

**Agreement between the Commonwealth of Virginia
Department of Medical Assistance Services
and**

Recitals

THIS AGREEMENT, made on _____, and effective on the date of _____ between the Virginia Department of Medical Assistance Services (“DMAS”, “the Department” or “the State”), an administrative agency within the executive agency of the Commonwealth of Virginia responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and, the Code of Virginia § 32.1-325, et seq., and _____ (“Medicare Advantage Health Plan” or “MA D-SNP”), a corporation organized under the laws of the State of Virginia and having a principal place of business at _____.

WHEREAS, pursuant to the Medicare Improvements for Patients and Providers Act and the Patient Accountability and Affordability Act of 2008, MA D-SNPs are required by CMS to contract with State Medicaid agencies. Accordingly, the MA D-SNP wishes to enter into a contract with the Department that satisfies federal contracting requirements.

WHEREAS, MA D-SNP has entered or has applied to enter into a Medicare Advantage Dual-Eligible Special Needs Plan Agreement (“MA Agreement”) with the Centers for Medicare and Medicaid Services (“CMS”) whereby MA D-SNP provides or desires to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under a Dual Eligible Special Needs Plan in the state of Virginia.

WHEREAS, MA D-SNP desires to enter into an Agreement with the State to (i) meet the requirements of federal regulations described in 42 CFR 422 and 423; and (ii) ensure the MA D-SNP can appropriately and accurately identify Medicare beneficiary eligibility for the State’s Medicaid benefits and the MA D-SNP.

WHEREAS, MA D-SNP has entered into an Agreement, or is applying to enter into an Agreement, with the State to provide Long Term Services and Supports (“LTSS”) to qualified beneficiaries under a Managed Long Term Services and Supports (“MLTSS”) contract.

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

Article I. DEFINITIONS

Behavioral Health Services Administrator (BHSA) - An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. The BHSA is responsible for administering the Department's behavioral health benefits for fee-for-service and managed care enrollees, unless otherwise excluded, on a statewide basis. BHSA services include but are not limited to: network management, those behavioral health services considered non-traditional as described in the Community Mental Health and Rehabilitation Services manual and reimbursement of behavioral health services.

Coinsurance – means a percentage of the costs normally paid for covered services by members of a MA D-SNP. Coinsurance amounts must comply with the terms of the MA Agreement.

Co-payments – mean fixed dollar amounts that an MA Health Plan enrollee normally must pay for a medical service provided under a Medicare Advantage Product. Co-payments amounts must comply with the terms of the MA Agreement.

Deductible – means fixed dollar amounts that an MA D-SNP enrollee normally must pay out-of-pocket before the costs of services are covered by an MA D-SNP. Deductibles must comply with the terms of the MA Agreement.

Department of Medical Assistance Services (DMAS/The State/The Department) – means the single State agency that administers the Medicaid Program in the Commonwealth of Virginia.

Dual Eligible – means individuals who are eligible for coverage from Medicare (Medicare Part A, Part B, or both) and Virginia Medicaid.

Dual Eligible Special Needs Plan (D-SNP) – means the Medicare Part C and other health plan services provided to MA Health Plan enrollees who are dually eligible for Medicare and Medicaid under a Special Needs Plan as defined by and pursuant to an MA Agreement.

Long-Term Services and Supports (LTSS) - means services and supports provided through Medicaid for individuals who are elderly or have a chronic disability that requires ongoing services and supports in order to meet their functional needs. The goal of LTSS is to help individuals remain as independent as possible and live in the residential setting of their choice, which may include living in one's own home, with their family, in a group home setting, or in an institutional setting. LTSS under Medicaid include, but are not limited to, Personal Care, Respite Care, Companion Care, Adult Day Care, nursing, occupational/speech/physical therapies, and other rehabilitative and habilitative services and supports that help maximize their independence.

MA Agreement – means the Medicare Advantage Plan Agreement between the MA Health Plan and CMS to provide MA Dual-Eligible Special Needs Plan.

MA Dual Eligible Special Needs Plan (MA D-SNP) – means a Medicare Advantage Health Plan contracted with CMS to provide Medicare Part A, B and D benefits to beneficiaries who are dually eligible for Medicare and Medicaid as defined and pursuant to an MA Agreement.

Managed Long Term Services and Supports (MLTSS) Program – The program name for the Department's mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals (except duals participating in other managed care delivery models), and individuals receiving long term services or supports (LTSS). LTSS includes services received through nursing

facility (NF) care or one of the Department's six home and community-based services (HCBS) waiver programs.

Other full benefit dual eligible (FBDE) - an individual who is entitled to Medicare, does not meet the income or resource criteria for QMB+ or SLMB+, but is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers.

Qualified Disabled Working Individual (QDWI) - an individual who has income that does not exceed 200% of the Federal Poverty Level (FPL) and whose resources do not exceed \$2,000. The Medicaid agency pays Medicare Part A premiums. No other cost sharing is covered for these individuals. The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement for individuals in the QDWI group defined in subsection 26 of [12VAC30-30-10](#).

Qualified Individuals (QI) - an individual who has income that does not exceed 135% of the Federal Poverty Level (FPL) and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. The Medicaid agency pays their Part B premiums.

Qualified Medicare Beneficiary (QMB) - an individual who is entitled to Medicare Part A, has income that does not exceed 100% of the Federal Poverty Level (FPL), and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. A QMB is eligible for Medicaid Payment of Medicare premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). These individuals are not eligible for additional benefits available under the State Plan for fully eligible Medicaid recipients.

Qualified Medicare Beneficiary Plus (QMB+) - an individual who is entitled to Medicare and meets the Federal income standard of income equal to or less than 100 percent of the Federal Poverty Level (FPL) and is determined eligible for full Medicaid coverage. Some QMB Plus individuals may achieve eligibility through a spend-down. A QMB Plus is eligible for Medicaid Payment of Medicare Part A premiums, Medicare Part B premiums and Medicare coinsurance and Medicare deductibles for Medicare covered services (except for Medicare Part D).

Significant Change – A change (decline or improvement) in an individual's status that: (1) will not normally resolve itself without intervention or by implementing standard disease-related clinical or social interventions, is not "self-limiting;" or (2) impacts more than one area of the individual's health or psychosocial status; and (3) requires interdisciplinary review and/or revision of the ICP.

Special Low Income Medicare Beneficiary (SLMB) - an individual who has income that does not exceed 120% of the Federal Poverty Level (FPL) and whose resources do not exceed the limit set for the Medicare Part D Low-Income Subsidy (LIS) program. The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in subsection 27 of [12VAC30-30-10](#).

Special Low Income Medicare Beneficiary Plus (SLMB+) - an individual who is entitled to Medicare and meets the Federal income standard of income greater than 100 percent but less than 120 percent of the FPL and who also meets the financial criteria for full Medicaid coverage. Some SLMB Plus individuals may achieve eligibility through a spend-down. The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals determined eligible as a SLMB+.

State Plan – means the Commonwealth of Virginia’s plan for the Medicaid Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

Article II. MA D-SNP Obligations

2.1. Staffing Contacts

2.1.1 Contact Information. MA D-SNP shall provide the Department with name and contact information responsible for the following duties: D-SNP National Lead, D-SNP State Lead, State Lead for D-SNP care coordination, State Lead for D-SNP coordination with Medicaid Plans, State Lead for D-SNP contracting and State Lead for D-SNP quality improvement and oversight.

2.2. Standards, License(s) and Certificates

2.2.1 Financial Stability. The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed plans in Virginia. The MA D-SNP shall comply with all Bureau of Insurance standards. Bureau of Insurance standards may be found at <http://www.scc.virginia.gov/PublicForms/561/hmo.pdf>

2.2.2 Statutory State Licensing and Certification Requirements. MA D-SNP shall retain at all times during the period of this agreement a valid license issued by the Virginia 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 5-210-10 et. seq., and any and all other applicable laws of the Commonwealth of Virginia, as amended.

2.2.3 Quality Health Care and Consumer Protections. Pursuant to §32.1-137.1 through §32.137.7 Code of Virginia, and 12VAC5-408-10 et. seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the Virginia State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services they deliver.

2.2.4 CMS Approved D-SNP. MA D-SNP shall retain at all times during the period of this agreement signed approval by CMS to comply with all rules and regulations set forth in 42 CFR 422 and operate as a MA D-SNP to provide Medicare Covered health care benefits to qualified Medicare beneficiaries under a D-SNP in the state of Virginia.

2.3 Eligibility

2.3.1 Approved Service Area(s). MA D-SNP shall offer their D-SNP to eligible beneficiaries, as described in 2.3.2. For this contract period, January 1, 2017 through December 31, 2017, the contractor may offer their D-SNP in the localities identified in Appendix A.1.

While not pertaining to this contract period it is the intent of the State that for future contract periods the contractors' D-SNP approved service area will exactly match (locality for locality) the contractors' MLTSS approved service area. In any instance when the CMS approved D-SNP service areas do not match the State's approved MLTSS service areas, the State may restrict the MLTSS service areas to align with the CMS approved D-SNP service areas, or may terminate the D-SNP contract. When appropriate the State will work with the contractor to achieve fully aligned service areas prior to terminating a contract.

2.3.2 Approved Populations. MA D-SNP shall offer their D-SNP to beneficiaries that meet the following requirements:

2.3.2.1 Entitled to benefits under Medicare Part A, B and D, and receiving full Medicaid benefits such as:

2.3.2.1.1 Qualified Medicare Beneficiary Plus (QMB+),

2.3.2.1.2 Special Low Income Medicare Beneficiary Plus (SLMB+), and

2.3.2.1.3 Other Full-Benefit Dual Eligible (FBDE).

2.3.3 Excluded Populations. MA D-SNP is prohibited from enrolling those that meet one of the following criteria:

2.3.3.1 Individuals for whom DMAS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries such as:

2.3.3.1.1 Qualified Medicare Beneficiaries (QMBs);

2.3.3.1.2 Special Low Income Medicare Beneficiaries (SLMBs);

2.3.3.1.3 Qualified Disabled Working Individuals (QDWIs); or,

2.3.3.1.4 Qualifying Individuals (QIs).

2.3.3.2 Individuals residing outside of the MA D-SNP approved service areas as described in 2.3.1 of this contract.

2.3.3.3 Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll with MA-DSNP if they choose to disenroll from their PACE provider.

2.3.4 Exceptions. If a MA D-SNP was operating a D-SNP in Virginia prior to this contract period and has enrollees that do not meet the eligibility criteria described in 2.3.1 and 2.3.2, the MA D-SNP will have until December 31, 2017 to transition those enrollees to another Medicare benefit plan including Medicare Fee-For-Service.

2.4 Enrollment Responsibilities

2.4.1 Verifying Eligibility. MA D-SNP is responsible for accurately verifying both Medicare and Medicaid eligibility of potential and enrolled members. MA D-SNP will be provided with the means to verify Medicaid eligibility by the Department as defined in 3.1.1 of this contract.

2.4.2 Non-discrimination. Unless a dual eligible is otherwise excluded under federal Medicare Advantage plan rules or does not meet dual eligible Medicaid eligibility as described in 2.3.2, the MA D-SNP will accept all dual eligibles who select the MA D-SNP's D-SNP without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital

status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.

2.4.3 Enrollee Materials. MA D-SNP is required to provide enrollees with all applicable materials as described in 42 CFR 422, 42 CFR 423 and Chapter 3 of the Medicare Managed Care Manual.

2.5 Disenrollment

2.5.1 Sharing of Enrollee Health Information. MA D-SNP shall provide all pertinent health information, including assessments, plan(s) of care and Medicare encounter data, to another MA D-SNP contracted by the Department when a former enrollee enrolls with the other MA D-SNP and when the new MA D-SNP has requested such information.

2.6 Marketing

2.6.1 Geographic Extent. MA D-SNP shall only market in localities where they have been approved to provide services under this contract. Approved service areas are defined in 2.3.1 and Appendix A of this contract.

2.6.2 Population Restrictions. MA D-SNP shall only market to those individuals that are eligible to receive services under this contract as defined in section 2.3 of this contract and that are enrolled in their MLTSS plan.

2.6.3 After an individual has enrolled in the contractor's D-SNP the contractor may market to them regardless of their MLTSS enrollment status.

2.7 Coordination of Benefits

2.7.1 Aligned Enrollment. If the contracted MA D-SNP (or its' siblings) has a member that is also enrolled in any of the MA D-SNP's, health plans to provide Medicaid services in Virginia, the MA D-SNP is responsible for coordinating all benefits covered under this contract and the Medicaid plan(s).

The MA D-SNP must utilize both Medicare and Medicaid health care data to coordinate all aspects of the member's health care including, but not limited to: Medicare A, B, and D, historical data, Medicaid historical data, data from the State's BHSA, discharge planning, disease management, chronic conditions and care management.

2.7.2 Un-aligned Enrollment. If the contracted MA D-SNP (or its' siblings) has a member that is not also enrolled in any of the MA D-SNP's, health plans to provide Medicaid services in Virginia, the MA D-SNP is responsible for coordinating with the enrollee's Medicaid MLTSS or Medallion Three plan. To facilitate coordination the MA D-SNP must, at a minimum, meet the following requirements:

2.7.2.1 MA D-SNP shall provide the Medicaid plan with contact information of the person and division responsible for coordination of the enrollee's Medicare benefits,

2.7.2.2 MA D-SNP shall provide the Medicaid plan with contact information of the person or division responsible for coordination of cost sharing between Medicare and Medicaid,

- 2.7.2.3 MA D-SNP shall request a representative from the enrollee's Medicaid plan to participate in all needs assessments and person centered planning,
- 2.7.2.4 MA D-SNP shall provide the Medicaid plan with the results of all needs assessments and person-centered planning,
- 2.7.2.5 MA D-SNP shall, at a minimum, provide the Medicaid plan with timely (within 48 hours of becoming aware, either through a claim submission or other means, 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 MA D-SNP and Medicaid plan,
- 2.7.2.6 MA D-SNP shall coordinate with the Medicaid plan regarding discharge planning from inpatient setting, including hospital and nursing facility,
- 2.7.2.7 MA D-SNP shall request a representative from the enrollee's Medicaid plan participate in all Interdisciplinary Care Team meetings,
- 2.7.2.8 MA D-SNP must be able to 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 an enrollee's Medicaid plan regarding the effective coordination of benefits and cost sharing, and
- 2.7.2.9 At the request of a Medicaid plan, MA D-SNP must participate in training of the Medicaid plan's staff regarding coordination of benefits and cost sharing between Medicare and Medicaid.
- 2.7.3 Behavioral Health. MA D-SNP shall coordinate all behavioral health benefits with the State's contract BHSa when appropriate.
- 2.7.4 Coordination with State. At the Department's request, the MA D-SNP shall meet with the Department in person or by phone regarding dual eligible enrollees and provide the Department with all requested data in a timely manner.
- 2.7.5 Staff Training. MA D-SNP shall train their care coordinators and other related staff on available Medicaid benefits and coordination of Medicare and Medicaid benefits.
- MA D-SNP will also be required to train staff on topics as requested by the Department and within a timeframe designated by the Department.
- 2.7.6 Provider Training. MA D-SNP shall train network providers on available D-SNP and MLTSS benefits and services as requested by a provider or provider association.
- 2.7.7 Member Transition. The MA D-SNP Health Plan is required to participate in all activities as directed by the Department which relate to member transition as a result of termination of this contract. This applies to terminations directed from the Department, CMS or the MA D-SNP.

2.8 Covered Services

2.8.1 Medicaid Covered Services. MA D-SNP is not responsible for the provision or reimbursement of any Medicaid benefits. Medicaid benefits will be provided and reimbursed by the Department or through a separate contract. MA D-SNP is required to maintain knowledge and familiarity with current Medicaid covered services as described in Appendix B through ongoing review of State laws, rules, policies, health plan contracts, guidance as well as through information posted on its website.

MA D-SNP shall coordinate Medicare and Medicaid benefits as described in section 2.7 of this contract and as required by CMS through federal laws, rules, policies, health plan contracts and other guidance.

2.8.2 Cost Sharing Protections. MA D-SNP and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible enrollees that would exceed the amounts permitted under the Virginia State Plan for Medical Assistance.

MA D-SNP shall assure that its contracts with participating providers contain provisions that require such participating providers to accept MA D-SNP payment as payment in full, or bill the appropriate Medicaid health plan for additional payments that may be reimbursed under Medicaid through the Virginia State Medicaid plan.

2.9 Reporting and Other Deliverables

2.9.1 Standards, License(s) and Certificates.

2.9.1.1 MA D-SNP 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.

2.9.1.2 MA D-SNP shall submit to the Department biennial certifications by the Virginia State Health Commissioner Center for Quality Health Care Services to operate as a managed care health insurance plan (MCHIP).

2.9.1.3 MA D-SNP shall submit to the Department all revocations of the license(s) and certifications as described in section 2.2 of this contract.

2.9.2 Federal Authority.

2.9.2.1 MA D-SNP shall submit to the Department annual approval issued by CMS to operate a D-SNP in the Commonwealth of Virginia.

2.9.3 Enrollee Communications.

2.9.3.1 MA D-SNP shall submit to the Department an electronic copy of the enrollee handbook annually and upon any significant change.

2.9.3.2 MA D-SNP shall submit to the Department a copy of the comparison charts upon startup of the D-SNP operation in the Commonwealth and upon significant change or request of the Department.

2.9.3.3 MA D-SNP shall submit to the Department a copy of all D-SNP marketing materials upon request of the Department.

2.9.4 Actions, Sanctions and Audits.

2.9.4.1 MA D-SNP shall submit to the Department a copy of all CMS-issued compliance actions within 48 hours of receipt.

2.9.4.2 MA D-SNP shall submit to the Department a copy of all CMS issued sanctions within 48 hours of receipt.

2.9.4.3 MA D-SNP shall submit to the Department a copy of all corrective action(s) the MA D-SNP is required to provide to CMS in response to CMS-issued compliance actions and sanctions.

2.9.4.4 MA D-SNP shall submit to the Department all CMS notices of audits when the MA D-SNP is provided the notice in advance.

2.9.4.5 MA D-SNP shall submit to the Department all CMS audit summary reports with 48 hours of receipt.

2.9.5 Contract Monitoring and Other Reporting Requirements.

2.9.5.1 MA D-SNP shall submit to the Department, in a format determined by the Department, Medicare encounter data on the fifteenth day, or the next closest business day, of each month.

2.9.5.2 MA D-SNP shall submit to the Department, in a format determined by the Department, a list of all D-SNP enrollees, on the fifteenth day, or the next closest business day, of each month.

2.9.5.3 MA D-SNP shall submit to the Department all information requested on the “D-SNP Dashboard” as defined in Appendix C of this contract on the fifteenth day, or the next closest business day, of each month.

The Department may modify the D-SNP Dashboard at any point during the contract term.

2.9.5.4 MA D-SNP shall submit to the Department a copy of the D-SNP Model of Care summary document annually and upon any significant change.

2.9.6 Quality Improvement Reporting.

2.9.6.1 MA D-SNP shall submit to the Department a copy of the Quality Improvement Program (QIP) document approved by CMS within 48 hours of CMS approval.

MA D-SNP shall also submit to the Department a report on the results of the previous years’ QIP on July 15, or the next closest business day.

2.9.6.2 MA D-SNP shall submit to the Department all Healthcare Plan Effectiveness Data and Information Set (HEDIS) measures and results that they are required to report by CMS for this D-SNP.

This will be required by July 15, or the next closest business day, each year the MA D-SNP is required to report HEDIS data to CMS for this D-SNP.

2.9.6.3 MA D-SNP shall submit to the Department a copy of the Consumer Assessment of Healthcare Providers and Services (CAHPS) survey questions and results upon request of the Department.

The Department may require supplemental questions to be included in this survey.

2.9.6.4 MA D-SNP shall submit to the Department a copy of the pre and post Health Outcome Survey (HOS) questions and results upon request of the Department.

Article III. DMAS Obligations

3.1 Verifying Eligibility

3.1.1 Verification Method. The Department will provide the MA D-SNP access to real-time Medicaid eligibility information through an online system operated by the Department or its contractor.

MA D-SNP and the Department each acknowledge that the MA D-SNP is a “Covered Entity,” as defined in the Standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164) pursuant to the Health Insurance Portability and Accountability Act of 1996 (the “Privacy Rule”). Access to the eligibility data is conditioned on the MA D-SNP’s agreement to abide by the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act on 2009, and an executed Business Associate Agreement with the Department.

3.2 Benefit Information

3.2.1 Medicaid Benefit Eligibility. The Department will provide MA D-SNP with information regarding the services offered under the Virginia State Plan and the MLTSS demonstration on an annual basis. A table of these services can be found in Appendix B.

3.3 Financial Responsibility

3.3.1 State Financial Responsibilities. The State, or its contractors, shall retain financial responsibility for applicable Medicaid cost sharing obligations including premium payments, coinsurance and/or copayments to healthcare providers. The State’s obligation shall be no greater than it would be if beneficiaries were not enrolled in the MA D-SNP.

3.4 Provider Information

3.4.1 Medicaid Provider Information. Upon request of the MA D-SNP the Department will provide the MA D-SNP with information on Medicaid provider participation on an annual basis.

Article IV. TERM, TERMINATION

4.1 Term

5.1.1 Contract Term. The term of this Agreement will begin on January 1, 2017 (the “Effective Date”) and end December 31, 2017.

4.2 Termination

4.2.1 Termination Conditions. This Agreement may be terminated under the following conditions:

4.2.1 The Agreement shall automatically terminate the day the MA Agreement expires or is terminated.

4.2.2 This Agreement may be terminated by mutual agreement of the parties. Such agreement must be in writing.

4.2.3 The State may terminate the Agreement in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of the Commonwealth of Virginia. The termination will be effective on the date specified in the State’s notice of termination. The State will provide the MA D-SNP written notice of such termination at least 60 calendar days prior to the effective date of termination, unless the State determines that circumstances warrant a shorter notice period.

4.2.4 In addition to the reasons set forth above, the State reserves the right to terminate this Agreement, in whole or in part, upon the following conditions:

- (1) The State may terminate this Agreement at any time if a court of competent jurisdiction finds MA D-SNP failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MA D-SNP’s duties under this Agreement.
- (2) The State may terminate the Agreement at any time if the MA D-SNP: files for bankruptcy; becomes or is declared insolvent, does not meet the Virginia Bureau of Insurance financial requirements, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it; makes an assignment for the benefit of all or substantially all of its creditors; or enters into an agreement for the composition, extension, or readjustment of substantially all of its obligations.
- (3) The State will have the right to terminate the Agreement at any time and in whole or in part if it determines, at its sole discretion, that the MA D-SNP has breached the Agreement.
- (4) The State has the right to terminate this contract if the MA D-SNP or any of its contracted entities or subsidiaries: is determined to have a Star Rating of three stars or less; has been issued a Notice of Noncompliance or had sanctions imposed upon them by CMS.

4.2.5 The MA D-SNP may terminate this Agreement by providing the State written notice at least 90 calendar days prior to termination. The termination will be effective on the date specified in the MA D-SNP's notice of termination.

4.2.6 Any MA D-SNP that has been approved by DMAS to offer a D-SNP for this contracting period (January 1, 2017 through December 31, 2017) will be allowed to operate during the contracting period regardless of if they have been awarded a separate contract by DMAS to provide Managed Long Term Services and Supports ("MLTSS"). (The MLTSS program is now known as Commonwealth Coordinated Care Plus (CCC+)). However, DMAS will not contract with any MA D-SNP beyond this contracting period if they are not awarded a MLTSS contract. (It is anticipated that all MLTSS contracts will be awarded by January 1, 2017.)

Article V. MISCELLANEOUS PROVISIONS

- 5.1 Entire Agreement. This Agreement contains the entire understanding between the parties hereto with respect to the subject matter of this Agreement and supersedes any prior understandings, agreements or representations, written or oral, relating to the subject matter of this Agreement.
- 5.2 Severability. Whenever possible, each provision of this Agreement will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this Agreement is held to be invalid, illegal or unenforceable under any applicable law or rule, the validity, legality and enforceability of the other provisions of this Agreement will not be affected or impaired thereby.
- 5.3 Confidentiality of Protected Health Information (HIPAA). Each party shall protect the confidentiality of Protected Health Information and shall otherwise comply with the requirements of the Privacy Rule and with all other State and Federal Laws governing the confidentiality of medical information.
- 5.4 Successors and Assigns. This Agreement will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by Section 6.4, successors and assigns.
- 5.5 Modification, Amendment or Waiver. No provision of this Agreement may be modified, amended, or waived except by a written agreement signed by the parties to this Agreement. No course of dealing between the parties will modify, amend, waive any provision of this Agreement or any rights or obligations of any party under or by reason of this Agreement.
- 5.6 Notices. All notices, consents, requests, instructions, approvals or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

Virginia Department of Medical Assistance **HEALTH PLAN CONTACT INFO**
Services
Cynthia B. Jones, Agency Director
600 E. Broad Street, Suite 1300
Richmond, VA 23219

A party may change the contact information set forth above by giving written notice to the other party.

- 5.7 Headings. The headings and any table of contents contained in this Agreement are for reference purposes only and will not in any way affect the meaning or interpretation of this Agreement.
- 5.8 Governing Law. This Agreement is governed by the laws of the Commonwealth of Virginia and interpreted in accordance with Virginia law, except to the extent preempted by federal law.

- 5.9 No Third-party Beneficiaries. Nothing in this Agreement, express or implied, is intended to confer upon any other person any rights, remedies, obligations or liabilities of any nature whatsoever.
- 5.10 Publicity. Except as otherwise required by this Agreement or by law, no party will issue or cause to be issued any press release or make or cause to be made any other public statement as to this Agreement or the relationship of the parties, without obtaining the prior approval of the other party to the contents and manner of presentation and publication thereof.
- 5.11 No Waiver. No delay on the part of either party in exercising any right under this Agreement will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.
- 5.12 Approval by CMS. This Agreement shall be effective only if CMS approves MA D-SNPs application to offer a dual eligible SNP in the localities specified in this contract.
- 5.13 Non-Debarment. MA D-SNP represents that neither it nor any of its employees, agents, officers or directors is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any state or federal health care program.
- 5.14 Mutual Obligations. The parties will carry out their obligations under this Agreement in the manner prescribed by all applicable laws, regulations and policies, including Federal and State law governing the Medicare and Medicaid programs.
- 5.15 Performance Evaluation. The MA D-SNP may be subject to performance evaluation by the Department. Performance reviews may be conducted at the discretion of the Department upon reasonable prior written notice to the MA D-SNP, and may relate to any responsibility and/or requirement of the MA D-SNP under this Agreement.

Appendix A. Approved Service Area

A.1 Approved Service Area. MA D-SNP shall offer their D-SNP to eligible beneficiaries, as described in 2.3.2. For this contract period, January 1, 2017 through December 31, 2017, the contractor may offer their D-SNP in the localities listed below.

While not pertaining to this contract period it is the intent of the State that for future contract periods the contractors' D-SNP approved service area will exactly match (locality for locality) the contractors' MLTSS approved service area. In any instance when the CMS approved D-SNP service areas do not match the State's approved MLTSS service areas, the State may restrict the MLTSS to align with the CMS approved D-SNP service areas, or may terminate the D-SNP contract. When appropriate the State will work with the contractor to achieve fully aligned service areas prior to terminating a contract.

Approved Service Area:

MA D-SNP to list localities

Appendix B. Medicaid Covered Services

PLACE HOLDER

Appendix C. D-SNP “Dashboard”

PLACE HOLDER