costs cannot exceed the $5,000.00 limit. This means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals. Tiers do not apply to this service. Size does not apply to this service.
Personal Emergency Response System (PERS) This service applies to all 3 of the DD waivers. PERS NURSING = H2021 TD (RN) PERS NURSING = H2021 TE (LPN)

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
PERS INSTALLATION = S5160 PERSON INSTALLATION + MEDICATION MONITORING = S5160 U1 PERS MONITORING = S5161 PERS MEDICATION MONITORING = S5161 PERS nursing services are billed in 30 minute increments. PERS installation (w/ or w/out medication monitoring) is billed as per visit. PERS monitoring (w/ or w/out medication monitoring) is billed as monthly. Personal emergency response systems (PERS): an electronic device and monitoring service that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.
Transition Services = T2038 (limited to per item with a total cost regardless of the number of items is a set limit of $5,000.00) This service applies to all 3 of the DD waivers. This means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Tiers do not apply to this service. Size does not apply to this service.
Community Guide/Peer Mentoring = H0038 This service applies to all 3 of the DD waivers. This service has a delayed implementation date of July 2017.
Benefits Planning = T1023 (billed as hourly) This service applies to all 3 of the DD waiver This service has a delayed implementation date of July 2017.
Non-Medical Transportation = T2001 (billed based on mileage) This service applies to all 3 of the DD waiver(s): This service has a delayed implementation date of July 2017.
Crisis Support Services = T2034 (billed as hourly) This service applies to all 3 of the DD waivers. Includes the following components:

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
Crisis Prevention: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis prevention may be authorized for up to 60 days per ISP year. **Crisis Intervention**: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year. **Crisis Stabilization**: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year. Services may be authorized for an individual who has a history of at least one of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) previous residential/day placement or placements were terminated; or (iv) behaviors that have significantly jeopardized placement. Services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times). Tiers do not apply to this service. Size does not apply to this service.
Center-Based Crisis Supports = H2011 UA and H2011 U1 (billed as hourly) This service applies to the following waiver(s): 1) Building Independence Waiver formerly Day Support (DS) Waiver 2) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 3) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver The service includes crisis prevention and stabilization services in a residential setting (a crisis therapeutic home) using plan and emergency admissions. Services are approved for those individuals who will need ongoing crisis supports for long term. Services may be authorized for individuals who are at risk of at least one of the following: 1) psychiatric hospitalization; 2) emergency ICF/IID placement; 3) immediate threat of loss of community service due to severe situational reaction; or 4) causing harm to himself or others. Tiers do not apply to this service. Size does not apply to this service.
Community-Based Crisis Supports = H0040 and H0040 U1 (billed as hourly for up to 6 months per year in 30 day increments) This service applies to the following waiver(s):

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
1) Building Independence Waiver formerly Day Support (DS) Waiver 2) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 3) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver In order to be approved to receive this service, the individual shall 1. have a history of at least one of the following: a. previous psychiatric hospitalization or hospitalizations; b. previous incarceration; c. lost previous residential/day placement or placements; or d. his behavior or behaviors have jeopardized his community placement. 2. meet at least one of the following: a. is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning; b. is experiencing an increase in extreme emotional distress; c. needs continuous intervention to maintain stability; or d. is actually causing harm to himself or others. 3. also: a. be at risk of psychiatric hospitalization; b. be at risk of emergency ICF/IID placement; c. be at immediate threat of loss of community service due to a severe situational reaction; or d. is actually causing harm to himself or others. The service provides ongoing supports to individuals in their homes and community settings or both. Tiers do not apply to this service. Size does not apply to this service.
Supported Living Residential (formerly part of Congregate Residential Supports) = H0043 (billed as per diem with a maximum of 344 days/year) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver This service provides access to 24 hour supports in an apartment setting operated by a DBHDS licensed provider. Services are provided to the individual in the form of ‘round the clock availability of paid staff who have the ability to respond in a timely manner. These supports may be provided individually or

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
simultaneously to more than one individual living in the apartment, depending on the required support. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. The unit of service billed will be "daily" when the new waivers take effect. Tiers 1-4 do apply to this service and are stand-alone tiers. Size does not apply to this service.
In-Home Supports (formerly In-home Residential Supports) = H2014 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver This is a supplemental service that take place in an individual's home, family's home or community setting. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Usually, In-home supports involve one staff person to one individual, but now may include 1:2 or 1:3 as appropriate. The latter is a change from previous allowances. The unit of service billed remains "hourly." Tiers do not apply to this service. Size applies to this service. Size is defined as: 2 or Fewer Individuals/Staff = Size 1 = UA 2+ TO 4 Individuals/Staff =Size 2 = U2 4+ Individuals/Staff = Size 3 = U3
Skilled Nursing: RN = S9123 (TD) LPN = S9124 (TE) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Services are billed as 15 minute increments. This is an existing service that will not change as part of the waiver redesign; however, individuals receiving this service may be assessed to determine whether private duty nursing is now the appropriate service.

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
Skilled nursing services: means both skilled and hands-on care, as rendered by either licensed RN or LPN, of either a supportive or health-related nature nursing services ordered by a physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver. Tiers do not apply to this service. Size does not apply to this service.
Private Duty Nursing: RN = T1002 (TD) LPN = T1003 (TE) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Services are billed as 15 minute increments. This is a new service that is designed to provide individual and continuous medically necessary care as certified by a physician, physician assistant or nurse practitioner to individuals with a serious medical condition and/or complex health care need. It allows individuals to remain at home to receive care instead of in a nursing facility, hospital or ICF-IID. This service is provided to an individual at his place of residence or other community setting. Tiers do not apply to this service. Size does not apply to this service.
Therapeutic Consultation - Therapists/Behavior Analysts/Rehab Engineer = 97139 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service. Tiers do not apply to this service. Size does not apply to this service.
Therapeutic Consultation - Psychologist/Psychiatrist = H2017 (billed as hourly)

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service. Tiers do not apply to this service. Size does not apply to this service.
Therapeutic Consultation - Other Professionals = 97530 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service. Tiers do not apply to this service. Size does not apply to this service.
Personal Assistance AD = T1019 (billed as hourly) CD = S5126 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Personal assistance: means assistance with ADL's, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition. These services may be agency-directed or consumer-directed. Tiers do not apply to this service. Size does not apply to this service.

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
Respite Services AD = T1005 (billed as hourly) CD = S5150 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Respite: services means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. These services may be agency-directed or consumer-directed. Tiers do not apply to this service. Size does not apply to this service.
Companion Services AD Companion = S5135 (billed as hourly) CD Companion = S5136 (billed as hourly) This service applies to the following waiver(s): 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Companion: means non-medical care, or support and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail (routine) hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature. Companions may assist or support the individual (enrolled in the waiver) with such tasks as meal preparation, community access and activities, laundry, and shopping but companions do not perform these activities as discrete services. Companions may also perform light housekeeping, tasks (such as bed-making, dusting, and vacuuming, laundry, grocery shopping, etc.) which such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. These services may be agency-directed or consumer-directed. Tiers do not apply to this service. Size does not apply to this service.
Services Facilitation (SF) This service applies to the following waiver(s):

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver SF Initial Comprehensive Visit = H2000 (billed as visit). SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit). SF Routine Visit = 99509 (billed as visit). SF Reassessment Visit = T1028 (billed as a visit). Service Definition – Services Facilitation During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. The SF is responsible for completion of the following tasks related to service facilitation: • Service Facilitation Comprehensive Visit: • Consumer (Individual) Training: • Routine On-site Visits • Reassessment Visit • Management Training Tiers do not apply to this service. Size does not apply to this service.
Group Home Residential (formerly part of Congregate Residential Supports) = H2022 (billed as per diem with a maximum of 344 days/year) This service applies to the following waiver(s): 1) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver Provides services in a home in which an individual lives with other individuals with developmental disabilities receiving supports from paid staff. These supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Providers must be licensed by DBHDS and follow state and federal guidelines to participate in the service. The unit of service billed will be "daily" when the new waivers take effect. Tiers 1-4 do apply to this service and are stand-alone tiers. Size applies to this service. Size is defined as:

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
4 or Fewer Individuals/Staff = Size 1 = UA 5 individuals/staff = Size 2 = U2 6 individuals/staff = Size 3 = U3 7 individuals/staff = Size 4 = U4 8 individuals/staff = Size 5 = U5 9 individuals/staff = Size 6 = U6 10 individuals/staff = Size 7 = U7 11 individuals/staff = Size 8 = U8 12 individuals/staff = Size 9 = U9
Sponsored Residential (formerly part of Congregate Residential Supports) = T2033 (billed as per diem) This service applies to the following waiver(s): 1) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver **Effective January 1, 2017:** Provides individuals the ability to live with a family or single "sponsor" in the community. No more than two individuals can live in the sponsor's home. The supports provided by the sponsor may include skill building, supports with ADLs and IADLs, community access and recreation/social supports, as well as general supports. Sponsors are generally not related to the individual unless all other alternatives were investigated and found not to be appropriate for the individual. Sponsors are affiliated with a DBHDS licensed agency. Tiers 1-4 do apply to this service and are stand-alone tiers. Size does not apply to this service.
Independent Living = T2032 (full month) T2032 U1 (partial month) This service applies to the following waiver(s): 1) Building Independence Waiver formerly Day Support (DS) Waiver This is a new service provided to adults (18 and older) that offers skill building and supports necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with a roommate in their own homes or apartments. The roommate may be paid (see Shared Living above) or unpaid. The unit of service billed is "monthly" or "partial month." Monthly services = no modifier Partial Month services = U1 modifier Tiers do apply to this services There are only two Tiers for this service.

Services Available Under the DD Waivers ***(Carved out of this contract and covered through fee-for-service.)***
Tier 1 (stand-alone) Tiers 2-4 (combined together) Size does not apply to this service.

ATTACHMENT 6 - DMAS DEVELOPMENTAL DISABILITY WAIVER SERVICES

SERVICES	Building Independence Waiver	Family and Individual Support Waiver	Community Living Waiver
Shared Living	X	X	X
Group Home Residential			X
Sponsored Residential			X
Supported Living Residential		X	X
In Home Supports		X	X
Independent Living Supports	X		
Community Engagement	X	X	X
Community Coaching	X	X	X
*Community Guide/Peer Mentoring	X	X	X
Group Day Services	X	X	X
Individual Supported Employment	X	X	X
Group Supported Employment	X	X	X
Workplace Assistance Services		X	X
Private Duty Nursing Services		X	X
Skilled Nursing Services		X	X
Therapeutic Consultation		X	X
Crisis Support Services	X	X	X
Center-based Crisis supports	X	X	X
Community-based Crisis Supports	X	X	X
Personal Assistance Services		X	X
Respite Services		X	X
Companion Services		X	X
PERS	X	X	X
Assistive Technology	X	X	X
Environmental Modifications	X	X	X
Individual & Family/Caregiver Training		X	
Transition Services	X	X	X
Electronic Home-Based Supports	X	X	X
Services Facilitation		X	X
*Benefits Planning	X	X	X
*Non-Medical Transportation	X	X	X

ATTACHMENT 7 - CCC PLUS PROGRAM REGIONS AND LOCALITIES

CENTRAL REGION					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLES CITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
49	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		
TIDEWATER REGION					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK
NORTHERN & WINCHESTER REGION					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
CHARLOTTESVILLE WESTERN REGION					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		
ROANOKE/ALLEGHANY REGION					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
063	FLOYD	141	PATRICK		
SOUTHWEST REGION					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

ATTACHMENT 8 - COMMON DEFINITIONS FOR MANAGED CARE TERMS

PER 42 CFR § 438.10(c)(4)

Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by our plan if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Co-payment: See definition for cost sharing.

Cost-sharing: The costs that Members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and co-payments, or similar charges.

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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or are 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 provide your 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.

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."

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: See Service Authorization.

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 (PCP): Your primary care physician (also referred to as 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.

Primary care provider: Refer to Primary care physician.

Provider: A person who is authorized to give health care or services. Many kinds of providers participate with your plan, including doctors, nurses, behavioral health providers and specialists.

Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, or major operation.

Service authorization: Also known as 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.

Skilled nursing care: care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Urgently needed care (Urgent care):. Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

ATTACHMENT 9 - 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.

_____
(INDICATE NAME AND TITLE)
(CFO, CEO, OR DELEGATE)
on behalf of

_____
(INDICATE HEALTH PLAN NAME)

ATTACHMENT 10 – EI FAMILY DECLINING TO BILL PRIVATE INSURANCE

Infant & Toddler Connection of Virginia

Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance

The parent(s) of _____ (child's name) has declined access to their private health/medical insurance for covered early intervention services.

_____
Name of Local Early Intervention System Representative

_____
Signature of Local Early Intervention System Representative

_____
Date

ATTACHMENT 11 - MOC ASSESSMENT (HRA) AND INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS BY POPULATION

Population	Initial HRA *New Members*	Initial ICP *New Members*	Reassessment and ICP Review	As Needed ICP Revised	Annual LOC Review and NF Reassessments
CCC Plus Waiver Technology Assisted Benefit Plan	Within 14 days of enrollment with Contractor (must be face-to-face)[1]	Within 30 days of enrollment (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.[2]) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.	Every 6 months[3] (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor conducts annual face-to-face LOC review for continued eligibility for the Tech assisted individuals in the CCC Plus Waiver[4]
CCC Plus Waiver Standard Benefit Plan	Within 30 days of enrollment with Contractor (must be face-to-face)	Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.	Every 6 months[5] (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor conducts annual face-to-face level of care review for continued eligibility for the CCC Plus Waiver
Other High-Risk Populations SMI & Not well managed"	Within 60 days of enrollment with Contractor; SMI must be face-to-face.	Within 90 days of enrollment. (Contractor must honor existing ICPs and SAs until SA ends or for the duration of the continuity of care period, whichever is sooner.) ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.	By ICP anniversary date; SMI must be face-to-face.	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Nursing Facility Including Long-Stay Hospital	Within 120 days of enrollment with Contractor (must be face-to-face and incorporate MDS)	Within 120 days of enrollment. (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA. Contractor must make initial contact with the Member and NF within first 30 days of enrollment	Follow MDS guidelines/time frames for quarterly & annual reassessment and ICP development	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor works with facility on annual reassessment reviews for continued nursing facility placement
Emerging High Risk Populations Moderate to Low Risk; "well managed."	Within 120 days of enrollment with Contractor (180 during Medallion ABD Transition)	Within 120 days of enrollment (180 during the ABD Transition). Contractor must honor existing ICPs & SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of existing SA. Contractor must make initial contact within 30 days of enrollment.	By ICP anniversary date	Upon triggering event such as a hospitalization or significant change in health/functional status	N/A

[2] The clock starts at the effective date of enrollment and days are measured in calendar days.
[3] SAs data will be shared in the Member's transition report. Reference Section 5.14, *Continuity of Care*; until 4/1/18 = 90 days (or more until HRA completion); 4/1/18 and after = 30 days+ (or more until HRA completion).
[4] Contractors shall comply with requirements for the CCC Plus Waiver for the Tech assisted subpopulation as described in 12 VAC 30-120-900 et seq.
[5] Local and Hospital Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, CCC Plus Waiver).
[6] Contractors must comply with requirements for the CCC Plus Waiver individuals as established in 12 VAC 30-120-900 et seq.

ATTACHMENT 12 - INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS CHECKLIST (PER CMS FINAL RULE)

The **Individualized Care Plan (ICP)** must reflect the services and supports that are important for the individual's identified needs and preferences for delivery of such supports and services. According to Section **441.301 (2) (i)** through **(xiii)** of the Final Rule (**CMS 2249-F/2296-F)**, a **written ICP** must:

- Reflect that the current residential setting was the individual's choice and is integrated in, and supportive of full access of the individual to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs that have been identified through a functional needs assessment.
- Includes individually identified goals and outcomes.
- Reflect the (paid/unpaid) services/supports, and providers of such services/supports that will assist the individual to achieve identified goals.
- Reflect risk assessment, mitigation, and backup planning.
- Be understandable (e.g. linguistically, culturally, and disability considerate) to both the individual receiving HCBS/the individual's support system.
- Identify the individual and/or entity responsible for monitoring the ICP.
- With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the ICP.
- Be distributed to the individual and others involved in the ICP.
- Include services that afford the individual the option to self-direct.
- Prevent service duplication and/or the provision of unnecessary services/supports.
- Document that any modifications to compliance with the HCB settings requirements for provider owned/operated residential settings are supported by a specific assessed need and justified in the ICP in the following manner:
    1. Identify a specific and individualized assessed need.
    2. Document previous positive interventions and supports utilized prior to any modifications to the ICP.
    3. Document less intrusive methods of meeting the need(s) of the individual that did not work.
    4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
    5. Include a regular collection and review of data to measure the ongoing efficacy of the modification.
    6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    7. Included informed consent of the individual.
    8. Include an assurance that interventions and supports will cause no harm to the individual.
    - The ICP must be reviewed and revised upon reassessment of functional need at least once every 12 months, **OR** when the individual's circumstances/needs change, **OR** at the request of the individual.

ATTACHMENT 13 - NOTIFICATION OF PROVIDER INVESTIGATION

This form is to be used to notify the Department of Medical Assistance Services (DMAS) that your organization plans to conduct an audit of this provider. Once an allegation has been vetted and determined to warrant further investigation/audit, it is at this point that a notification should be sent to DMAS via email at:

CCCPlusReporting@dmas.virginia.gov

This form shall be sent to DMAS for all audits conducted by Contractor staff, as well as any audits that may be conducted by Contractors. Once an allegation has been vetted and determined to warrant further investigation/audit, it is at this point that DMAS should be notified of the case through the **Notification of Provider Investigation**. This is regardless of whether the target of that allegation is scheduled to be audited immediately, or is merely being placed in the queue to be audited when resources come available. Every Notification of Investigation should be reported on the quarterly fraud, waste and abuse tracking spreadsheet and remain on that spreadsheet until the case has been investigated and closed.

A **Notification of Provider Investigation** does not need to be sent for all "allegations" of provider misconduct. An **allegation** is any referral that a Contractor receives that indicates a potential program integrity issue that may warrant investigation. These allegations can come from a variety of sources including hotlines, EOMBs, Member complaints, other divisions outside of the SIU, DMAS, HHS-OIG, as well as data analyses that identify potential fraud, waste or abuse through outliers or other aberrant patterns. These allegations should be tracked internally and do not need to be reported on a case-by-case basis to DMAS. These allegations should then be assessed to determine if they warrant further investigation. This assessment can consist of a variety of activities including contacting the source of the allegation, evaluating claims data, examining prior audits of that provider, and potentially even contacting the provider. In most cases, this assessment will not involve requesting and reviewing medical records.

Referred by
Name: Title: Phone: Email:
Managed Care Organization Name
Address
Date of DMAS Notification

Provider Investigation Detail

Provider name	
Medicaid ID (NPI)	
Tax Identification Number (TIN) – if available	
Address	
City or County	
	FIPS:
Provider type	
Source/origination of allegation	
Description of suspected misconduct Category of service	
Factual explanation of the allegation	
Description of planned investigation Type/description of investigation to be conducted	
Specific Medicaid statute, rule, regulation, and/or policy violations being investigated	
Date(s) of conduct being reviewed.	
Dollar amount of claims being reviewed	
Amount paid to provider during the past 3 years or during the period of the alleged misconduct, whichever is greater	
Note any attachments you are sending with this notification	

ATTACHMENT 14 – CCC PLUS WAIVER CHANGE NOTICE FORM

Date: _____/_____/_____

Sender Information:

CCC Plus MCO: _____

CCC Plus Care Coordinator Name: _____

Care Coordinator Telephone Number: _____

IDENTIFICATION INFORMATION

Member Name: _____
First Middle Last

Birthdate: _____/_____/_____ **Sex:** [ ] Male [ ] Female **Region:** _____

Medicaid No: _____ (12-digit number)

IMPORTANT: IF THE MEMBER DOES NOT MEET WAIVER MEDICAL NECESSITY CRITERIA, A LEVEL OF CARE REVIEW MUST BE COMPLETED. THIS FORM DOES NOT SERVE AS A LEVEL OF CARE REVIEW.

☐ **1. CCC Plus Waiver – NO SERVICES ACCEPTED**
Member meets CCC Plus Waiver criteria but has refused services.
Date of refusal: _____/_____/_____ Reason for refusal: Attach Documentation

☐ **2. No CCC Plus Waiver or other LTSS Services for more than 30 consecutive days**
Member meets CCC Plus Waiver criteria but has gone without services.
Upon enrollment, member had no prior authorization or claims data. [ ] Yes [ ] No
Validated by DMAS: [ ] Yes [ ] No
What was the last date of CCC Plus Waiver or other LTSS services? _____/_____/_____
Attach Documentation answering the following questions:

- What is the reason for no LTSS services for more than 30 consecutive days?
- What contacts have been made with the member by the Care Coordinator in the last 60 days?
- What strategies were utilized by the Care Coordinator to maintain services, as applicable?

☐ **3. Level of Care Change –** Private Duty Nursing request forms must be submitted to DMAS within 2 business days after identifying need to begin or end PDN service. **Date of change:** _____/_____/_____

[ ] Starting PDN Service [ ] Ending PDN Services

Attach Completed Documentation:

- Technology Assisted Waiver Adult or Pediatric Referral Form (DMAS-108 or 109) and
- CMS 485 (physician's orders) if starting PDN services

If PDN services are discontinuing, check the required continued CCC Plus Waiver service:
_____ Personal Care: (Agency or CD)
_____ Adult Day Health Care
_____ Respite Care (Agency or CD)

FOR DMAS USE ONLY: Date of Review: _____CM Specialist: _____ Change Effective Date: _____
Outcome: ____ Disenroll for refusal of services _____ Change LOC from 9 to A_____ Change LOC from A to 9
NO MMIS ENTRY REQUIRED: ___ CC to submit/enter LOC Review ___ Returned to CC for further action

INSTRUCTIONS

Purpose: This form is used by all Commonwealth Coordinated Care Plus Managed Care Programs when: a member is enrolled in the CCC Plus Waiver, meets criteria but refuses CCC Plus Waiver services or has not received Waiver or other LTSS Services for more than 30 consecutive days. Other LTSS services include NF days, previous PACE enrollment, and Alzheimer's Assisted Living Waiver enrollment. Inpatient Rehabilitation admission and dates of stay are not LTSS services. ***The health plan shall not terminate CCC Plus Waiver enrollment.***

Date: Please enter the date that the form is completed.

Sender Information: Provide name of CCC Plus Health Plan, the name of the member's Care Coordinator and their phone contact information.

IDENTIFICATION INFORMATION
Member Name: Please enter the member's complete name.
Birth date: Please enter the member's complete date of birth.
Sex: Please mark the appropriate box for the gender of the member.
Region: Please enter the number associated with the region where member lives.

1	Tidewater
2	Central
3	Western/Charlottesville
4	Roanoke / Alleghany
5	Southwest
6	Northern / Winchester

Medicaid Number: Please enter the 12-digit Medicaid number. The 12-digit Medicaid number must be completed in order to process the form.

If member no longer meets CCC Plus medical necessity waiver criteria, a Level of Care review must be completed instead of this form. The Level of Care is entered into the LOCERI system following the review by the DMAS Care Management Unit.

Check which box applies to the change being requested.

1. CCC Plus Waiver - NO SERVICES ACCEPTED

Member meets CCC Plus Waiver criteria but has refused services. Please indicate that the member appears to meet CCC Plus Waiver criteria based on the Care Coordinator assessment.
Date of refusal: Please enter the date the member refused all qualifying CCC Plus Waiver services
Reason for refusal or change in circumstances: Please write a brief description of the reason for refusal and submit as an attachment to this form. In the documentation, any issues or concerns creating the refusal must be addressed, as indicated. The Waiver will not be terminated until all concerns or needs have been addressed.

2. No CCC Plus Waiver or other LTSS Services for more than 30 consecutive days
This category is for when a member meets CCC Plus Waiver criteria but has gone without services. Please indicate that the member appears to meet the Waiver criteria based on the Care Coordinator assessment but has not accessed services.

Please indicate whether upon enrollment with the health plan whether there were services in place that member was receiving. If services were not in place at enrollment into the CCC Plus Program, prior service authorization and claims history data provided by DMAS must be reviewed to determine the most recent service. Prior to submitting this

form, the member information must be sent to DMAS via email to CCCPlusMCOs@dmas.virginia.gov for research and guidance.

Please enter the last date the member received LTSS services.

Attach documentation answering the questions to explain in detail the reason the member has gone without services when criteria indicate a medical need for services. Please write a description of the reason for the lapse in services. Please describe in detail the efforts made by the Care Coordinator to ensure the member's care needs are met. Provide the dates and type of contacts made by the Care Coordinator within the past 60 days. For reasons other than a lengthy inpatient admission or similar circumstance, provide a summary of strategies used by the Care Coordinator to maintain services, including alternative benefit planning with network and enhanced coverage.

3. Level of Care Change

Date of Change: Please indicate the date of the changes. PDN request forms must be submitted to DMAS within 2 business days after identifying need to begin or end PDN.

Please check if the change is to start PDN Services or end them.

Beginning Private Duty Nursing: Please certify that the member meets criteria to receive PDN and complete the DMAS 108 or 109 as appropriate. (See Medicaid Provider Portal for provider forms listed under Technology Assisted Waiver.) Please attach the 108 or 109 form, along with the CMS 485 with the submission of the CCC Plus Waiver Change Notice Form.

Discontinuing Private Duty Nursing: Please certify that the member no longer meets criteria to receive PDN services and complete the DMAS 108 or 109 as appropriate. Please also check which waiver service the member will continue to receive. If no service is checked, member will no longer qualify for the waiver. A Level of Care review must be completed.

Upon DMAS approval, Care Coordinator discusses termination of PDN services with the provider and member, and sends notice of services ending (within 10 days) and appeal rights to the member; CC will work with the member and/or caregiver to revise the Individualized Care Plan to meet individual's needs.

SUBMISSION INSTRUCTION: CC submits the CCC Plus Waiver Change Notice Form with all attached supporting documentation to DMAS via email at CCCPlusCareCoordination@dmas.virginia.gov or the form can be faxed with attachments to DMAS at 804-452-5442. All email or fax subject lines should read: CCC PLUS WAIVER CHANGE NOTICE FORM.