

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

600 E. BROAD STREET, SUITE 1300

RICHMOND, VA 23236

Dear Prospective Supplier:

The Department of Medical Assistance Services (DMAS or the Department) is soliciting proposals from firms that meet the external quality review organization qualifications, as defined by federal regulations (§ 42 CFR Part 438.354, Subpart E) AND that have certification as a federally designated Quality Improvement Organization (QIO). The offering QIOs shall submit certification of their status. The selected Contractor will be responsible for implementing federally mandated and optional quality improvement activities, as well as evaluating the access to, quality of, appropriateness, timeliness of, and satisfaction with services provided to the Medicaid and FAMIS recipients.

Specific details about this procurement are in the enclosed Request for Proposals (RFP) 2021-02. Suppliers must check eVA VBO at http://www.eva.virginia.gov for all official addenda or notices regarding this RFP. While DMAS also intends to post such notices on the DMAS website at <https://www.dmas.virginia.gov/#/procurement> eVA is the official and controlling posting site. The Commonwealth will not pay any costs that Suppliers incur in preparing a proposal. As provided in the Virginia Public Procurement Act, the Department may reject any and all proposals received or cancel this

RFP.

Potential Suppliers are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Whitney Wallace to [RFP2021-02@dmas.virginia.gov](mailto:RFP2021-02@dmas.virginia.gov).

**PREPROPOSAL CONFERENCE:** A virtual preproposal conference will be held **on August 11, 2021 at 10:00AM** Eastern Time. The purpose of this conference is to allow DMAS an opportunity to clarify various facets of the RFP. It is important Offerors have a clear understanding of the specifications/scope of work and requirements of this RFP. **Offerors should be able to reference a copy of the RFP during the conference. Any changes resulting from questions posed or as a result of this conference will be issued in a written addendum to the RFP.**

Sincerely,

***Whitney Wallace***

DMAS Contract Officer

REQUEST FOR PROPOSALS (RFP) 2021-02

**Issue Date:** July 30, 2021

**Title:** External Quality Review Services

**Period of Contract:**  An initial period of four (4) years from award of contract, with provisions for four (4) 12-month renewal options to be exercised at DMAS’ sole option.

**Commodity Code:** 95856, 94848, 91806, 94807

**Single Point of Contact:** Whitney Wallace, DMAS Procurement & Contract Officer

**E-Mail Address:** RFP2021-02@dmas.virginia.gov

**Pre-proposal Conference:** **10:00 A.M. Eastern Time, August 11, 2021**

**Deadline for submitting inquiries:** **5:00 P.M. Eastern Time, August 12, 2021**

**Proposal Due Date:** **2:00 P.M. Eastern Time, September 9, 2021**

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

DMAS is committed to increasing procurement opportunities for small and micro businesses, including small or micro businesses that are owned by minorities, women, or disabled veterans, and strengthening the Commonwealth’s overall economic growth through the development of its suppliers.

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*Request for Proposals (RFP)*

**Department of Medical Assistance Services**

***External Quality Review Services***

RFP No. 2021-02

|  |  |
| --- | --- |
| Procurement Schedule | |
| Issue Date | July 30, 2021 |
| Questions Due | August 12, 2021 by 5:00 PM **Eastern** Time |
| Pre-proposal Conference | August 11, 2021 at 10:00 AM **Eastern** Time |
| Proposals Due Date/Time | September 9, 2021 by 2:00 PM **Eastern** Time |
| Estimated Time for Supplier Demonstrations | To Be Determined |

**Single Point of Contact (SPOC):** Whitney Wallace, DMAS Procurement & Contract Officer

**E-Mail Address: RFP202102@dmas.virginia.gov**

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# INTRODUCTION

## DMAS Overview

The Department of Medical Assistance Services, herein after referred to as the “Department” or “DMAS” is the single state agency in the Commonwealth of Virginia that administers the Medicaid Program authorized under Title XIX of the Social Security Act and the Virginia Children’s Health Insurance Program, known as FAMIS, under Title XXI of the Social Security Act for low income people. These programs are financed by federal and state funds and administered by the state according to federal guidelines. These programs include coverage of medical services for eligible Medicaid/FAMIS members. Information about the Virginia Medicaid and FAMIS programs are available at: <https://www.dmas.virginia.gov>; <http://coverva.org/>; <http://famis.org/>.

## DMAS Mission Statement and Values

Our mission at the Department is to improve the health and well-being of Virginians through access to high-quality health care coverage. In order to achieve this mission, DMAS focuses on the following core values that guide the work of the agency: service, collaboration, trust, adaptability, and problem-solving.

## RFP Objective and Project Overview

The Department of Medical Assistance Services, hereinafter referred to as the "Department" or "DMAS," is the single state agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the *Social Security Act* and the Virginia State Child Health Insurance Program, known as the Family Access to Medical Insurance Security (FAMIS), and under Title XXI of the *Social Security Act* for low-income people and children. These programs are financed by federal and state funds and administered by the State according to federal guidelines. Both programs include coverage of medical services for eligible Medicaid and FAMIS members. Information about the Virginia Medicaid program is available at <https://www.dmas.virginia.gov/#/index>.

The purpose of this Request for Proposal RFP 2021-02 is to solicit proposals to establish one contract through competitive negotiations for the purchase of external quality review (hereinafter “EQR”) services, by the Department. The vendor must meet the external quality review organization qualifications, as defined by federal regulations (§ 42 CFR Part 438.354, Subpart E) AND have current certification as a federally designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO). The offering QIOs shall submit proof of their certification

The selected QIO (hereinafter “Supplier” or “EQRO”), will serve as the external quality review organization for the Title XIX Virginia Medical Assistance Program (hereinafter “Medicaid”) and Title XXI Virginia Children’s Health Insurance Program (hereinafter “FAMIS”). The Supplier shall be responsible for evaluating the access, quality, appropriateness, timeliness, and satisfaction with services provided to Medicaid and FAMIS recipients in Virginia. The Contractual Agreement with an EQRO will allow the Department to meet the Centers for Medicare & Medicaid Services’ (hereinafter “CMS”) requirements for EQR and to monitor and help improve the care received through Virginia’s Medicaid and FAMIS programs. This RFP integrates the tasks for Medicaid and FAMIS EQR functions. All proposals submitted must be for the entire range of services identified in this contract.

Suppliers shall meet all of the following minimum requirements:

* 1. At least five (5) years of demonstrated experience in each of the following:
     1. Evaluation of Medicaid managed care organizations’ adherence to State contracts;
     2. Evaluation of managed care delivery systems, organizations, and financing;
     3. Quality assessment and performance improvement methods; and,
     4. Research design, methods and statistical analysis.
  2. At least five (5) years of combined experience performing external quality review activities for at least two states with Medicaid managed care.
  3. At least five (5) years of combined experience in performing external quality review activities for at least two (2) National Committee for Quality Assurance (NCQA) accredited Medicaid managed care plans and at least two (2) non-accredited Medicaid managed care plans.
  4. Have assigned staff, or have a subcontract with a qualified organization, that is designated as a NCQA as a certified Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor;
  5. Must have designation as, or a subcontract with, a qualified organization that is designated as, an NCQA‐certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor
  6. Possess information technology capacity that is adequate for receiving, storing, organizing, managing, synthesizing, analyzing and transferring large data sets that cover a population of approximately 1.7 million individuals;
  7. Must demonstrate independence from the state Medicaid Agency and health plans under review as required by 42 CFR Part 438.354; and,
  8. Must have current Federal designation as a Medicare Quality Improvement Organization for at least one state.

**The objectives of this RFP include:**

* Providing a contract for external quality review services as required by the Virginia Department of Medical Assistance Services for the Medicaid and FAMIS managed care delivery system;
* Obtaining, through a contract with an EQRO, a group of highly skilled, responsive, flexible, technically competent, ethical, and professional personnel adept at conducting external quality review services and who have subject matter expertise; and
* Obtaining, through a contract, an EQRO that produces timely, accurate, and meaningful products that are useful to the specified internal and external audiences and meet all applicable federal and state regulations.

Section 5 sets forth the service/solution detailed requirements. DMAS reserves the right to adjust the requirements or scope of this RFP. In the event that any modifications become necessary, an amendment to this RFP will be posted on the Commonwealth’s procurement portal, eVA, at: <http://www.eva.virginia.gov>.

The duration of the contract resulting from this RFP is four (4) years from award of contract. This contract may be renewed by the Commonwealth upon written agreement of both parties for up to four (4) successive one-year periods to be exercised at DMAS’ sole discretion, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

For the purposes of this RFP, “**Supplier**” (or “**Bidder**” or “**Offeror**”) means any entity that submits a proposal in response to this RFP.

## Innovation to Government

The Commonwealth encourages all Suppliers to bring innovative ideas and/or solutions to government—ideas that result in cost and operational efficiencies or improvements while enhancing the services that governments provide its citizens.

# PROPOSAL ADMINISTRATION AND INSTRUCTIONS

## Overview

This RFP was developed to provide all potential Suppliers with the information required to prepare proposals. This section outlines the administrative procedures and guidelines you must use and comply with when preparing a proposal. Nothing in this RFP constitutes an offer or an invitation to contract.

## Virginia Public Procurement Act (VPPA)

This RFP is governed by the Virginia Public Procurement Act (“**VPPA**”), Code § 2.2-4300 *et seq.*, and other applicable laws.

## Anti-Discrimination- § 2.2-4310 and § 2.2-4311, and § 2.2-4343.1(E)

By submitting its proposal, a Supplier certifies to the Commonwealth that it will conform to the provisions of the Federal Civil Rights Act of 1964, as amended as well as the Virginia Fair Employment Contracting Act of 1975, as amended; and, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and § 2.2-4311 of the VPPA.

## Ethics in Public Contracting - § 2.2-4367 *et seq.*

By submitting its proposal, a Supplier certifies that its proposal is made without collusion or fraud; that the Supplier has not offered or received any kickbacks or inducements from any other bidder, supplier, manufacturer, or subcontractor in connection with its proposal; and that the Supplier has not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged. In addition, a Supplier will disclose any actual or perceived conflicts of interest in its proposal and will notify DMAS if it becomes aware of a potential conflict of interest in the future.

## Announcement of Award - § 2.2-4300 *et seq.*

If a contract is awarded or announced as a result of this RFP, the purchasing agency will post notice of the award decision on the DGS/DPS eVA web site (<http://www.eva.virginia.gov>) for a minimum of 10 days. No award decision will be provided verbally. Any final contract, including pricing, awarded as a result of this RFP will be made available for public inspection.

## Authorized to Transact Business in the Commonwealth - § [2.2-4311.2](http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-4311.2)

All Suppliers organized as a stock or nonstock corporation, limited liability company, business trust, or limited partnership, or registered as a registered limited liability partnership must be authorized to transact business as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the Code, or as otherwise required by law. In its proposal, Supplier must include either (i) Supplier’s identification number issued to it by the State Corporation Commission; or (ii) a statement explaining why Supplier is not required to be registered. No award can be made to any Supplier without this information unless this requirement is waived. Appendix D of this solicitation includes a space for Supplier to provide the information required in (i) or (ii) of this subsection. If a Supplier anticipates the use of additional resources through a partnership or subcontracting relationship with other entities, the requirements of this Section 2.F will also apply to any entities that are engaged as partners or subcontractors of Supplier providing services directly to the Commonwealth upon award of a contract.

## Prohibited Products and Services - § 2.2-5514

No Supplier may include as part of its proposal, whether directly or indirectly through subcontractors, any hardware, software, or services that have been prohibited for use on federal systems by the U.S. Department of Homeland Security.

## Prohibited Contributions and Gifts - § [2.2-4376.1](http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-4376.1)

No Supplier that submits a proposal in response to this solicitation, and no individual who is an officer or director of the Supplier shall knowingly provide a contribution, gift, or other item with a value greater than $50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Secretary of Administration during the period between the submission of the proposal and the award of any resulting contract award with an expected value of $5 million or more dollars.

## Liability

The issuance of this RFP and the receipt of information in response to this RFP will not cause DMAS to incur any liability or obligation, financial or otherwise, to any Supplier. DMAS assumes no obligation to reimburse or in any way compensate a Supplier for expenses incurred in connection with its proposal.

## Nondisclosure

All proposal information submitted by a Supplier will be treated as confidential prior to contract award and will not be disclosed except as required by law or by court order.

## Proprietary Information

DMAS reserves the right to use information submitted in response to this document in any manner it may deem appropriate in evaluating the fitness of the solution(s) proposed. Ownership of all data, materials, and documentation originated and prepared for DMAS pursuant to the RFP shall rest exclusively with DMAS and shall be subject to public inspection in accordance with the § 2.2-4342 of the VPPAand the Virginia Freedom of Information Act.

Trade secrets or proprietary information submitted by a Supplier in connection with a procurement transaction or prequalification application submitted pursuant to subsection B of § 2.2-4317 of the Code shall not be subject to theVirginia Freedom of Information Act (Code § 2.2- 3700 *et seq.*) if a Supplier:

1. invokes the protections of this section in writing prior to or upon submission of the data or other materials,
2. identifies specifically the data or other materials to be protected, and
3. states the reasons why protection is necessary.

Please note that you may not designate as trade secrets or proprietary information (a) an entire bid, proposal, or prequalification application; (b) any portion of a bid, proposal, or prequalification application that does not contain trade secrets or proprietary information; or (c) line item prices or total bid, proposal, or prequalification application prices.

**FAILURE TO COMPLY WILL RESULT IN THE DATA OR OTHER MATERIALS BEING RELEASED TO SUPPLIERS OR THE PUBLIC AS PROVIDED FOR IN THE VIRGINIA FREEDOM OF INFORMATION ACT.**

You should provide as a separate appendix to your proposal a list of all pages in the proposal that contain proprietary information and the reason you deem the information proprietary(See Appendix M). The classification of an entire proposal as proprietary or trade secret is not acceptable and will not be honored by DMAS, nor the Commonwealth.

## Proposal Protocol

The proposals, shall be submitted **electronically via eVA** no later than 2:00 PM Eastern Time on September 9, 2021. The Supplier must be registered in eVA in order to submit an electronic proposal. Suppliers must submit one (1) complete copy of the proposal and attachments electronically via eVA. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals will not be accepted and will be automatically rejected from further consideration. The following are instructions for submitting an electronic proposal:

* 1. Go to [www.eva.virginia](http://www.eva.virginia);
  2. Click on “I Sell to Virginia”;
  3. Click on “eVA Vendor Training”; and
  4. Click on “Respond to IFBs-RFPs and more”.

If a Supplier needs assistance in submitting an electronic response, the Supplier must contact eVA Customer Care at (866) 289-7367 or email [eVACustomerCare@dgs.virginia.gov](mailto:eVACustomerCare@dgs.virginia.gov).

All proposal copies (electronically in eVA) should be submitted as follows:

1. One (1) copy of the complete proposal, without redactions, with permission to make copies. Note that the cost proposal should be a separate file.
2. One (1) copy of the complete proposal, with redactions (proprietary/confidential information removed), if necessary, consistent with the requirements of RFP, Section 2, subsection K, Proprietary Information. Note that cost proposals may not be redacted and should be submitted as a separate file from the rest of the proposal.

All proposal materials must be provided in either Microsoft Word, Adobe PDF, or Excel, as specified.

The proposal must be signed by an authorized representative of the Supplier.

Proposals should be prepared and organized as indicated in Section 3, “Proposal Format”, providing a concise description of capabilities to satisfy the requirements of the RFP. Emphasis should be placed on completeness and clarity of content.

Suppliers should be prepared to incorporate all statements made in the proposal in response to Sections 5 (including Appendix I RTM), 6, 7, and 8 into the final contract in the event that the Supplier is awarded the contract.

DMAS reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Supplier is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Suppliers must check the eVA VBO at http://www.eva.virginia.gov for all official postings of addendums or notices regarding this RFP. Posting of such notices will also be done on the DMAS website at <https://www.dmas.virginia.gov/#/procurement,> but the eVA VBO is the official posting site.

## Single Point of Contact

Submit all inquiries concerning this RFP in writing by email, subject: “Questions on RFP # 2021-02 to:

SPOC: Whitney Wallace

Email: RFP2021-02@dmas.virginia.gov

No questions will be addressed orally.

To ensure timely and adequate consideration of proposals, **Suppliers are to limit all contact**, whether verbal or written, pertaining to this RFP to the designated SPOC for the duration of this proposal process.

## Pre-Proposal Conference/Teleconference

There will be an optional pre-proposal teleconference held on the date specified in Table 1 in this Section. The pre-proposal conference is open to all interested Suppliers, and Suppliers are encouraged to attend. There will be no opportunity for a private or individual tour or presentation.

To participate in the pre-proposal teleconference, register with Whitney Wallace at RFP2021-02dmas.virginia.gov by sending an email stating your firm’s name and your participating representative(s). You will receive the location of the conference and you will receive a teleconference number for the call. It is strongly recommended that Suppliers register with Whitney Wallace not later than 4:00 pm Eastern Time on the day prior to the teleconference to ensure that Supplier receives a teleconference number.

## Evaluation Process

DMAS will review each proposal received by the due date and time to determine whether it meets the Must Have factors of this RFP. All Must Have factors are evaluated on a met-or-not-met basis. Any proposal that does not meet all of the Must Have factors will be set aside and receive no further consideration.

The proposals that meet all the Must Have criteria will be distributed to the evaluation team who will assess and score each Supplier’s response to Sections 5 (Appendix I RTM),6,7 and 9 of this RFP based on a review of the submitted materials.

DMAS may elect to continue the evaluation of the most qualified proposal (s) and may request that Suppliers clarify or explain certain aspects of their proposals.

A numerical scoring system will be used in evaluation of proposals. The point values assigned to each of the evaluation criteria shall be posted in eVA prior to the due date and time for receiving proposals.

At any point in the evaluation process DMAS may employ any or all of the following means of evaluation:

* Reviewing industry research
* Supplier presentations
* Site visits
* Supplier’s status as a small business or micro business, including small or micro businesses that are owned by minorities, women, or disabled veterans, and certified by the Department of Small Business and Supplier Diversity (“**DSBSD**”)
* Supplier’s planned amount of spend with certified SWaM or micro business (as defined in Section 7 below) subcontractors, and Non-SWaM businesses.
* Contacting Supplier's references
* Review of Supplier’s ability and willingness to comply with the commonwealth’s security and data privacy policies, standards, guidelines and related contract terms as specified in the RFP
* Product demonstrations/pilot tests/detailed demonstrations
* Review of pricing
* Contacting Supplier’s customers
* Interviewing key personnel
* Requesting Suppliers elaborate on or clarify specific portions of their proposal, including, as applicable, any responses to the RFP’s security requirements

DMAS may limit all of the above to the most qualified proposals. No Supplier is guaranteed an opportunity to explain, supplement or amend its initial proposal. Each Supplier is encouraged to ensure that its initial proposal contains and represents its best offering. **You should submit your best proposal and not assume there will be an opportunity to negotiate, amend or clarify any aspect of your initial submitted proposal.**

Each Supplier should be prepared to conduct product demonstrations, pilot tests, presentations or site visitsat the time, date and location of DMAS’s choice, should DMAS so request.

DMAS will select for negotiation those proposals deemed to be fully qualified and best suited based on the factors as stated in the RFP. Negotiations will be conducted with these Suppliers. After negotiations, DMAS may select the proposal(s) that, in its opinion, is the best proposal(s) representing best value and may award a contract to that Supplier(s). For purposes of this RFP, DMAS will determine best value based on the value relative to the cost of the Service/Solution, giving consideration to the project's budget objectives. If this is a cloud-based procurement (i.e., off-premise hosting), following DMAS’ selection of the best proposal(s) representing best value to the commonwealth, Supplier’s failure to successfully answer, negotiate, and/or comply with any resulting security exceptions that may arise in order to approve Supplier’s cloud application, may result in removal from further consideration. Refer to Appendix K of the RFP.

If any Supplier fails to provide the necessary information for negotiations in a timely manner, or fails to negotiate in good faith, DMAS may terminate negotiations with that Supplier at any time.

DMAS reserves the right, at its sole discretion, to reject any proposal or cancel and re-issue the RFP. In addition, DMAS reserves the right to accept or reject in whole or in part any proposal submitted, and to waive minor technicalities when in the best interest of the Commonwealth.

DMAS SHALL NOT BE CONTRACTUALLY BOUND TO ANY SUPPLIER PRIOR TO THE EXECUTION OF A DEFINITIVE WRITTEN CONTRACT.

## Evaluation Factors

The evaluation factors involved in this RFP are as follows:

1. Must Have (M) factors identified in the table below:

|  |  |
| --- | --- |
| **No.** | ***Must Have (M) Factors*** |
| 1. 1 | (M) Proposal must be received by the due date and time. No late proposals will be reviewed. |
|  | (M) All mandatory Terms and Conditions must be accepted. See: [https://www.vita.virginia.gov/supply-chain/scm-policies-forms/mandatory-contract-terms/](https://www.vita.virginia.gov/supply-chain/scm-policies-forms/mandatory-contract-terms/%20) |
|  | (M) Have designation as, or a subcontract with, a qualified organization that is designated as, an NCQA‐certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Vendor. |
|  | (M)  Must have certification as a federally designated Quality Improvement Organization (QIO). |
|  | (M) Must demonstrate compliance with all applicable Federal and State laws and policies, including (but not limited to) an attestation that the Supplier meets the external quality review organization qualifications and ability to demonstrate independence from the state Medicaid Agency and health plans under review, as defined by federal regulations (§ 42 CFR Part 438.354). |

1. The extent to which the Supplier’s proposal satisfies the requirements identified in Sections 5 (including Appendix I RTM) and 9.
2. Supplier’s viability and past performance (see Section 6 Supplier Profile), this will include Supplier’s diligence and thoroughness in following and completing the requirements of this solicitation.
3. Supplier’s status as a DSBSD-certified small business or micro business, including small businesses or micro businesses that are owned by minorities or women, and Supplier’s proposed Supplier Procurement and Subcontracting Plan (see Section 7).
4. Cost, which may include submitted price, negotiated price, discounted price, total cost of ownership, etc. (See Section 8).

## Procurement Website

The Commonwealth’s procurement portal, <http://www.eva.virginia.gov>, provides information about Commonwealth solicitations and awards. Suppliers are encouraged to check this site on a regular basis and, in particular, prior to submission of proposals to identify any amendments to the RFP that may have been issued.

## Timetable

**Table 1**

|  |  |
| --- | --- |
| **Activity** | **Target Completion Date** |
| RFP posted to eVA | July 30, 2021 |
| Register for pre-proposal [tele]conference due to DMAS | August 10, 2021 |
| Supplier pre-proposal [tele]conference | August 11, 2021 |
| Deadline for all questions | August 12, 2021 |
| Proposals due | September 9, 2021 |
| Contract(s) awarded | TBD |

The timetable above is provided for planning purposes only.

## eVA Registration Required

By the date of award, the selected Supplier(s) is required to be registered and able to accept orders through eVA. To register with eVA, select the “Vendor” tab at the eVA website, <http://www.eva.virginia.gov>, for registration instructions and assistance.

## Excluded Parties List

A Supplier will not be awarded a contract if it, or any of its affiliates or subcontractors, is an excluded entity on the federal government’s System for Award Management (“**SAM**”) at <https://www.vita.virginia.gov/supply-chain/scm-policies-forms/#sam>, or the Commonwealth’s Debarment List as provided by Code § 2.2-4321 at the time of award.

# PROPOSAL FORMAT

All Suppliers must adhere to the specific format set forth in Table 2 below in order to aid the evaluation team in its efforts to evaluate all proposals fairly and equitably. Proposals that deviate from the requested format will require additional time for review and evaluation. DMAS may reject any proposal that is not in the required format, or does not address all the requirements of this RFP.

Proposals should be written specifically to answer this RFP. General “sales” material should not be used within the body of the proposal and any additional terms or conditions on the “sales” material will be considered invalid. If desired, you may attach “sales” material in a separate appendix to your response.

It is essential that your proposal be thorough and concise. You should avoid broad, unenforceable, or immeasurable responses and should include all requested information in each section as indicated below.

In order to facilitate DMAS’s review of the submitted proposals, you must provide the requested information in the following format: YOU MUST PLACE YOUR NAME, not “DMAS”, IN EACH FILE NAME (e.g., ABC Corp No Name Transmittal.doc).

## Supplier's Proposal Format

**Table 2**

| **FILE No.** | **Section Title** | **Contents/Deliverables (Each a separate file)** |
| --- | --- | --- |
| **1.** | **Transmittal** | A signed cover letter, identifying the individuals authorized to negotiate on behalf of the Supplier and their contact information. A copy of a completed eVA registration confirmation. |
| **2.** | **Executive Summary** | Top level summary of the most important aspects of the proposal, containing a concise description of the proposed solution(s). Requested limitation: 2 pages. |
| **3.** | **Detailed Description of Proposed Solution(s)** | Supplier’s response to the requirements set forth in Section 5, including Appendix I RTM, clearly identifying and detailing the proposed Solution, and any processes, methodologies, and resources required by the Solution defined in Section 5. |
| **4.** | **Supplier Profile** | Pursuant to Section 6. |
| **5.** | **Supplier Procurement and Subcontracting Plan** | Pursuant to Section 7 and Appendix B. |
| **6.** | **Contracts and Appendix E** | Any comments or edits regarding DMAS’ proposed contractual terms and conditions pursuant to Section 9, provided and submitted in redline format in the contract document along with the completed table from Appendix E setting forth your reasons for the requested changes to each clause individually. This Section should also include Appendix A- Services Level Agreement(s) **(“SLA”**). In addition and if applicable, Supplier should also include all agreements to VITA’s “License Agreement Addendum” signed by each proposed software manufacturer (see Section 9). |
| **7.** | **Appendices** | Should include any required appendices including Appendix D- the completed State Corporation Commission form, and Appendix M- Proprietary/Confidential Information Identification Form, and Appendix K, the completed ECOS Questionnaire Assessment form (if applicable). Provide the implementation plan as requested in Section 5. Any optional information Supplier may wish to submit, not including pricing data. |
| **8.** | **Pricing** | Detailed pricing as specified in Section 8 and Appendix C. Submitted in a separate electronic response file. Do not include any pricing data in any other section of your proposal. |
| **9.** | **Redaction** | Fully redacted complete proposal. Submitted as a separate response file. Note that cost proposals cannot be redacted |

By submitting a proposal, you certify that all information provided in response to this RFP is true and accurate.

# PRESENT SITUATION

This section presents background information on the Virginia Medicaid program for DMAS RFP for External Quality Review Services. It is not intended to set forth requirements. A Supplier should thoroughly explain in the narrative portion of its proposal how it will meet and manage the long-term program goals and expectations stated below.

## DMAS Current Responsibilities

The Department reserves the right to approve hires and rehires to project management level positions. Please refer to the staffing tab of the RTM for more details.

## Key Features of the Virginia Medicaid Managed Care Programs

**Medallion 4.0 Program**

The Medallion 4.0 program provides for the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for most of Virginia’s Medicaid Title XIX members and for all members of FAMIS, Virginia’s Title XXI CHIP. The Medallion 4.0 population includes children, low income parents and caretaker relatives living with children, pregnant women, FAMIS members, and current and former foster care and adoption assistance children. This program covers approximately 1.2 million lives as of January 2021.

**Commonwealth Coordinated Care (CCC) Plus Program**

The CCC Plus program’s focus is to improve the quality of, access to, and efficiency of healthcare and services and support for individuals residing in facilities and in home and community-based settings. The CCC Plus program, which began in 2017, uses a person-centered program design in which all members receive care coordination services to ensure they receive appropriate quality of care. Individuals receiving Long Term Services & Support (LTSS) through nursing facilities and the Elderly or Disabled with Consumer Direction (EDCD) waiver are also eligible to participate in the CCC Plus managed care program. The CCC Plus care coordinators coordinate the care for Virginia’s Medicaid Title XIX and Title XXI members enrolled in both Medicare and CCC Plus. This program covers approximately 268,000 lives, as of January 2021.

**Medicaid Expansion**

The Medicaid expansion benefit plan, which began in Virginia in 2019, includes all services currently covered by Medicaid for the existing populations as well as additional federally required adult preventive care and disease management programs. Medicaid expansion provides coverage for adults ages 19–64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the Federal Poverty Level (FPL), and who are not already eligible for a mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability). In addition, women that are 60 days postpartum may remain eligible for coverage as an expansion member.

**Fee-for-Service (FFS)**

FFS is the traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. DMAS is responsible for the clinical, administrative, and claims functions of the FFS population. The members of the FFS population include those Medicaid covered groups that are not in managed care, as well as those members who are awaiting managed care assignment and are temporarily placed in FFS until they are assigned to a managed care program and participating MCO.

**Virginia Medicaid Enrollment**

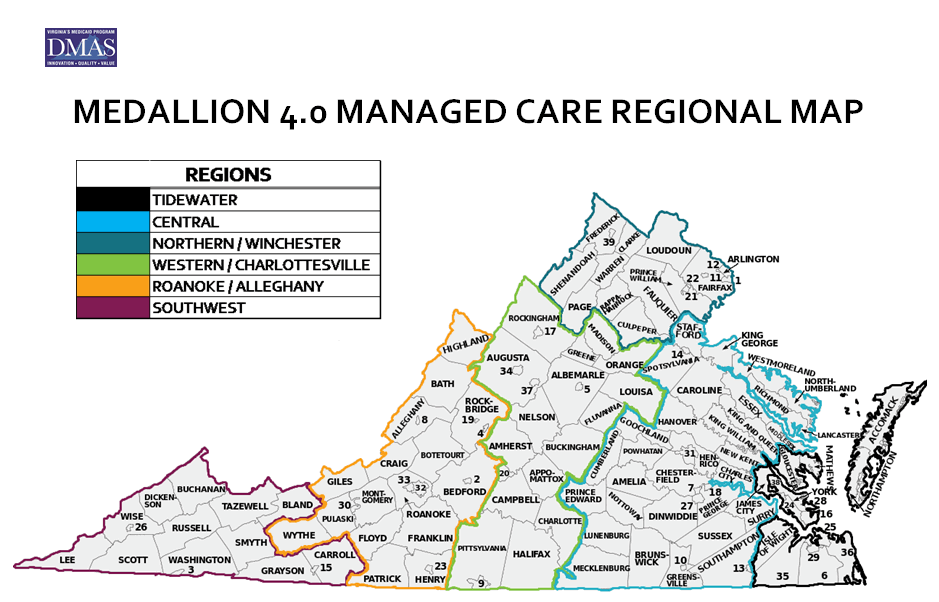
For a breakdown of enrollment by delivery system and programs as of January 2021, please see table below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Delivery System** | **Medicaid Enrollment** | **FAMIS Enrollment** | **Total Enrollment** |
| Medallion 4.0 | 1,254,450 | 80,717 | 1,335,167 |
| CCC Plus | 268,045 | 0 | 268,045 |
| Fee-for-Service | 21,107 | 403 | 21,510 |

DMAS currently contracts with six managed care organizations to administer the Medallion 4.0 and CCC Plus programs on behalf of the Commonwealth. The table below outlines the total enrollment by managed care organization as of January 2021, as well as current accreditation status with NCQA.

| **Managed Care Organization** | **Total Medicaid and FAMIS Enrollment** | **NCQA Accreditation Status** | **Location for Onsite EQRO Activities** |
| --- | --- | --- | --- |
| Aetna | 216,447 | Accredited | Richmond, VA |
| Anthem | 485,696 | Accredited | Richmond, VA |
| Magellan | 110,824 | Accredited | Richmond, VA |
| Optima | 307,240 | Accredited | Norfolk, VA |
| United | 165,140 | Accredited | Richmond, VA |
| Virginia Premier | 317,865 | Commendable | Richmond, VA |

Additionally, the Department programs divide the Commonwealth into six (6) regional service areas. Those six healthcare service regions are outlined in the map below:



# FUNCTIONAL AND TECHNICAL REQUIREMENTS

Each Supplier must indicate its capability of fulfilling each specific requirement below. Each Supplier’s responses will be reviewed and compared across Suppliers in order to determine the best solution for DMAS.

If this RFP includes requirements for cloud services (Software as a Service, Platform as a Service or Infrastructure as a Service), in order to be awarded a contract, an assessment must be conducted by VITA based on Supplier’s responses to Appendix K. of the RFP, “Security Assessment and Governance Map for Non-Premise Based Services”. Supplier should ensure that before submitting its proposal it has provided sufficient and complete responses to reduce the need for additional information.

Detailed requirements are presented in a separate excel worksheet titled Appendix I Requirements Traceability Matrix (RTM) to facilitate direct responses and establish accountability regarding delivery of Service by Suppliers. You must respond to each requirement by entering, in the space provided in Columns C and D, a code that best corresponds to its intended response for the requirement listed.

The acceptable codes for Column C are as follows:

Y - "Yes" - Supplier can fully meet the requirement as documented with its current application or proposed solution. If applicable, Supplier should provide in Column G an explanation of how it will fulfill the requirement. This may include use of alliances with other suppliers. Supplier may also use Column G to cross-reference a detailed explanation included in an attachment of its proposal.

N - "No" - Supplier cannot meet the requirement and has no firm plans to be in the position to meet this need within six months from the date of the proposal

The acceptable codes for Column D are as follows:

A= Functionality is currently operational

B= Functionality is planned

C= Functionality is not currently planned

The Tasks below are for External Quality Review Activities that will need to be implemented under this RFP 2021-02, during the duration of the approved contract. Each Supplier must indicate its capability of fulfilling each specific Task requirement below. Each Supplier’s responses will be reviewed and compared across Suppliers within each service type in order to determine the best solution for the Commonwealth.

## Task A. Contract Start-Up and Transition

Within 10 business days from the Contract award, the Supplier shall schedule and attend a meeting (entrance conference) at DMAS with the Department’s EQRO Contract Administrator and other key staff to discuss all pertinent items relative to the Contract. The Supplier shall bring all staff included in the proposal who are designated to provide a level of effort that amounts to 25% or greater of one FTE for the first contract year. The Supplier shall prepare and submit an Annual Work Plan (AWP) within 20 calendar days after the entrance conference. The AWP shall be prepared in Microsoft MS Project, or other DMAS approved project management tool, and shall delineate each task, with milestones, deliverables, and planned completion dates through the end of the first contract year. The Supplier and Department will work together during initial Contract start-up to establish a schedule for key activities and define expectations for the content and format of contract deliverables for at least the first contract year.

The AWP will present separate sub-tasks for listed Tasks for the contract year and include:

* + 1. A logical sequence of sub-tasks;
    2. A clear definition of each sub-task;
    3. A specified planned completion date for each sub-task;
    4. Sub-task relationships and dependencies; and,
    5. Staff assigned to each sub-task.

The Supplier will work closely with DMAS to define project management, status reporting standards, and communication protocols.

**DMAS will:**

* + 1. Coordinate communications and act as a liaison between the new Supplier and the incumbent Supplier, if applicable;
    2. Coordinate the transfer of files from the incumbent Supplier to the new Supplier on a schedule outlined in the approved work plan, if applicable;
    3. Provide all available relevant documentation on operations currently performed by the incumbent Supplier and DMAS, if applicable;
    4. Establish protocols for problem reporting and controls for the transfer of data or information from the incumbent Supplier to the new Supplier, if applicable;
    5. Work with the Supplier to review and finalize the project work plan for the Transition Phase, if applicable;
    6. Review and approve procedure and protocols defined by the Supplier; and,
    7. Monitor Supplier progress through Supplier’s periodic status reports, weekly meetings, and work plan updates.

**The Supplier shall:**

* + 1. Finalize the AWP, including the Transition Phase activities (if applicable) and submit it to DMAS for approval;
    2. Work with DMAS to establish communication protocols between the Supplier and DMAS;
    3. Coordinate the transfer of files with DMAS and the incumbent Supplier to ensure appropriate and secure data migration, validation, and data integrity, if applicable
    4. Plan, coordinate and facilitate weekly meetings throughout the start-up and planning phase to discuss and resolve any issues, establish procedures and protocols to support operations, and promote communications among all parties;
    5. Work with DMAS to establish project management and reporting standards;
    6. Submit periodic (at least weekly) written status reports on the progress of tasks compared to the approved work plan and include action items and decisions made during weekly meetings with DMAS including identification of any problems and resolutions encountered during the reporting period and,
    7. Launch a document management system for DMAS and the MCOs to use for exchanging files securely. MCOs cannot be able to access other MCOs’ files. There should be at least one shared folder for access by DMAS and all MCOs under contract with DMAS (or deemed as eligible for access by DMAS, such as new MCOs).

**Deliverables:**

* + 1. DMAS’ approved annual work plan submitted no later than 20 calendar days after the entrance conference date.
    2. Weekly status reports are due to DMAS by end of business day each Friday until deemed no longer necessary by DMAS.
    3. Each year thereafter, the EQRO shall provide DMAS with an annual work plan at least two months prior to the start date of the contract fiscal year.
    4. The secure web portal shall be fully operational for DMAS, the MCOs, and the Supplier within 20 business days of contract start date.

**Deliverable Exception:**

The Supplier will need to be prepared to develop and present virtual arrangements for any contractual task that is unable to take place onsite due to emergencies, such as a natural disaster or public health emergency that requires social distancing. These virtual arrangements shall be submitted and approved by DMAS in advance.

## Task B. Operations Preparedness

During the operations preparedness task, the Supplier will install and test all hardware, software, and telecommunications required to support the contract.

**DMAS will:**

* + 1. Act as a liaison between the new Supplier and incumbent Supplier, if applicable, during the development of the transition plan and schedule for the operations cross-over;
    2. Communicate project progress to interested parties, including DMAS’ senior management and the MCOs, on a periodic basis; and,
    3. Assess the Supplier’s understanding of its responsibilities and capabilities to implement the functions required under the Contract, via weekly update meetings or as otherwise specified and agreed upon by both parties.

**The Supplier shall:**

* + 1. Install, test and report findings to DMAS for all hardware, software, and telecommunication capabilities;
    2. Participate with DMAS in defining and testing needed modifications to existing data extraction processes;
    3. Meet with DMAS staff on a periodic basis to discuss progress;
    4. Hire and train staff to implement the operations responsibilities in the contract Scope of Work;
    5. Conduct orientation and training for DMAS’ personnel on Supplier organization, functional responsibilities, and operational procedures;
    6. Prepare a Coordination Plan that documents how the Supplier will coordinate its business activities with those activities performed by any contracted vendors. The Supplier will update the information in this document throughout the life of the Contract;
    7. Ensure that Task B is a detailed component of the AWP; and, provide test data to all interfaces.
    8. Prepare a Detailed Implementation Plan to Install and test all hardware, software, and telecommunication capabilities

**Deliverables:** The installation and testing for all hardware, software, and telecommunication capabilities shall be completed within 20 calendar days after the AWP is approved by DMAS.

## Task C. Provide Education and Technical Assistance on Quality Improvement

**Task:** The Supplier will provide up to 1000 hours per contract year of quality improvement education and technical assistance to DMAS (or key partners, including MCOs) upon request by DMAS. The Supplier will also provide as a part of this proposal, the hourly rate for appropriate labor classifications, for any technical assistance that exceeds 1000 hours. This task is not intended to replace the time and effort the Supplier will provide DMAS and each MCO for the CMS- required EQRO activities Performance Improvement Project Validation PIP), Performance Measure Validation ( PMV), and operational systems review (OSR). Support and technical assistance for those activities should be included in the scope of work and costs for the respective tasks.

**Purpose:** The Supplier shall provide education and technical assistance that further enables DMAS (or its key partners) to understand the industry standards for continuous quality improvement in healthcare processes, systems, programs, clinical guidelines, and policies.

**Methodology:** Education may be in the form of presentations, meeting facilitation, review and recommendations to improve upon DMAS’ quality improvement activities, which may include, web-based presentations (e.g., WebEx), conference calls, and desk-review of quality related documents. Education may also include a synthesis of new and relevant federal regulations, synthesis and presentation of MCO HEDIS scores, notice of industry best practices, analysis of published research, and notification and summary of nationally recognized clinical guidelines.

**Correspondence:** The Supplier shall provide the education and technical assistance in the most effective and efficient way as determined by DMAS. This may include, for example, conference calls, in-person meetings and presentations, webinars, or fact sheets.

**Analysis and Reporting:** The Supplier shall identify the needs and interests of DMAS (or its key partners) with regards to education and technical assistance. The Supplier shall maintain documentation and reports on education and technical assistance requested and provided.

Documentation and reports shall include number and names of participants, and a measure of satisfaction in the form of an evaluation among participants.

**Deliverables:** Within 30 calendar days of the effective date of this Contract, the Supplier shall have a DMAS-approved standardized process to enable DMAS to request and receive high- quality education and/or technical assistance from the EQRO in a timely and cost effective manner; and, the Supplier shall include a method and tool(s) for evaluating and reporting on customer satisfaction for the education and technical assistance received.

## Task D: Annual Technical Reports

**Task:** The Supplier shall prepare and provide Annual Technical Reports (ATR) for each line of business, to DMAS using the relevant CMS protocol. The Supplier shall include both MCO and non-MCO tasks it performed under contract with DMAS during the year. The tasks shall be prepared separately for the two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) populations as outlined in Tasks D.1 and D.2.

**Purpose:** To provide a review of the external quality review process, major findings from the tasks completed, and recommendations for DMAS and the MCOs for the two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) populations as outlined in Task D.1 and D.2.

## Task D.1: CCC Plus Annual Technical Report

**Methodology:** Prior to initiating the report, the Supplier shall ascertain the expectations that DMAS has for content and format. The Supplier shall use the CMS requirements for the annual technical report and gather the information in a timely and methodical manner in order to meet the federal reporting deadline. The Supplier will provide DMAS with a draft of the report for review and comment. The Supplier shall also review the CMS ATR assessment letter that was sent to DMAS as a means for identifying additional elements to the content of the ATRs. The Supplier shall prepare final 508 compliant reports for public review and posting to the DMAS website.

**Correspondence:** The Supplier shall engage DMAS staff in the development of the ATR outlines each year.

**Analysis and Reporting:** The ATRs shall include the required content outlined by CMS in the CFR. In addition to having a focus on MCOs, the EQRO shall include an annual assessment on progress made toward the goals outlined in the Virginia Medicaid Managed Care Quality Strategy (current version is 2020 – 2022). In order to meet CMS timelines for inclusion of the ATRs in the CMS annual report, DMAS is requiring the ATRs to be final each year by March 15. For example, the first contract year ATR will be due no later than March 15, 2023.

**Deliverables:** The Supplier shall provide the Department with a draft and final ATR. The report shall contain a 2-3 page executive summary suitable for use by CMS, the Office of the Governor, the Virginia Legislature, and conclusions readable by program and policy makers. DMAS is requiring the ATR to be final each year by March 15 and reflect EQRO contractual activities from the previous contract year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format. At a minimum, the ATR must include:

1. Progress on achieving goals outlined in DMAS’ quality strategy
2. Gap analysis of the DMAS quality strategy
3. MCOs’ CAHPS Survey Results for child and adults (composite scores)
4. CAHPS results
5. MCOs’ HEDIS scores – stratified by MCO and aggregated for Virginia
6. All EQRO mandatory activities that were completed during the year
7. Highlights of the Virginia Medicaid Managed Care Quality Collaborative
8. All EQRO optional activities that were conducted during the year
9. Summary of each MCOs best practice presentation

## Task D.2: Medallion 4.0 Annual Technical Report

**Special Instruction:** Replicate Task D.1 of RFP 2021-02. The ATR for Medallion 4.0 and FAMIS managed care shall be separate from the ATR for CCC Plus managed care.

## Task E: Validate MCO Performance Improvement Projects (PIPs)

**Task:** As required by DMAS, the Supplier shall validate a managed care rapid cycle performance improvement project (PIP) through the managed care quality collaborative. The PIP topic will be chosen by DMAS. DMAS may choose to use the same PIP topic for all of the MCOs or may select different topics for each MCO.

**Purpose:** The PIPs validation is a CMS mandated EQR activity that must be completed every 12 to 18 months. The PIP validation is designed to assist the MCOs in practicing effective continuous quality improvement to improve the care received by Medicaid and FAMIS members. The PIP validation includes a rapid cycle improvement model.

## Task E.1: CCC Plus Performance Improvement Project (PIPs)

**Methodology:** The Supplier shall follow the most recently published CMS recommended protocol for PIP validation, entitled "Validating Performance Improvement Projects, A Protocol for use in Conducting Medicaid External Quality Review Activities." The rapid-cycle PIP framework is a modified version of the Institute for Healthcare Improvement (IHI) IHI Module for Improvement.

**Correspondence:** The Supplier shall position itself as a technical consultant, facilitator, and instructor for the rapid cycle improvement approach to performance improvement and the validation of the PIP. In addition, the EQRO shall have ongoing dialogue with DMAS during the rapid cycle performance improvement project and the PIP validation process. The Supplier is expected to engage each MCO and DMAS in the review of preliminary findings and the draft PIPs validation reports for the CCC Plus managed care program, as needed, to complete any remaining PIP activities from the previous cycle not completed by the termination of the emergency extension. The Supplier shall also engage DMAS on preliminary findings and draft evaluation process reports.

**Analysis and reporting:** The Supplier shall track the development of, and validation of, the PIP. The Supplier shall follow the CMS required content for the PIP validation final reports. The Supplier shall provide monthly updates to DMAS on the actions taken with each MCO, the MCO quality collaborative, and DMAS for the CCC Plus managed care program. Additionally, DMAS shall be notified by the Supplier when any of the MCOs do not meet a deadline or a Supplier requirement for the rapid cycle improvement project.

**Deliverables:** The CCC Plus annual report for each MCO is due to DMAS no later than January 15 of each year. The Supplier shall provide annual rapid cycle improvement project and PIP validation training at a Medicaid managed care quality collaborative meeting. The training shall include a slide presentation that could be used by the MCOs for training their staff on the rapid cycle improvement module and the PIP validation process. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task E.2: Medallion 4.0 Performance Improvement Project (PIPs)

**Special Instruction**: Replicate Task E.1 of RFP 2021-02. The PIPs for Medallion 4.0 and FAMIS managed care shall be separate from the PIPs for CCC Plus managed care.

## Task F: Performance Measure Validation (PMV)

To meet the CMS EQR mandated activity for validating performance measures, the Supplier shall validate a select group of each MCO’s performance scores on an annual basis. The Supplier should plan to validate scores for the same measures for each MCO. The selected measures for validation will be determined by DMAS on an annual basis and will be contingent upon concerns related to particular performance measures (such as, HEDIS scores, contract deliverables, or other quantitative measures). The measures used for validation for each MCO will include at least one hybrid measure and one administratively calculated measure.

**Purpose:** The performance measure validation is a CMS mandated activity that must be completed every twelve months. At least one hybrid measure and one administratively calculated measure will be validated each year.

**Methodology:** The Supplier shall follow the CMS External Quality Review (EQR) Protocol 2. Validation of Performance Measures, October 2019, or most current protocol.

## Task F.1: CCC Plus Performance Measure Validation (PMV)

**Correspondence:** The Supplier shall have ongoing dialogue with each MCO to enable them to adequately prepare for the onsite visit for the performance measure validation process so it can take place in an efficient and effective manner. The Supplier shall engage each MCO and DMAS in the review of preliminary findings and draft quality measure validation reports for the CCC Plus program.

**Analysis and reporting:** The Supplier shall complete a performance measure validation worksheet and report for each MCO’s validated measures. In addition to the worksheets, the Supplier shall produce one report for each MCO that includes all of the EQRO- validated measures. In order to leverage the benefits of NCQA accreditation, the final report for each MCO shall include a description of the HEDIS audit methodology that each MCO experienced for the same measurement year and results for each MCO’s HEDIS measures that were required by DMAS for annual reporting, per the CCC Plus contract, AND validated by the MCO’s HEDIS auditor.

**Deliverables:** The Supplier shall develop a template for and produce a separate performance measure validation worksheet for each MCO’s measures that are validated by the Supplier and one report that includes all of the validated measures. A preliminary PMV report shall be due to DMAS no later than October 15 of each year. The final PMV report for each MCO is due to DMAS no later than October 31of each year and shall reflect the validated performance measures that stem from health care services provided to members in the previous calendar year. For example, the first PMV final reports from this Supplier are due to DMAS by October 31, 2022 and shall reflect the validation of at least one hybrid measures and one administratively calculated score that reflects services received by members from January 1, 2021 through December 31, 2021. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task F.2: Medallion 4.0 Performance Measure Validation (PMV)

**Special Instruction**: Replicate Task F.1 of RFP 2021-02. The PMV for Medallion 4.0 and FAMIS managed care shall be separate from the PMV for CCC Plus managed care.

## Task G: Consumer Decision Support Tool

**Task:** Annually, the EQRO shall analyze the MCO's prior year's Healthcare Effectiveness Data and Information Set (HEDI S®) results including Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) data for the development of both the CCC Plus and Medallion 4.0 (Medicaid/FAMIS) Consumer Decision Support Tools.

**Purpose:** CMS published in the Federal Register the Medicaid and CHIP Managed Care Final Rule that each State contracting with an MCO to furnish services to Medicaid beneficiaries must adopt and implement a quality rating system within three years of the publication of the Final Rule. As such, DMAS, per CMS, began publishing annual consumer decision support tools to satisfy this deliverable.

## Task G.1: CCC Plus Consumer Decision Support Tool

**Methodology:** For this activity, the Supplier shall use the most recent CAHPS results and HEDIS data for the CCC Plus MCOs. The Supplier will receive the data from the MCOs and/or DMAS. The Supplier will work with DMAS to determine the measure list and reporting categories (e.g., Care for Chronic Conditions, Getting Care) for inclusion in the CCC Plus Consumer Decision Support Tool.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier is expected to engage DMAS in the preliminary findings and the draft of the consumer decision support tool.

**Analysis and reporting:** Each reporting category shall contain a summary score for each of the CCC Plus MCOs. The summary score for each MCO shall then be compared to the Virginia CCC Plus MCO average to determine differences in MCO performance.

**Deliverables:** Supplier will submit a work plan, methodology, draft consumer decision support tool results, and final consumer decision report tool to DMAS. The final consumer decision support tool is due to DMAS no later than December 15 of each year. DMAS and/or the MCOs will be responsible for providing the Supplier with the data files for this tool. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

**Special Instructions:** Given the population differences, methodology development and measure selection will need to occur independent of Medallion 4.0 based on available data for CCC Plus. The consumer decision tool for CCC Plus shall be conducted and reported separately from Medallion 4.0 and FAMIS Managed Care.

## Task G.2: Medallion 4.0 Consumer Decision Support Tool

**Special Instructions:** Replicate Task G.1 of RFP 2021-02. The Consumer Decision Support Tool for Medallion 4.0 and FAMIS managed care shall be separate from the Consumer Decision Support Tool for CCC Plus managed care. Given the population differences, methodology development and measure selection will need to occur independent of CCC Plus based on available data for Medallion 4.0.

## Task H: Performance Withhold Program (PWP)

**Task:** The Department introduced the Performance Withhold Program (PWP) to reinforce Value-Based Purchasing (VBP) principles by setting performance standards and expectations for MCOs in key areas influencing member health and health outcomes. By tying financial incentives to MCO performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members. This effort also aligns with the Virginia Medicaid focus areas by including measures pertaining to behavioral health and chronic conditions.

DMAS reserves the right to augment the measures and corresponding weights included in the PWP composite in future years. The withhold percentage shall remain one percent (1%) for the PWP unless determined otherwise by the Department.

**Purpose**: The Supplier shall establish and maintain measurement and scoring mechanisms necessary to implement the PWP, including capture and evaluation of performance measure results and the development and execution of a scoring methodology for assessing MCO performance.

## Task H.1: CCC Plus Performance Withhold Program (PWP)

**Methodology:** The Supplier shall develop and implement a valid measurement and scoring mechanism for the PWP. The MCOs shall provide their audited HEDIS and non-HEDIS measure rates to the Supplier for each measure. The Supplier shall review this information for accuracy and completeness, working with the MCO to correct reporting errors for those measures, when necessary.

The current measures for the CCC Plus Performance Withhold Program and associated weights are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Measure** | **Domain** | **Measure Type** | **CY 2019**  **Weight** |
| Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total | Behavioral Health | NCQA HEDIS | 7.5% |
| Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total | Behavioral Health | NCQA HEDIS | 7.5% |
| Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total | Behavioral Health | NCQA HEDIS | 10% |
| Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total | Behavioral Health | NCQA HEDIS | 10% |
| Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total | Behavioral Health | NCQA HEDIS | 7.5% |
| Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total | Behavioral Health | NCQA HEDIS | 7.5% |
| Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate | Chronic Conditions | CMS Adult Core | 15% |
| Comprehensive Diabetes Care | Chronic Conditions | NCQA HEDIS | 20% |
| Heart Failure Admission Rate | Chronic Conditions | CMS Adult Core | 15% |

**Correspondence:** The Supplier shall have ongoing dialogue with DMAS to establish the processes, methodology, and reporting of scores for the PWP.

**Analysis and Reporting:** The Supplier shall produce a methodology document and scoring tool for the PWP and a result document with quantitative information for each MCO and the overall CCC Plus Program.

**Deliverables:** The Supplier shall produce a methodology document and scoring tool for the PWP. The Supplier shall also develop an MCO-specific and CCC Plus Program result document template that shall demonstrate how the final PWP results will be displayed. Once the data is received and the results are finalized, the Supplier shall provide MCO-specific and CCC Plus Program results documents to DMAS. The final report is due to DMAS by October 15th of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task H.2. Medallion 4.0 Performance Withhold Program

**Methodology:** The Supplier shall develop and implement a valid measurement and scoring mechanism for the PWP. The MCOs shall provide their audited HEDIS and non-HEDIS measure rates to the Supplier for each measure. The Supplier shall review this information for accuracy and completeness, working with the MCO to correct reporting errors for those measures, when necessary.

The current measures for the Medallion 4.0 Performance Withhold Program and associated weights are as follows:

|  |  |  |
| --- | --- | --- |
| **Measure** | **Measure Type** | **SFY 2021 Weight** |
| Adolescent Well-Care Visits—Total | NCQA HEDIS | 16.67% |
| Childhood Immunization Status Combination 3 | NCQA HEDIS | 16.67% |
| Prenatal and Postpartum Care | NCQA HEDIS | 16.67% |
| Comprehensive Diabetes Care | NCQA HEDIS | 16.67% |
| Asthma Admission Rate | AHRQ: PDI #14 | 16.67% |
| Follow-Up After Emergency Department (ED) Visit for Mental Illness—7- Day Follow-Up—Total | NCQA HEDIS | 8.33% |
| Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total | NCQA HEDIS | 8.33% |

**Correspondence:** The Supplier shall have ongoing dialogue with DMAS to establish the processes, methodology, and reporting of the scores for the PWP.

**Analysis and reporting:** The Supplier shall produce a methodology document and scoring tool for the PWP and a result document with quantitative information for each MCO and the Medallion 4.0 Program.

**Deliverables:** The Supplier shall produce a methodology document and scoring tool for the PWP. The Supplier shall also develop an MCO-specific and Medallion 4.0 Program result document template that shall demonstrate how the final PWP results will be displayed. Once the data is received and the results are finalized, the Supplier shall provide MCO-specific and Medallion 4.0 Program results documents to DMAS. The final report is due to DMAS by October 15th of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task I. Population Focused Studies

Within the first three (3) months of the Contract Year, DMAS will select focused study topic(s) with input from the Supplier. Should the focused study scope of work exceed the contracted budget amount, the Supplier and DMAS will negotiate the scope of work to realign it within the budgeted amount.

DMAS is strengthening its collaboration with its contracted MCOs to improve birth outcomes and outcomes for children involved in child welfare. As part of these focused studies, the Supplier shall include DMAS-selected participants in the requirements gathering session, with the intent of adding value to the existing methodology; data sources; number and type of quality measures; and, final report.

For each focused study that DMAS authorizes, DMAS will expect the Supplier to coordinate with DMAS on including the following elements:

* + 1. Study design, stated goal of study, populations, approach, activities, specifications, and definitions;
    2. The type and intended use of data, including any tools to be utilized;
    3. Methodologies for collecting, calculating and analyzing data;
    4. The degree of confidence required for the data and the statistical tests to be performed on the data;
    5. The EQRO's project requirements;
    6. DMAS' expectations regarding deliverables, including data; and
    7. Timeline for delivery of the report.

The Supplier must confirm the agreement in writing, and DMAS must approve of it to be fully executed.

## I.1 Medicaid Maternal and Child Health Focused Study

**Purpose:** To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve women’s reproductive health, maternal care and outcomes, as well as prenatal care and birth outcomes among Medicaid (including Expansion), FAMIS MOMS, and FAMIS members, in both managed care and fee for service.

**Methodology:** Data used by the Supplier should include claims data, encounter data, and birth records (to be obtained from the Virginia Department of Health via DMAS). Medical record abstraction is not required for this study.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier must engage DMAS in the review of preliminary findings and draft focused study reports.

**Analysis and Reporting:** Results shall be reported for all CHIP and Medicaid covered births. The report shall include, at a minimum but not be limited to, a focus on women’s reproductive health, early and adequate prenatal care, maternal depression screening, disparities in maternal health data and outcomes, birth outcomes including preterm births and low birthweight births, early elective deliveries, and the Screening, Brief Intervention and Referral to Treatment (SBIRT) program activities. Additionally, the study should include an evaluation of women who are 12 months postpartum of delivery examining care and services received, and outcomes. The data shall be stratified, at a minimum, by race, program, delivery system, DMAS managed care region, age, and by MCO.

The focused study report shall follow all of the recommended steps from the most recent CMS-Focused Study Protocol and include sections on key findings, conclusions, and recommendations. The report shall demonstrate year over year trends in the measures/indicators, as applicable and as supported by the DMAS-approved methodology. The report shall also contain a stand-alone executive summary. The Supplier shall prepare a deck of slides on the report that can be used by internal and external stakeholders to explain the methodology and results of the focused study.

The Supplier shall include comparisons between focused study results with national and statewide averages and benchmarks from reputable sources, as applicable. The Supplier shall identify sources of the averages and benchmarks and obtain DMAS approval on their use for comparative purposes.

**Deliverables:** The Supplier will provide DMAS with an analytic dataset with submission of the final report. The final report is due no later than December 31 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## I.2 Child Welfare Focused Study

**Purpose:** To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve the delivery of quality health care for children in foster care, adoption assistance children, and former foster care members as defined by the Department.

**Methodology:** Data used by the Supplier will include claims and encounter data. Medical record abstraction is not required for this study.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier must engage DMAS in the review of preliminary findings and draft focused study reports.

**Analysis and Reporting:** Results shall be reported for foster care children, adoption assistance children, and former foster care members and a statistically derived comparative population of non-child welfare involved children in aggregate for statewide measures of performance, and shall be stratified, at a minimum, by DMAS managed care region, race, sex, age, MCO, and include a health disparities focus. The focused study will include, at a minimum, a focus on child welfare member transitions as well as measures and study indicators as agreed upon with the Department, including but not limited to behavioral health, psychotropic medication usage and appropriate access to medical care, including well care visits and emergency department utilization, dental visits, and overall service utilization.

The report shall demonstrate trends in the measures/indicators, as applicable and as supported by the DMAS-approved methodology. The focused study report shall follow all of the recommended steps included in the Focused Study Protocol and include sections on key findings, conclusions, and recommendations. The report shall also contain a stand-alone executive summary. The Supplier shall also prepare a deck of slides on the report that can be used by internal and external stakeholders to explain the methodology and results of the focused study.

The Supplier shall include comparisons between focused study results with national and statewide averages on benchmarks from reputable sources, as applicable. The Supplier shall identify sources of the averages and benchmarks and obtain DMAS approval on their use for comparative purposes.

**Deliverables:** The Supplier will also provide DMAS with an analytic dataset with submission of the final report. The final report is due no later than December 31 of each year for the focused study. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task J: Calculate Performance Measure

**Purpose:** The Supplier will calculate one performance measure, as determined by DMAS, following the most current CMS EQR Protocol 7: Calculation of Additional Performance Measures in accordance with 42 CFR 438.310(c)(3), found here: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Results shall be stratified by managed care geographic region using FIPS codes and mapping software. Results will also be stratified by key demographic stratifications (e.g., race, gender, age) and other stratifications, as determined by DMAS.

**Methodology:** The Supplier will assist DMAS with selecting a performance measure that meets DMAS’ goals and objectives. Once DMAS confirms the measure, the Supplier will submit a methodology document that outlines the technical specifications of the measure and the stratifications that will be calculated by the Supplier.

**Correspondence:** The Supplier shall have ongoing dialogue with DMAS to establish the performance measure, methodology, reporting, and timeline for this task.

**Analysis and Reporting:** The Supplier will calculate the performance measure for a calendar year. To calculate the performance measure, the Supplier will submit a data request to DMAS outlining the necessary claims/encounter data necessary for measure calculation. To allow for six months of data run-out, DMAS will provide the Supplier with data in July of each year.

**Deliverables:** Final report to DMAS every year no later than November 30.

## Task K. Conduct MCO Operational Systems Review (OSR)

**Task:** Federal regulations mandate that the EQRO complete a comprehensive operational systems review (OSR) a minimum of once every three years to determine compliance with federal and state program requirements. The last comprehensive review took place in calendar year 2021. Unless otherwise determined by the Department, the Supplier can concurrently review Medallion 4.0 and CCC Plus. However, two separate OSR deliverables will be generated for the two managed care programs.

Based on the federal regulations, the MCOs, with evidence of national accreditation within a previous 3-year period, may be exempt from a review of certain administrative functions, when the accrediting organization’s standards are comparable to the federal and state program requirements.

The EQRO shall conduct the OSR on all currently contracted Medicaid MCOs every three years from the previous compliance review conducted for the Department to meet federal regulation. The Supplier shall conduct the full OSR, without deeming, unless determined by DMAS that deeming may occur. Unless otherwise specified or amended by the Department, deeming for this activity would mean determining any elements, if any, of the compliance review are met by the MCO through other activities, such as NCQA accreditation standards. If deeming is permitted by DMAS, the Supplier shall include additional elements, added by DMAS, for review during the OSR that are of equal level of effort to those deemed as already met.

The Supplier shall use the most current CMS EQR Protocol for Managed Care Compliance with Standards and, as a source document, shall use the NCQA-CMS crosswalk published annually by NCQA as a source for identifying deeming opportunities for the MCOs that are accredited by NCQA. The Supplier will include in the OSR all standards and requirements that the Supplier determines to not meet the requirements for deeming and will notify the Department of the results of this determination.

**Purpose:** The Supplier shall perform an onsite review of each of the MCOs operational systems as mandated by CMS through 42 CFR § 438.358(b) (3). Specifications for the annual MCO reviews may change over the course of the contract, as federal regulations or state requirements change. The comprehensive OSR shall occur once every three years. Operational and Systems Reviews shall include the following Standards:

* + 1. 42 CFR §438.56 Enrollment and Disenrollment
    2. 42 CFR §438.100 Enrollee Rights and Protections
    3. 42 CFR §438.114 Emergency and Post-Stabilization Services
    4. 42 CFR §438.206: Availability of services.
    5. 42 CFR §438.207: Assurances of adequate capacity and services.
    6. 42 CFR §438.208: Coordination and continuity of care.
    7. 42 CFR§ 438.210: Coverage and authorization of services.
    8. 42 CFR §438.214: Provider selection.
    9. 42 CFR §438.224: Confidentiality.
    10. 42 CFR §438.228: Grievance and appeal systems.
    11. 42 CFR §438.230: Subcontractual relationships and delegation.
    12. 42 CFR §438.236: Practice guidelines.
    13. 42 CFR §438.242: Health information systems.
    14. 42 CFR §438.330: Quality assessment and performance improvement.

## Task K.1: CCC Plus Operational Systems Review (OSR)

**Methodology:** The Supplier shall conduct the operational and systems review according to the CMS protocol. The Supplier should plan to schedule up to three consecutive calendar days at each MCO for the additional document review, interviews, and preliminary findings meeting with the MCO. The MCOs will be expected to provide the EQRO with the documents in advance of the onsite OSR and it is up to the Supplier to manage these timelines and expectations of the MCOs. The Supplier must have a secure web portal to enable each MCO to electronically upload the documents required for the desk review.

**Analysis and Reporting:** The Supplier shall produce a detailed operational and systems review report containing the results of each MCO’s OSR and, where applicable, a summary of components of each MCO’s NCQA accreditation elements that were not included in the OSR because they were deemed by the Supplier to be duplicative.

**Correspondence:** The Supplier shall provide training and ongoing communications to the MCOs and DMAS on the process, timeline, and expectations to enable the OSR process to be methodical, efficient, and effective.

**Deliverables:** The Supplier shall:

* Provide timely and appropriate trainings to the MCOs and DMAS on the process, timeline, and expectations to enable the OSR process to be methodical, efficient, and effective.
* Provide a detailed operational and systems review report for each MCO and a summary MCO aggregate report. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.
* Provide, no later than 15 business days after the onsite review, an initial summary letter of findings that includes a list of unmet or partially met elements.
* Provide to DMAS and the respective MCO the draft operational and systems review report no later than 4 weeks after the MCO’s onsite review.
* The final individual MCO report shall be due within 12 weeks of the onsite review. All OSR final reports shall be completed and approved no later than December 15.

## Task K.2 Medallion 4.0 Operational Systems Review

**Special Instruction:** Replicate Task K.1 of RFP 2021-02. The comprehensive OSRs for the Medallion 4.0 and FAMIS Managed Care shall be conducted concurrently and align where appropriate but shall be reported separately from CCC Plus.

## Task L. FAMIS CAHPS for Children

In order to assess consumer satisfaction among FAMIS members who either receive their care through FFS or managed care, the Supplier shall administer a CAHPS Child Medicaid Health Plan Survey with the children with chronic conditions (CCC) measurement set. The result will be a report that synthesizes the children’s CAHPS survey results for both general population and Children with Chronic Conditions.

**Purpose:** The report will be used to assess customer satisfaction for the FAMIS program and will be used to meet the regulatory requirement that states administer the CAHPS survey annually to the CHIP population.

**Methodology:** Data collection for the CAHPS survey shall be completed by the end of the second quarter of each calendar year. The Supplier should design methodology that will aim toward having response rates that will provide meaningful results and at least meet the minimum required response rate set forth by NCQA for CAHPS. The EQRO must be an NCQA-certified CAHPS vendor or sub-contract with an NCQA-certified CAHPS vendor for this task. The Supplier will be expected to add two supplemental questions of DMAS’ choosing to either the CAHPS survey each year.

**Analysis and Reporting:** Standardized CAHPS analysis and reporting as is usual and customary per CAHPS certified vendor requirements.

**Correspondence:** The Supplier shall engage DMAS in on-going communication regarding methodology and enrollment data needs.

**Deliverables:** The annual CAHPS for FAMIS final report is due by December 31 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task M: Quality Strategy

**Task:** The Supplier shall work with DMAS to review and update the DMAS agency wide quality strategy that covers the Medallion Program, the Commonwealth Coordinated Care (CCC) Plus Program and the DMAS fee-for-service (FFS) as determined by DMAS. The current quality strategy covers years 2020-2022 and captures all program and population changes.

**Purpose:** To assist with any updates required by DMAS for the current Quality Strategy and to assist DMAS in preparing for the next Quality Strategy document as determined by the Department and federal regulations. For example, the next Quality Strategy document will cover 2023-2025.

**Methodology:** The Supplier will serve as the primary author for, as well as updating the quality strategy in an aesthetically pleasing and informative way that is useful and meaningful to DMAS and the managed care organizations (MCOs), and that meets CMS requirements for a state managed care quality strategy.

The Supplier shall also work with DMAS on an approach for evaluating the effectiveness of the quality strategy through the creation of short- and long-term goals and suggest presenting these results as a chapter within the EQR technical report.

**Correspondence:** The EQRO is responsible for communicating progress made to DMAS. The EQRO is expected to engage DMAS in the review of preliminary review of the quality strategy and draft amendment documents.

**Analysis and Reporting:** The Supplier shall serve as the primary author of any quality strategy and/or amendment for DMAS review and input, which includes amendments to the current Quality Strategy and preparation for the next Quality Strategy (as appropriate). The Supplier shall work with DMAS on gathering key external stakeholder input and feedback and public comments, as well as consider and incorporate, as appropriate, the valuable feedback gathered into the quality strategy amendment.

**Deliverable:** The Supplier shall be responsible for review, analysis, and report amendment. For any quality strategy amendments, the final amended quality strategy is due no later than December 15 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task N: Dental Utilization in Pregnant Women Data Brief

**Task:** The EQRO shall provide an annual data brief to assess dental utilization among pregnant women covered by Virginia Medicaid and FAMIS MOMS using the Deliveries Value Set referenced in the Healthcare Effectiveness Data and Information Set (HEDIS ®) technical specifications to identify women with a delivery during the measurement period.

**Purpose:** To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve prenatal care and birth outcomes among Medicaid and FAMIS MOMS members receiving dental services.

**Methodology:** Data used by the Supplier shall be sourced from the Medicaid recipient, claims, and encounter data files previously supplied by DMAS for use in other tasks, including the Birth Outcomes focused study. The Supplier shall use dental encounter data to assign each study member a series of indicators that identify which dental services, if any, are utilized during the member's pregnancy. Pregnancies that did not result in a live birth will be excluded from the stud y population using the HEDIS Non-Live Births Value Set. As women younger than 2 l years of age are eligible for dental services under a separate children’s benefit, this assessment **will** be limited to women 21 years of age and older as of the beginning of their pregnancy (i.e., 280 days prior to the date of delivery).

**Correspondence:** The EQRO is responsible for communicating progress made to DMAS. The EQRO must engage DMAS in the review of preliminary findings and draft briefs.

**Analysis and Reporting:** The Supplier shall use the dental encounter data to assign each study member a series of indicators that identify which dental services, if any, were utilized during the member’s pregnancy. Up to seven dental utilization indicators, defined by the EQRO and approved by DMAS, shall be reported. Statistical comparisons shall be made between dent al utilization indicators and up to five birth outcome indicators, defined by the EQRO and approved by DMAS. The Supplier will aggregate the indicator information across all study members for presentation in a data brief.

**Deliverables:** A report outline and final slide deck are not expected deliverables for this Task. The Supplier shall be responsible for data synthesis, analysis, and reporting. The final data brief is due no later than October 1 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task O: Addiction & Recovery Treatment Services (ARTS) Measurement Specification and Reporting

**Purpose:** To provide an annual data report, consisting of quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve Addiction and Recovery Treatment Services for members in Medicaid and CHIP (including the Medicaid expansion population). As needed, the Supplier shall assist with identifying and/or maintaining appropriate existing performance measures for the ARTS benefit. ARTS measures will be used to evaluate the ARTS benefit.

**Methodology:** Data used by the Supplier shall be sourced from DMAS Medicaid recipient, claims, encounter data, and HLA lab data files. The Supplier shall use this data to present findings on members using DMAS approved specifications for measures that shall include the following measures:

* Concurrent Prescribing of Naloxone and High Dose Opioids
* Naloxone Use for High Risk of Overdose
* Treatment of Hepatitis C for those with Hepatitis C and Substance Use Disorder (SUD)
* Treatment of Human Immunodeficiency Virus (HIV) for those with HIV and SUD
* Preferred Office-Based Opioid Treatment (OBOT) Compliance
* Cascade of Care for Members with Opioid Use Disorder (OUD)
* Cascade of Care for Members with Hepatitis C
* Cascade of Care for Members with HIV

DMAS reserves the right to change the measures included in the report outlined in this task. The Supplier shall present data using a broad set of health equity, disparities, and demographic indicators to stratify data. DMAS shall provide the measure specifications to those measures listed above to the Supplier, including code sets and relevant documentation for the first year of the contract. The Supplier will then be responsible for keeping the measures up to date as required by the Department, including but not limited to updating code sets based on the availability of new codes (e.g., Common Procedural Terminology [CPT] codes, revenue codes), further testing of codes on newer data (i.e., calendar year [CY] 2022 and 2023 data), and researching the potential services to be added/removed from measures based on changes in covered services and/or program requirements.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier is expected to engage DMAS in the selection of measures identified for the annual report as well as those identified for measure maintenance...

**Analysis and reporting:** ARTS performance measure results shall be reported, at a minimum, for the full Medicaid benefit (e.g., Medicaid Expansion, FAMIS, and FAMIS MOMS). The data shall be stratified, at a minimum, by race, gender, program, delivery system, DMAS managed care region, age, eligibility group and by MCO. A final report of progress and outcomes shall include sections on key findings, conclusions, and recommendations. The report shall demonstrate year over year trends in the measures/indicators, as applicable and as supported by the DMAS-approved methodology. The report shall also contain a stand-alone executive summary. The Supplier shall prepare a deck of slides on the report that can be used by internal and external stakeholders to explain the methodology and results of the report.

The Supplier shall include comparisons between ARTS performance measure results, and those of national and statewide averages and benchmarks from reputable sources, as applicable. The Supplier shall identify sources of the averages and benchmarks and obtain DMAS approval on their use for comparative purposes.

**Deliverables**: The Supplier will provide DMAS with an analytic dataset with submission of the final report. The final report is due no later than January 15 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task P: Appointment Standards Monitoring

**Task:** Health plans are expected to arrange to provide care as expeditiously as the member's health condition requires. Ensuring that members receive timely appointments for maternity care and routine primary care are important components of quality improvement efforts that address access to care.

**Purpose:** To review MCO compliance of DMAS established appointment standards for managed care organizations contracted to serve the Medicaid population. Health plans must meet specific contractual standards for the availability of health care appointments for members.

## Task P.1: Appointment Standards Monitoring Prenatal Care Secret Shopper Survey for Medallion 4.0

**Methodology:** The Supplier shall conduct a secret shopper telephone survey of appointment availability to collect information on members’ access to initial prenatal care services under the Medallion 4.0 managed care program annually. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

The primary purpose of the secret shopper survey is to collect appointment availability information among prenatal care providers enrolled with the Medallion 4.0 Managed Care Organizations (MCOs). Specific survey objectives include the following:

* Determine whether prenatal care service locations accept patients enrolled with MCOs and the degree to which this information aligns with the MCOs’ provider data
* Determine whether prenatal care service locations accept new Medallion 4.0 patients for the requested MCO
* Determine appointment availability at the sampled prenatal care service location for initial prenatal care services during the first and second trimester of pregnancy, including in-person, non-emergency after hours services.

The study shall review MCO compliance with the Maternity Care Appointment Standards:the health plan must be able to provide initial prenatal care appointments for pregnant members as follows:

* First trimester Appointments shall be scheduled within seven (7) calendar days of request.
* Second trimester Appointments shall be scheduled within seven (7) calendar days of request.
* Third trimester Appointments shall be scheduled within three (3) business days of request.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier must engage DMAS in the preliminary survey findings and the drafts of the report and presentations.

**Analysis and Reporting:** The Supplier will develop the timeline, methodology, and script for each survey with DMAS' approval. Each survey methodology will include details of the Supplier's approach to data collection, sampling, survey administration and oversight, and data analysis. The Supplier will work with DMAS and the MCOs to gather complete provider data for use in the survey.

The Supplier will supply DMAS with a list of sampled providers prior to initiating each survey.

**Deliverable:** Following data collection for the survey, the Supplier will supply DMAS with one aggregate report and MCO-specific analytic datasets. These deliverables will be based upon DMAS-approved templates. The final report is due by December 15 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

The Supplier will develop up to two presentations for the survey and will present to DMAS and/or the MCOs via WebEx (e.g., one presentation to introduce the survey and one presentation to summarize the survey results). The final presentations are due by December 15th of each year.

## Task P.2 Appointment Standards Monitoring- PCP Secret Shopper Survey

**Methodology**: The Supplier shall conduct a secret shopper telephone survey of appointment availability to collect information on members’ access to primary care services under the Medallion 4.0 and CCC Plus managed care programs annually. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

The primary purpose of the secret shopper survey is to collect appointment availability information among primary care providers (PCPs) enrolled with the Medallion 4.0 and CCC+ Managed Care Organizations (MCOs). Specific survey objectives include the following:

* Determine whether primary care service locations accept patients enrolled with MCOs and the degree to which this information aligns with the MCOs’ provider data
* Determine whether primary care service locations accept new Medallion 4.0 or CCC Plus patients for the requested MCO
* Determine appointment availability at the sampled primary care service location for urgent and routine primary care services, including in-person, non-emergency after hours services.

The study shall review MCO compliance with the Routine Primary Care Services Appointments: The MCOs are to ensure that routine, primary care service appointments shall be made within thirty (30) calendar days of the member's request. This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days, or for routine specialty services like dermatology, allergy care, etc.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier must engage DMAS in the preliminary survey findings and the drafts of the report and presentations.

**Analysis and Reporting**: The Supplier will develop the timeline, methodology, and script for each survey with DMAS' approval. Each survey methodology will include details of the Supplier's approach to data collection, sampling, survey administration and oversight, and data analysis. The Supplier will work with DMAS and the MCOs to gather complete provider data for use in the survey.

The Supplier will supply DMAS with a list of sampled providers prior to initiating each survey.

**Deliverable:** Following data collection for the survey, the Supplier will supply DMAS with one aggregate report and MCO-specific analytic datasets. These deliverables will be based upon DMAS-approved templates. The final report is due by December 15 of each year. All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

The Supplier will develop up to two presentations for the survey and will present to DMAS and/or the MCOs via WebEx (e.g., one presentation to introduce the survey and one presentation to summarize the survey results). The final presentations are due by December 15th of each year.

## Task Q: Encounter Data Validation (EDV)

**Task:** The task will be performed with the intent of enabling DMAS to recognize the validity of encounter data from the MCOs; identify opportunities for improvement; and establish a quantified baseline encounter validation.

**Purpose:** The Encounter Data Validation Task will assess the validity of each contracted MCOs’ encounter data.

## Task Q.1: CCC Plus Encounter Data Validation (EDV)

**Methodology:** The Supplier is expected to use the most recently published version of the CMS encounter data validation protocol. The current CMS protocol includes the following activities:

* + 1. Review State requirements for collecting and submitting encounter data;
    2. Review the MCO’s capacity to produce accurate and complete encounter data;
    3. Analyze MCO electronic encounter data for accuracy and completeness;
    4. Review of medical records for confirmation of findings of analysis of encounter data; and
    5. Submission of findings.

The Supplier shall conduct a targeted encounter data information systems survey to assess DMAS’ and MCOs’ information systems and processes as well as assess the DMAS encounter data completeness, accuracy, and timeliness through an administrative profile.

**Correspondence:** The Supplier is responsible for communicating progress made to DMAS. The Supplier must engage DMAS in the preliminary review findings and the drafts of the report.

**Analysis and Reporting:** Analysis and reporting shall be separate for each MCO and the Supplier shall also produce one summary report for the managed care delivery system.

Correspondence: The Supplier shall engage DMAS in on-going communication regarding methodology and enrollment data needs.

**Deliverables**: This task will be conducted every other year with the first set of final reports due to DMAS no later than October 31, 2023 (for 2022 encounter data) and the second encounter data validation final report due to DMAS no later than October 31, 2025 (for 2024 encounter data). All final reports, unless otherwise specified by the Department, shall be submitted in 508 compliant format.

## Task Q.2: Medallion 4.0 Encounter Data Validation (EDV)

**Special Instructions:** Replicate Task S.1 of RFP 2021-02. The Encounter Data Validation shall be conducted and reported separately from the Medallion 4.0 and FAMIS Managed Care, and the Commonwealth Coordinated Care Plus (CCC Plus) populations.

## *Optional EQR Task Enhancements*

The Department values innovation and is looking to the future for potential opportunities to improve the quality of Medicaid member services and experiences. To this effect, the Department is outlining a select number of optional enhancements that the Department may or may not elect to include in the services rendered by the Supplier for this RFP. The Supplier shall prepare and submit a response for each optional enhancement listed below. The Supplier will not be evaluated based on the responses provided for services in this section for the overall evaluation of the RFP.

**A. Proposed Virginia Managed Care Program Merge**

There is currently a provision in the proposed Virginia 2021 Appropriations Act for the Department to advance plans to merge the two managed care programs (Medallion 4.0 and CCC Plus) into a single, unified program by July 1, 2022. If the Governor signs the 2021 Appropriations Act with this provision, the Department will need to work with the EQRO Supplier to make revisions to the tasks outlined in Section 5 to accommodate Department needs and to meet federal reporting guidelines, and in accordance with the state regulation. Most tasks within the first year of the proposed EQRO contract will not be immediately impacted by a merger and will be addressed by contract modification of this contract by the Department; however, some tasks have been identified to be a potential impact. The Supplier shall respond to the following projected impacts to the EQRO contract:

* + 1. **Performance Improvement Projects:** the Performance Improvement Project (PIP) (Task E in Section 5 of this RFP) will be immediately impacted, with adjustments needed to the methodology and execution of the task, including measure selection and intervention design. The Supplier shall propose how they will address this proposed system-wide program change of the merging of the two managed care programs and outline potential impacts to the mandatory Performance Improvement Project (PIP) tasks to ensure that DMAS maintains federal reporting requirements and deadlines, as well as ensure a high level of communication and coordination between the EQRO, the Department, and the MCOs to implement any necessary adjustments to the program. The Supplier shall include projected timeline of response, implementation and revisions to a projected work plan for Task E.
    2. **Managed Care Readiness Review:** If required by the Department, the Supplier will provide a proposed plan to address a readiness review of each of the MCOs as part of the managed care program merger to align with federal and state requirements and in accordance with current CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations* and in coordination with Department needs. Utilizing that protocol, the Supplier shall review each MCO and assess each MCO’s ability to meet the readiness review requirements and report on their findings. The primary objective will be for the Supplier to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions as of the date of the managed care program merge in accordance with standards and protocols determined by the Department and the EQRO. The scope of the review will be defined by the Department in collaboration with the Supplier, and may include up to all or some subset of the specifications outlined in Task L: Operational Systems Review. The proposed plan shall include items such as desk review tools, preliminary and kick-off readiness review webinars, readiness review teams, proposed timeline proposals, communication structure between Supplier, MCOs, and DMAS, as well as a scoring methodology. Final reports on each MCOs will include, as necessary, corrective action plans (CAP) templates for MCOs, and shall include evaluation of CAPs by the Supplier and the Department.

**B. Focused Studies**

The Supplier shall respond to the Department with a proposed plan to address the development of additional focused studies, in accordance with CMS EQR Protocols and regulations, as well as provisions of the Focused Studies from this RFP. The developed reports that shall be used to evaluate quality, access, and/or value of care, and these studies will help the Department further develop appropriate policies and programs. The Supplier shall collaborate with the Department throughout the report development process, including proposed measures for each study and potential population comparison groups. The Supplier shall respond to each of the following areas with separate cost proposals for each proposed focused study areas.

1. Justice Involved Members

2. Nursing Facility Residents

3. Maternal and Child Health Focused Study: additional sub-focus on immigrant member population

**C. Measure Development**

The Supplier shall respond to the Department with a proposed plan to address the following areas of measure development, including the use of subject matter experts to research proposed areas, identification of data sources needed for proposed measures, measure maintenance once the measures are developed, and ability for the Supplier to calculate, monitor, and trend developed measures. The developed measures shall be used to evaluate quality, access, and/or value of care. The Supplier shall collaborate with the Department throughout the measure development process. The Supplier shall respond to each of the following areas with separate cost proposals for each measure development area.

1. Justice Involved Members

2. Social Determinants of Health

3. Health Equity

**D. Additional Population for Mandatory EQR Activities**

The Supplier shall respond to the Department with a proposed plan to include additional population of focus for mandatory EQR activities, including performance measure validation, performance improvement projects, and compliance reviews. The Supplier shall collaborate with the Department throughout the process on these additional population focused EQR activities and ensure alignment with any applicable state and/or federal regulation. The Supplier shall respond to each of the following areas with separate cost proposals for each measure development area.

1. Dual Eligible Special Needs Plan (D-SNP) Members

**E. Evaluations of New and/or Expanded Services**

The Supplier shall respond to the Department with a proposed plan to perform evaluations of proposed new and/or expanded services for Medicaid members. The Supplier shall collaborate with the Department throughout the evaluation development process, including utilizing subject matter experts to research proposed areas and ensure alignment with any applicable state and/or federal regulations for evaluation. The Supplier shall respond to each of the following areas with separate cost proposals for each proposed service area.

* + - 1. Behavioral Health Enhancement Services
      2. Telehealth Services
      3. Adult Dental Services

**F. CAHPS Survey Data Analysis**

The Supplier shall respond to the Department with a proposed plan to perform data intake and analysis of MCO CAHPS data for both Medallion 4.0 and CCC Plus, including review of analytic data sets from the MCOs and data calculation and evaluation of the data sets for the Department to align with CMS Core Set Reporting Requirements.

**G. National Core Indicators – Aging and Disabilities Survey**

The Supplier shall respond to the Department with a proposed plan to administer, collect, analyze, and report results to the Department on the National Core Indicators- Aging and Disabilities Survey for the applicable population in the CCC Plus managed care program. The Supplier shall collaborate with the Department throughout the process, including ensuring alignment with any applicable state and/or federal regulations, that the survey administration meets the most current specifications and expectations outlined by the data steward, Human Services Research Institute (HSRI), that the sampling strategy approach meets the needs of the Department, and that the reported results meet CMS Core Set reporting requirements.

## 

## R. Systems Overview

The Supplier will need to provide and meet all requirements regarding systems as outlined in the RFP & RTM. The word “systems” will refer to any or all electronic technology used at, in support of, or related to services provided for this RFP. The Supplier will need to comply, and ensure its subcontractors, comply with COV Information Security Standards, which include the following standards ans are specified here: https://www.vita.virginia.gov/policy--governance/itrm-policies-standards/:

* COV SEC 501-11.2 (or the latest) IT Information Security Standard, ITRM Standard
* COV SEC 502-03 (or then latest) IT Security Audit Standard, ITRM Standard
* COV SEC 514-05 (or then latest) Removal of Commonwealth Data from Electronic Media Standard, ITRM Standard
* COV SEC 520-01 (or then latest) IT Risk Management Standard, ITRM Risk Management Standard
* COV SEC 525-04.1(or then latest) Hosted Environment Information Security Standard ITRM Standard

The Department is a Covered Entity as defined by the Health Insurance Portability and Accountability Act of 1996, and as such the Department and its contractors must comply with the Omnibus Privacy and Security Rule at 45 CFR Parts 160 and 164 (2013), as amended.

The Department has incorporated in its security policy, best practices contained in the Centers for Medicare and Medicaid Services Minimum Acceptable Risk Standards for Exchanges (MARS-E v. 2.0). The Supplier shall comply with the Department’s policies. The Department is currently in a state of transition from a monolithic highly-customized legacy Virginia Medicaid Management Information System (VaMMIS or MMIS) to a new environment comprised of modular, interoperable, and configurable Commercial-off-the-Shelf (COTS) & Software-as-a-Solution (SaaS) offerings by multiple vendors, collectively referred to as the Medicaid Enterprise System (MES). As business needs require, the Supplier will be required to interface with one or more of the MES Modules and/or integrate into the MES environment through the Integrated Services Solution (ISS or Integrator) using established standards for data and file exchanges. The Supplier may also be required to connect through a Single-Sign On (SSO). More information about MES, interoperability requirements, Service-Oriented Architecture (SOA), and established file formats, (“MES Information”) will be communicated by the Department to the Supplier as it becomes applicable and available. The Supplier will be expected to obtain any necessary information to complete its functions from MES to complete its duties under the contract that results from this RFP. Supplier’s submitting a proposal should indicate any necessary connections, interfaces, exchanges, file formats, or other related limitations of the Supplier’s proposed system for consideration by the Department, as well as highlight ability to meet all the systems, data exchange, privacy/confidentiality, and Commonwealth requirements outlined in the Requirements Traceability Matrix. To the extent possible vendor will be required to leverage the managed file transfer solution (MFTS) developed by ISS Integration services solution) vendor using the MOVEit product by Progress (formerly ipswitch).The ISS MOVEit solution contains separate folders setup to receive incoming files from publishers and to send files out to subscribers. ISS has developed automated scripts to route the files between the Inbound and Outbound ISS folders. The Supplier shall, in its proposal, also indicate if it will request a direct user connection into DMAS SharePoint. If the Department grants the request, then the Supplier would be required to set up a Commonwealth of Virginia (COV) account with VITA. Once COV account has been set up, the Supplier will use those credentials to access MES via Single-Sign On. The Department encourages Supplier’s to make best use of the standardized and readily available exchanges and to utilize the Integrator’s existing API canonical models for general data, such as member data, provider data, claims data, etc.

The Supplier will need to provide and meet all requirements related to establishing a secure connection with DMAS including:

* + Setup of applicable Firewall and VPNs as required by the Agency.
  + Setup of SFTP (Secure FTP) connection between DMAS and Supplier for the purpose of transmission of data files.
* Document management system (e.g. SharePoint site) for the purpose of transfer of reports and other deliverables supported by SSO enabled Document management system (if hosted by Supplier)
* The Supplier shall support data volume transmission of at least 500GB per year in about 500 files in batches. The Supplier should be able to work with DMAS to identify and resolve errors in transmissions if any within the defined SLA.
* The Supplier shall support ingestion of data interfaces in the format (standard and customized layout) and the mode (Batch, Realtime, Near-Realtime) as specified by the Agency.
* The Supplier shall create relevant Project Management Plans including Project Transition Plans, Communications Plan, Scope Management Plan (RTM) and other plans as mutually agreed upon by the Agency and the Supplier.
* The Supplier shall create and provide the following additional reports.
  + Weekly DMAS Operations Meeting with reporting of updates and current CY7 Work Plan status
  + Monthly progress report
  + Monthly dashboard report
  + Annual VA EQR technical report
* The Supplier is expected to review current processes and offer innovative process improvement to the existing process that will lead to greater efficiency and better outcomes for DMAS including
  + More frequent data uploads aimed towards receiving and identifying data issues earlier.
  + Automated transfer of files

# SUPPLIER PROFILE

## Supplier Proposal Compliance

Before submitting your proposal, you should verify that: (i) your proposal is accurate and complete; (ii) your proposal is prepared in accordance with the solicitation requirements, including providing all information, content, responses and appendices requested and, (iii) all required communication, format and submission instructions are followed.

## Supplier Corporate Overview

### Business (Not to Exceed 3 Pages)

State the firm’s core business, background, and experience in the relevant market.

If you are proposing the use of a subcontractor(s) to perform the services or Solution sought under this Contract, provide the same information for each company.

### Corporate Identity (Not to Exceed 3 Pages)

Please provide the identity of any parent entity, including address, phone and fax numbers, FEIN or tax ID No., company web site and contact email. Provide the identity of any of your subsidiaries, as applicable.

If you are proposing the use of a subcontractor(s) to perform the services or Solution sought under this Contract, provide the same information for each company.

### Organization and Structure

Please provide an overview of your firm’s organizational operating structure and describe the operational and functional relationships of the business units within your organization, as they relate to your proposal and DMAS’ stated needs and requirements. Organizational charts are helpful supplements to the descriptions.

Indicate whether Supplier is proposing the use of a subcontractor(s) to carry out the scope of work requested in this RFP. If proposing the use of a subcontractor, describe the process for onboarding and integrating into the team that will be carrying out the scope of work requested in this RFP. If Supplier expects to utilize a partnership or subcontracting relationship, any such partner or subcontractor shall comply with the requirements of Section 2.F above.

### Locations

Please describe the geographical locations of your firm at the national, regional, and local levels, as applicable. Identify all locations that will be used to support any contract resulting from this RFP and the operations handled from these locations. Clearly identify any overseas locations that may be used to support the resultant contract or any related data transactions.

**(NOTE: All DMAS data and system information, components and services associated with the Suppliers proposed solution shall remain within the continental United States, Per SEC525, PE 18-COV).**

### Strategic Relationships

Please identify any and all strategic relationships with other related Suppliers you have or anticipate having. State all subcontractors expected to be employed and outsourced Service/Solution to be used in implementing the proposed solution. DMAS reserves the right to request that Supplier provide all the information described in this section for any and all major subcontractors proposed by Supplier.

### ISO 900X Certification

Please indicate if your firm is ISO certified. Yes or no is sufficient. If “yes”, identify the area(s) certified (e.g., services, manufacturing).

## Financial Information

### Total Annual Revenue

Please state your total annual revenue and indicate the revenues associated with the provision of Service /Solution relevant to your proposal.

### Dun and Bradstreet Credit Report

Include your firm’s current full D&B Business Report, and the two (2) previous reports, if D&B issues reports on Supplier.

### Annual Reports

Please provide certified, audited financial statements (i.e., income statements, balance sheets, cash flow statements) for the most recent three (3) years. (Any Supplier that has been in business for a shorter period of time is requested to submit any available certified, audited annual financial statements.) DMAS may request copies of or access to current and historic annual reports. DMAS reserves the right to access a Supplier’s publicly available financial information and to consider such information in its evaluation of such Supplier’s proposal.

## Future, Long Term Vision and Strategic Plans

Provide information on your firm’s future, long-term vision, and strategic plans as they relate to the direction of the proposed solution and describe a clear vision of how your firm plans to support emerging technologies and industry standards.

The Supplier should also include the follow items: i) Lessons learned from other similar projects, ii) Any project or performance risks that should be addressed and/or mitigated to include in the contract, iii) Assumptions to avoid unknown project delays or disruptions, iv) Critical factors to discuss during each phase of the project milestones, v) Technical, functional or operational expectations/responsibilities Supplier would assign to DMAS for project success, vi) risk mitigation concepts for both Supplier and DMAS for the type of procurement being pursued.

## Supplier Experience Level and Customer References

The Supplier should have a demonstrable, proven record of providing Services similar to those defined in Section 5 to customers of similar scope and complexity. Supplier shall provide three (3) customer references, preferably within the past five (5) years, with contact names, email addresses, phone numbers, Solution descriptions, and dates implemented that DMAS may use as a reference check in evaluating your proposal. DMAS will make such reasonable investigations as deemed proper and necessary to determine the ability of a Supplier to perform a resultant contract. These may include, but may not be limited to, reference checks and interviews. The references should be from organizations where Supplier is providing (or has provided) Service/Solution that are similar in type and scope to those identified in Section 5. **DMAS shall not be listed as a reference by the Supplier.**

On the following page, DMAS provides a table to utilize for each customer reference (**table to be repeated three (3) times, one (1) per reference**). The Supplier may adjust the table for purposes of formatting (e.g., Project Description row may break across multiple pages), but the actual content shall not be changed.

The Supplier is strongly encouraged to provide more than one point of contact for each reference. However, if necessary, the same contact information may be used.

**Customer Reference Information Table**

| Requested Information | Supplier Response |
| --- | --- |
| **Customer Name** | **(e.g., Company, State Department, etc.)** |
| **Project Name:** |  |
| **Point of Contact and Contact Information:** | [Name]  [E-mail]  [Phone] |
| **Project Manager and Contact Information:** | [Name]  [E-mail]  [Phone] |
| **Project Dates:** | MM/YYYY – MM/YYYY |
| **Project Description:** |  |
| **Case Study Results:** | [Provide a synopsis or case study of project results related to increased quality, increased operating efficiency, etc. This is requested to demonstrate the added value the Supplier offered and to indicate the typical on-going cost reductions and Solution efficiencies DMAS could similarly expect to realize.] |
|  |  |
| **What problems were encountered?**  **What resolutions resulted?**  **Were there any lessons learned?** |  |

\*Supplier shall use one table per reference.

## Performance Standards Methodology

Please describe the methodology used to develop your firm’s internal performance standards, the processes and tools used to monitor and measure performance against those standards, and the management reporting systems that capture these data.

Indicate your firm’s present customer satisfaction rating, summarize customer satisfaction criteria, and describe the methodology used to measure customer satisfaction. Please include any relevant publication ratings or articles.

## Governance and Compliance Management

Please describe your firm’s management processes that ensure governance and compliance with all federally mandated laws and regulations used by your industry, and in provision of your services to your customers. Also, please provide a detailed description on how you will provide governance and compliance with any of DMAS’ required security and data privacy requirements, or any other requirements specified in this RFP, that are not currently managed by your firm, but that you will be willing to do should an award be made to your firm.

## Security Risk Management Overview

Please provide an overview of your firm’s comprehensive security risk management processes including your application, monitoring, and management of the controls used. Provide details as to how you establish the context for security risk-based decisions, how you assess the risk, how you respond to the risk once it’s determined, and how you monitor the risk on an ongoing basis using communications and feedback for continuous improvement within your organization.

## Disaster Recovery/Security Plan

Describe in detail your firm’s plans to mitigate against any disaster that would affect the ability to provide DMAS with the proposed Service/Solution. Provide a detailed plan of your firm’s security infrastructure including, facility and information technology security. Provide your firm’s plans of action for the following security incidents, as applicable to the RFP:

* Interruption of service including denial of service attacks
* Vulnerability incidents
* Data loss or compromise
* Insider attacks

## Service and Support Management

### Post Implementation and Account Management Plan

1. Provide a detailed description of the approach that your firm would recommend in order to achieve maximum service levels within a minimal amount of time following service implementation.

### Account Management Plan

1. Provide a detailed description of the approach that your firm would take in order to manage the business and performance aspects of a rewarded contract. Provide a detailed description of the approach your firm would take to support self-sufficiency of DMAS with respect to the solution and the transition of solution management to DMAS.

2. By submitting a proposal, you agree that you shall, if awarded a contract pursuant to this RFP, consent to participation in the meeting(s) of the Steering Committee described in the Steering Committee section of the Contract template found in Exhibit J to this RFP. Please identify the titles and areas of responsibility of persons within your firm you would commit to serve on this Steering Committee.

### Project Team

1. Provide the resumes of all key members of the project team, including, if applicable, the Account Manager, Contract Administrator, Project Managers, and Regional Vice President(s) responsible for DMAS’ account. If an onsite or dedicated presence is part of your proposed solution, please forward the resumes of the top three candidates potentially available to lead your onsite efforts.

2. Describe the level of access the proposed project team members have within your organization and the authority they have to commit resources to meet unexpected surges in activity and/or to respond to service issues.

3. Describe your firm’s vetting practices, including background checks, fingerprinting and citizenship verification, for employees and subcontractors who have access to your firm’s security infrastructure and cloud hosting operations (if your proposal offering includes hosting by your firm or a third party) and any federal vetting requirements that your firm currently complies with/has complied with. Also, describe how your firm would comply with a customer’s particular security vetting requirements.

4. Provide the time frame for the availability of project team members and the percentage of time these individuals are expected to be assigned to the DMAS account. DMAS may require a Supplier to involve DMAS in the selection and rotation of any key account team members assigned to DMAS.

# SUPPLIER PROCUREMENT AND SUBCONTRACTING PLAN

It is the policy of the Commonwealth to contribute to the establishment, preservation, and strengthening of small businesses and micro businesses, including those small or micro businesses owned by women, minorities, or service-disabled veterans; and to encourage their participation in Commonwealth procurement activities. Further, DMAS is committed to enable a minimum of three percent (3%) participation by small businesses owned service disabled veteran businesses, as defined in Code §§ 2.2-2001 and 2.2-4310, when contracting for information technology goods and services.The Commonwealth encourages all Suppliers to provide for the participation of these small businesses through partnerships, joint ventures, subcontracts, and other contractual opportunities.

Any business that is a small business, a small woman-owned business, a small minority-owned business, or a small service disabled veteran-owned business, as defined in Code § 2.2-4310 or § 2.2-1604, or a certified micro business as defined in Executive Order Number 20 (2014), is a “**SWaM**” business. If your firm is a SWaM business, you should include a copy of all Virginia SWaM certifications with its proposal. No Supplier will be considered a SWaM business unless certified by the DSBSD. For information, go to: [http://www.sbsd.virginia.gov/.](http://www.sbsd.virginia.gov/)

Please provide a Supplier Procurement and Subcontracting Plan as set forth in Appendix B. In the submitted Supplier Procurement and Subcontracting Plan, please state the amount of the overall commitment percentage that will be directly spent with SWaM subcontractors in performing the Requirements of the contract. Please also include in your plan a list of all subcontractors you plan to utilize who are Non-SWaM businesses. If Supplier does not plan to use small business subcontractors in executing a contract resulting from this RFP, so state.

Describe in detail information on all mentor-protégé programs and participation with which your firm is involved.

# PRICING INFORMATION

DMAS requests that each Supplier provide detailed pricing for each of the pricing methods set forth. Pricing must be comprehensive. Additional information and backup detail should be attached as appropriate. Any scheduled price change must be identified, and actual new prices and proposed effective dates must be stated.

Submit all pricing data in the Excel Pricing Submittal spreadsheet provided in RFP Appendix C - Pricing. Altered formats or blank data will be considered incomplete and may be eliminated from further consideration.

Your pricing proposal must include all charges of any kind associated with the Service/Solution.. DMAS will not be liable for any fees or charges for the Service/Solution that are not set forth in the Excel Pricing Submittal. Any attempt to add these fees to submitted pricing will not be considered.

You should be willing and able to successfully provide the Service/Solution proposed for the prices given and to complete the project on a firm fixed-price or time-and-materials basis.

The pricing information supplied with your proposal will remain valid until a contract award has been made. If you wish to reserve the option to withdraw the pricing during that period, you must state so clearly in your proposal.

All one-time and recurring costs and any underlying assumptions on your proposal must be clearly, conspicuously and fully disclosed. If you are proposing more than one Service/Solution type, you may also submit a bundled cost in addition to the separate individual Service/Solution costs.

The “Supplier’s Option” category is provided to allow Suppliers to submit additional pricing data/models if they desire.

You must disclose pricing assumptions where possible. For example, if unit price is based on a certain volume, that assumption should be indicated. You must clearly identify any discount targets/ranges available.

# DMAS STANDARD AGREEMENT

Any resulting agreement will be defined by a written contract, which shall be binding only when fully executed by both parties. A copy of DMAS’s standard Service contract is provided as part of this RFP as a separate MS Word document titled, "Appendix J Contract ".

In the event that Supplier is a software reseller, DMAS will consider the software publisher’s license agreement language if the software publisher requires an End User License Agreement (“**EULA**”). In such case, Suppliers are advised that DMAS will require Supplier to obtain software’s seller’s agreement to DMAS’s License Agreement Addendum to the EULA to address terms and conditions in that EULA that DMAS, as a government entity, by law or by policy, cannot agree.

If a Supplier’s proposed Service/Solution requires DMAS to execute an EULA, Supplier shall contact the SPOC, who will provide Supplier with DMAS's “License Agreement Addendum” terms.

You must complete and submit a copy of the “DMAS Service/Solution Contract” with all changes indicated in redline format for DMAS’s review and evaluation along with your proposal, as well as a completed table in the format provided in Appendix E, “RFP Section 9.0 - Supplier Exceptions to DMAS Contract Template” setting forth your rationale and reasons for each of the proposed modifications. Only exceptions or recommended language revisions submitted with your proposal will be considered during negotiations. Please note, exceptions or recommended language revisions to the liability provisions of the contract will not be considered at this time. If your firm is selected to go forward into negotiations, you will be required to state any exceptions to any liability provisions contained in the Request for Proposal and the DMAS Contract Template at that time via email to the designated DMAS SPOC.

All Suppliers are encouraged to utilize the SPOC to address any questions you may have regarding any part of the DMAS Contract.

Include the completed table below in your response to this RFP.

|  |  |
| --- | --- |
| **Issue:** | **Supplier's response (Y & N)** |
| Do you agree that the contents of your response to Sections 5, including the RTM, 7 and 8 will become part of any contract that may be entered into as a result of this RFP? |  |
| Will you agree to begin measuring the service level (Appendix A) within 60 days of the start of the implementation of the Service/Solution? |  |
| The contract will include performance standards, measurement criteria and significant corresponding financial remedies.  Do you agree to include the Service Levels and remedies for non-compliance, as defined in Appendix A, as an Exhibit in the final contract? |  |
| Do you agree that all provisions of the DMAS Contract NOT addressed by you in the Appendix E table are acceptable? |  |
| Do you acknowledge that you will submit a Supplier Procurement and Subcontracting Plan stating whether or not and how you will be utilizing small businesses in your proposal? See Section 7. |  |
| Supplier acknowledges that no federal funds may be used to obtain any Service/Solution under a contract awarded, pursuant to this RFP, to any Supplier who appears on any excluded lists on the federal government’s System for Award Management (“**SAM**”) at <https://www.vita.virginia.gov/supply-chain/scm-policies-forms/#sam>. |  |
| Do you affirm that your response meets all of the Mandatory requirements listed in section 2.P? |  |
| Do you affirm that your organization is properly registered with the Virginia State Corporation Commission to conduct business in the Commonwealth? Supplier is to complete Appendix D and submit with its proposal. |  |
| Do you affirm that any anticipated partner or subcontractor that will provide Services/Solutions directly to the Commonwealth is properly registered with the Virginia State Corporation Commission to conduct business in the Commonwealth? Supplier is to complete and additional Appendix D for all anticipated partners or subcontractors and submit with its proposal. |  |
| Do you affirm that your organization and all affiliates are current with all sales tax obligations to the Commonwealth as of the due date of the proposals in response to this RFP? |  |
| Do you agree to accept the VITA “**Mandatory Contract Terms**” consisting of the:   * “Core Contractual Terms”; * “Required eVA Terms and Conditions”; and * “Mandatory Internal Revenue Service (IRS) Publication 1075 (required for FTI data only)”?   The provisions of each are set forth at the following URL:  <https://www.vita.virginia.gov/supply-chain/scm-policies-forms/mandatory-contract-terms/> |  |

# Appendix A – Service Level Agreements Chart (SLAs)

Effective with the Period of Performance of the contract.

Final Service Level Agreements (SLAs) will be included in the SLA Exhibit of the Final Contract that results from this RFP. Please note that Suppliers should include proposed Response times, Resolution Times, and Internal Escalation Procedures with the initial proposal response. Additional SLAs should be proposed for Cloud Services, which correspond to service levels guaranteed by the proposed cloud service provider, if applicable.

The Service Level Agreements (SLAs) Chart begins on the following page.

# Appendix A – Service Level Agreements (SLAs)

The Supplier must provide the Department with a Service Level Agreement (SLA) status summary for each SLA below. The SLA status summary will be developed in tandem by the Department and the Supplier to be due monthly during the term of the Contract. The SLA Status Summary will be subject to validation and verification by the Department.

|  |  |  |  |
| --- | --- | --- | --- |
| **RTM Location ID** | **Performance Standard** | **Measurement**  **Duration: Contract Term** | **Liquidated Damage** |
| CST-11 | Fully compliant with all state and federal laws, regulations, and policies governing the EQR activities contracted by DMAS. | Supplier shall be fully compliant with all state and federal laws, regulations, and policies governing the EQR activities contracted by DMAS, including utilizing the most current and appropriate CMS protocols for EQR activities. | $250 a calendar day will be imposed for each requirement out of compliance in the Requirements Task A Section in the RTM until the Supplier is fully compliant. The Supplier may also be liable for all incurred costs to the Department for the violation of applicable state and federal laws, regulations, and policies governing the EQR activities. |
| CST-07 | Comply with notification of subcontractor termination. | Supplier shall comply with the Notification of Subcontractor Terminations as outlined in the Section A-B RTM section. When a subcontract that relates to performance of EQR tasks is being terminated between the Supplier and a subcontractor, the Supplier agrees to give at least thirty (30) calendar days prior written notice of the termination to the Department. Such notice will include, at a minimum, a Supplier’s intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. | $500 per calendar day for failure to notify the Department timely (with at least thirty (30) calendar days prior written notice) of subcontractor terminations until the Supplier is fully compliant. |
| CST-07 | Comply with notification with subcontractor noncompliance. | Supplier shall comply with the Notification of Subcontractor Terminations as outlined in Section A of Contracts & Start Up within RTM. When a subcontract that relates to performance of EQR tasks results in noncompliance between the Supplier and a subcontractor, the Supplier agrees to give notice within ten (10) calendar days to the Department. Such notice will include, at a minimum, a Supplier’s intent to address any issues of noncompliance with the subcontractor for the provision of said services, an effective dates for action plans and/or changes to address issue, as well as any other pertinent information that may be needed. | $500 per calendar day for failure to notify the Department timely (within ten (10) calendar days) of subcontractor noncompliance until the Supplier is fully compliant. |
| CST-06 | Correction of final deliverables due to incorrect, missing, or inaccurate information that results in the need to resubmit previously complete deliverables. | As outlined in the Task A-Contracts & Start Up Section within RTM, the Supplier shall correct final deliverables due to incorrect, missing, or inaccurate information that results in the need to resubmit previously complete deliverables as requested by the Department within thirty (30) days of the Department’s request. Starting the thirty-first day the Supplier will be subject to penalty outlined in this service level agreement. | $5,000 per calendar day for each instance of final deliverable correction, with the beginning the 31st day until DMAS has determined the non- compliance has been resolved. |
| CST-10 | Supplier shall comply with all staffing requirements. | As outlined in the Task A-Contract and Start Up of RTM, the Supplier shall comply with all staffing requirements as described in the Contract & Start Up Section of Contract and RTM. | $250 for each key staff member per calendar day that they are not employed staffed as required in the Contract & Start Up Section of Contract and RTM. Employed with a maximum monthly liquidated damaged assessed of $5,000 for this SLA. |
| CST-10 | Supplier shall notify the DMAS of Key Staffing Changes | As outline in Task A-Contract and Start Up RTM section, the Supplier shall notify DMAS of Key Staffing Changes within 72 hours. | $250 for each staff member per calendar day after 72 hours, when the Supplier fails to notify DMAS. |
| CST-12 | Supplier will comply with all RTM Requirements | As outlined in the Task A-Contract and Start Up Section RTM, the Supplier will comply with all RTM requirements, if not Supplier shall submit to the Department, within five (5) business days, a plan addressing corrective action to include a timeline for correction. The plan must detail the activities and associated timeline to address deficiencies. | $250 per calendar day for each day the corrective action plan is not submitted as required. |
| CST-14 | Comply with Corrective Action Plan | As outlined in the Task A-Contract and Start Up RTM section, the Supplier shall comply with Corrective Action Plan and timeline for completion or incur penalties. | $500 per calendar day for each day the corrective action is not completed or complied with on the timeline and in the manner as outlined in the Corrective Action Plan. |
| CST-13 | Timely Submission of Reports and Deliverables | As outlined in the Task A-Contract & Start Up RTM Section, the Supplier shall submit reports and deliverables timely, correctly, and completely. For each day that an agreed upon report or deliverable is late, incorrect or deficient the supplier shall be liable to the Department for damages. | $200 per calendar day per report or deliverable, except if the delivery is delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the supplier or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the supplier or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the supplier, the Department may extend the time for performance of the contract or delivery of Deliverables herein specified, at the Department’s sole discretion, for good cause shown.    Liquidated damages for late, incorrect reports (except ad hoc or on-request reports), or deficient deliverables shall begin on the first day the report is out of compliance. For the purposes of determining liquidated damages in accordance with this SLA, reports or deliverables are due in accordance with the time period outlined in Section 5 or applicable contract section. (e.g., weekly, monthly, quarterly, etc.) |
| EQRO-PROJ-REQ-004 | Annual Efficiency and Process Improvement Review | The Supplier, on an annual basis or otherwise mutually agreed upon, agrees to review current processes and provide recommendation(s) that consist of innovative process improvement which focus on the following:   * Greater efficiency and better outcomes for DMAS * More frequent data uploads aimed towards receiving and identifying data issues earlier. * Automated transfer of files   If the Supplier fails to communicate the results of this review within thirty (30) calendars to DMAS from contract start date (starting in the second year of the contract or other mutually agreed upon deadline) the Supplier shall be liable to the Department for damages. | $200 per calendar day for failure to report, except if the delivery is delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the supplier or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the supplier or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the supplier, the Department may extend the time for performance of the contract or delivery of deliverables herein specified, at the Department’s sole discretion, for good cause shown. |
| EQRO-IS-001 | Secure Exchange of Data with MES Applications | The Supplier agrees to facilitate the secure exchange of data with other applications in the MES, if applicable, through asyncronous services using Queues through an Integration service.  If the Supplier fails to communicate any issue related to the secure exchange of data to DMAS within twenty-four (24 hours), including a timeline and corrective action plan, the Supplier shall be liable to the Department for damages. | $250 per calendar day for failure to report. |
| EQRO-NFR-DR-001 | Disaster Recovery Plan | The Supplier agrees to prepare and submit for Department approval a comprehensive Disaster Recovery Plan due to the Department on an annual basis and after a substantive change to the EQRO process or site that would require revision to the DR Plan. The DR Plan is expected to include all applicable provisions from the Disaster Recovery Tab of the RTM.  The Disaster Recovery Plan is due within thirty (30) calendar days of contract start up and annually thirty (30) days prior to the next contract fiscal year. If the Supplier fails to provide this DR plan as outlined, the Supplier shall be liable to the Department for damages. | $200 per calendar day of failure to report, except if the delivery is delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the supplier or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the supplier or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the supplier, the Department may extend the time for performance of the contract or delivery of deliverables herein specified, at the Department’s sole discretion, for good cause shown. |
| EQRO-NFR-DR-003 | Annual Demonstration of Disaster Recovery Plan | The Supplier agrees to coordinate with and demonstrate to the Department the Supplier's disaster recovery capabilities no less than annually. Supplier will include recovery of any new functionality implemented during the previous year.  If the Supplier fails to coordinate with and demonstrate to the Department the Supplier's disaster recovery capabilities no less than annually, the Supplier shall be liable to the Department for damages. | $200 per calendar day of failure to report, except if the delivery is delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the supplier or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the supplier or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the supplier, the Department may extend the time for performance of the contract or delivery of deliverables herein specified, at the Department’s sole discretion, for good cause shown. |
| EQRO-NFR-DR-002 | Back-Up Processing Capabilities | The Supplier agrees to provide back-up processing capability at a remote site from the primary site such that normal EQRO service processing can continue in the event of a disaster or major hardware problem at the primary site. All operations at the remote back-up site will meet established contractual performance requirements.  If the Supplier fails to utilize and provide back-up processing capability at a remote site from the primary site such that normal EQRO service processing can continue in the event of a disaster or major hardware problem at the primary site in accordance with the Department-approved disaster recovery plan, the Supplier shall be liable to the Department for damages. Communications are expected to include timelines and corrective action plans as appropriate. | $500 per calendar day for each day beyond deadline set as the earlier possible time in accordance with the Department-approved disaster recovery plan, or if corrective action is not completed or complied with as required. |
| EQRO-NFR-DR-004 | Resumption of Activity in the Event of Catastrophe or Disaster | The Supplier agrees to, in the event of a catastrophic (i.e. possibility of crimes, terrorism, hackers, intentional torts, human error, virus, etc.?) or natural disaster, resume normal operational business functions at the earliest possible time in accordance with the Department-approved disaster recovery plan.  If the Supplier fails to resume normal operational business functions at the earliest possible time in accordance with the Department-approved disaster recovery plan, the Supplier shall be liable to the Department for damages. Communications are expected to include timelines and corrective action plans as appropriate. | $500 per calendar day for each day beyond deadline set as the earlier possible time in accordance with the Department-approved disaster recovery plan, or if corrective action is not completed or complied with as required. |
| TBD | Progressive Strict Liquidated Damages | Any program issue outlined in this SLA Chart experienced in a consecutive three (3) month  time period is subject to progressively strict liquidated damages for instances of the same program issue. | Three  (3) times initial liquidated damage per program issue, incurred the first month following a consecutive three (3) month failure to meet the particular SLA. |

The Department may impose any or all of the liquidated damages above upon reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the RFP, provided, however, that the Department only imposes those damages it determines to be appropriate for the deficiencies identified. The Department may impose intermediate damages on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

Failure to meet the below described requirements may result in liquidated damages. In addition to liquidated damages, DMAS reserves the right to employ, at the Department’s sole discretion, any and all remedies available at law or equity.

**Payment of Liquidated Damages**

It is further agreed by the Department and the Contractor that any liquidated damages assessed by the Department shall be due and payable to the Department within thirty (30) calendar days after Contractor’s receipt of the notice of damages and if payment is not made by the due date, the amount of said liquidated damages may be withheld from future payments by the Department without further notice. It is agreed by the Department and the Contractor that the collection of liquidated damages by the Department shall be made without regard to any appeal rights the Contractor may have pursuant to this RFP; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Department will be immediately returned to the Contractor. The due dates mentioned above may be delayed if the Contractor can show good cause as to why a delay should be granted. The Department has sole discretion in determining whether good cause exists for delaying the due dates.

The Contractor shall be liable for all liquidated damages imposed by DMAS. Any dispute between the Contractor and any provider/subcontractor regarding responsibility for any events giving rise to the imposition of liquidated damages shall not relieve the Contractor of their liability for said damages.

All liquidated damages imposed pursuant to this RFP, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits.

# Appendix B - Supplier Procurement and Subcontracting Plan

**All small businesses must be certified by the Commonwealth of Virginia, Department of Small Business and Supplier Diversity (“DSBSD”) by the contract award date to participate in the SWAM program. Certification applications are available through DSBSD online at** <http://www.sbsd.virginia.gov/>**.**

**Supplier Name:**

**Preparer Name: Date:**

**Instructions**

**A**. If you are certified by the DSBSD as a small business or as a micro business, complete only Section A of this form. This shall include DSBSD-certified women, minority, or service-disabled veteran-owned businesses when they have received DSBSD small business certification.

**B.** If you are not a DSBSD-certified small business, complete Section B of this form.

**Section A**

If your firm is certified by the DSBSD, are you certified as a (**check all that apply**):

\_\_\_\_\_\_ Small Business

\_\_\_\_\_\_ Small and Women-owned Business

\_\_\_\_\_\_ Small and Minority-owned Business

\_\_\_\_\_\_ Small Service Disabled Veteran-owned Business

\_\_\_\_\_\_ Micro Business

\_\_\_\_\_\_ Micro Business and Women-owned Business

\_\_\_\_\_\_ Micro Business and Minority-owned Business

\_\_\_\_\_\_ Micro Service Disabled Veteran-owned Business

Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification Approval Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification Expiration Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B**

Populate the table below to show your firm's plans for utilization of DSBSD-certified SWaM businesses and Non-SWaM businesses directly performing the Requirements of this contract. This shall not exclude DSBSD-certified micro businesses or women, minority, or service disabled veteran-owned businesses when they have received the DSBSD small business certification. Include as well businesses that ARE NOT SWaM businesses that will be utilized in directly performing the Requirements of this contract. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Small Business Name & Address**  **DSBSD Certificate #**  **(Leave certificate number blank if Non-SWaM)** | **Status if Small Business is also: Women (W), Minority (M)**  **Service-Disabled Veteran (D),**  **Micro Business (O)**  **Non-SWaM (NS)** | **Contact Person, Telephone & Email** | **Type of Goods and/or Services** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **SWaM Overall Commitment Percentage**  **Please state here the overall commitment percentage for DSBSD-certified SWaM businesses directly performing the Requirements of this Contract:**  **Note: The percentage above ONLY APPLIES to DSBSD-certified SWaM businesses who are directly performing the Requirements of this Contract. Do not include in the percentage any businesses performing the Requirements of this Contract that are non-SWaM businesses.** | | |  |

# Appendix C – Pricing

This section provides the instructions for the Cost Proposal preparation. Use of the Microsoft Excel spreadsheet titled “Appendix C –Cost Proposal.xls” in the form and content provided with this RFP is **MANDATORY**. It is included as an attachment to this RFP.

# Appendix D – State Corporation Commission Form

**Virginia State Corporation Commission (“SCC”) registration information**. **The Supplier:**

 is a corporation or other business entity with the following SCC identification number: \_\_\_\_\_\_\_\_\_\_\_\_ **-OR-**

 is not a corporation, limited liability company, limited partnership, registered limited liability partnership, or business trust **-OR-**

 is an out-of-state business entity that does not regularly and continuously maintain as part of its ordinary and customary business any employees, agents, offices, facilities, or inventories in Virginia (not counting any employees or agents in Virginia who merely solicit orders that require acceptance outside Virginia before they become contracts, and not counting any incidental presence of the Supplier in Virginia that is needed in order to assemble, maintain, and repair goods in accordance with the contracts by which such goods were sold and shipped into Virginia from Supplier’s out-of-state location) **-OR-**

 is an out-of-state business entity that is including with this proposal an opinion of legal counsel that accurately and completely discloses the undersigned Supplier’s current contacts with Virginia and describes why those contacts do not constitute the transaction of business in Virginia within the meaning of § 13.1-757 or other similar provisions in Titles 13.1 or 50 of the Code of Virginia.

**\*\*NOTE\*\* >>** Check the following box if you have not completed any of the foregoing options but currently have pending before the SCC an application for authority to transact business in the Commonwealth of Virginia and wish to be considered for a waiver to allow you to submit the SCC identification number after the due date for proposals (the Commonwealth reserves the right to determine in its sole discretion whether to allow such waiver): 

# Appendix E – Supplier Exceptions to DMAS Contract Template

*Note to Supplier: You may add rows as needed or change the layout for this page to landscape.*

|  |  |  |
| --- | --- | --- |
| Page Number | Contract Section/Subsection | Exception Explanation |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Appendix F – Sample DMAS EQRO Contract Timeline

Dates within the Due Date column, reflect the dates which deliverables are due to DMAS. Items and due dates may be changed during the course of the contract to reflect DMAS programmatic priorities.

|  |  |
| --- | --- |
| **EQRO Task** | **Due Date** |
| **Sample Contract Task Deliverables** | |
| Task A: Contract Start-up and Transition: Approved Work Plan and Web Portal | Within 20 days of Contract Initiation |
| Task B: Operations Preparedness | Within 20 days of DMAS Approved AWP |
| Task C: Provide Education and Technical Assistance on Quality Improvement | Within 30 days of Contract Initiation |
| Task D: Annual Technical Reports | 03/15/2023 |
| Task E: Performance Improvement Plan (PIP) Reports | 01/15/2023 |
| Task F: Performance Measure Validation (PMV) Reports | 10/31/2022 |
| Task G: Consumer Decision Support Tools (CDST) | 12/15/2022 |
| Task H: Performance Withhold Program Report (PWP) | 10/15/2022 |
| Task I.1: Medicaid Maternal and Child Health Focused Study | 01/15/2023 |
| Task I.2 Child Welfare Focused Study and Presentation of Results | 12/31/2022 |
| Task K: Calculate Performance Measures | 11/30/2022 |
| Task L: Conduct MCO Operational System Review | 12/15 every 3 years |
| Task M: FAMIS CAHPS Survey Final Report | 12/31/2022 |
| Task N: Quality Strategy | 12/15/2022 |
| Task P: Dental Utilization in Pregnant Women Data Brief | 10/01/2022 |
| Task Q: Addiction & Recovery Treatment Services (ARTS) Measurement Specification and Reporting | 01/15/2023 |
| Task P.1 Appointment Standards Monitoring Prenatal Care Secret Shopper Survey Report | 12/15/2022 |
| Task P.2 Appointment Standards Monitoring- PCP Secret Shopper Survey Report | 12/15/2022 |
| Task Q: Encounter Data Validation | 10/31/2023 |

# Appendix G – EQRO RFP Glossary Terms

|  |  |
| --- | --- |
| **EQRO RFP Terms** | **Definition** |
| Abuse | Provider practices that are inconsistent with sound fiscal, business, or medical practices that result in unnecessary cost to the Medicaid or FAMIS program; or reimbursement for services that are not medically necessary; or fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid or FAMIS program. |
| Access | As defined in 42 CFR § 438.320, access as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services). |
| Accreditation | The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by an industry recognized accrediting agency, such as NCQA. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations. |
| Action also known as Adverse Action | Consistent with 42 C.F.R. § 438.400, action refers to the denial of a service authorization request or the denial of a member’s request to exercise his right under 42 C.F.R. § 438.52(b) (2)(ii) (described in Section 7.1 of this Contract) to obtain services outside of the network. |
| Actuarially Sound Capitation Rates | As defined in 42 CFR § 438.4(a), Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph 438.4(b) of this section. |
| Actuary | An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board; also refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates. |
| Acute Care | Preventive care, primary care, and other inpatient and outpatient medical and behavioral health care provided under the direction of a physician for a condition having a relatively short duration. |
| Addiction and Recovery Treatment Services | (ARTS) – A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This includes (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); (vi) substance abuse case management; (vii) opioid treatment services; and (viii) peer recovery support services. Providers will be credentialed and trained to deliver these services consistent with ASAM’s published criteria and the Department’s medical necessity criteria and using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT). |
| Administrative Dismissal | 1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or 2) A member appeal dismissal made on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the Contractor. |
| Adoption Assistance | A social services program, under Title XX of the Social Security Act, that provides the adoptive parents with the necessary assistance to adopt and care for the child who has special needs and who meets eligibility criteria. It is not intended to cover the full cost of raising the child. Rather, it supplements the resources of the adoptive parents. |
| Adverse Action | For providers that have already rendered a service, a denial in whole or in part, of a service authorization; or the denial, in whole or in part, of payment for a service. |
| Adverse Benefit Determination | For members, pursuant to 42 C.F. R. § 438.400, any of the following (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) the failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only one MCO, the denial of a member’s request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. |
| All Payers Claim Database | Established by the Virginia General Assembly to facilitate data- driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system as provided by Virginia Code § 32.1- 276.71 |
| Alternate Formats | Provision of enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternate Formats shall include, but not be limited to, braille, large font, audio tape, video tape, and information read aloud to an enrollee. |
| Ameliorate | To improve a condition or to prevent a condition from getting worse. |
| Annually | For the purposes of contract reporting requirements, annually shall be defined as 11:59PM on September 30th immediately following the effective Contract date and/or effective Contract renewal date, unless otherwise specified in the Contract or Managed Care Technical Manual. |
| Appeal | 1) For members, in accordance with 42 CFR § 438.400, is a request to DMAS for a State fair hearing of a Contractor’s internal appeal decision to uphold the Contractor’s adverse benefit determination. After a member exhausts the Contractor’s one-step internal appeal process, the member may appeal to DMAS. Member appeals to DMAS shall be conducted in accordance with regulations at 42 CFR§§ 431 Subpart E and 12 VAC 30- 110-10 through 12 VAC 30-110-370; or 2) For providers, is a request made by a provider (in-network or out-of-network) to review the Contractor’s reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the Contractor’s reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) with DMAS in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 et seq., and Virginia Medicaid’s provider appeal regulations, 12 VAC 30-20-500 et seq. |
| Assess | To evaluate an individual’s condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor’s observation of the individual. |
| Assessment | The Contractor’s appraisal and evaluation of its members to determine level of health and necessary interventions as may be appropriate. A successful assessment is considered a contact made by the health plan which assesses all health care needs, interventions received, and any additional services or referral needs. The health plan must submit the assessment procedures plan and a copy of the assessment tool annually to the Department. |
| Audit | A formal review of compliance with a particular set of internal (e.g., policies and procedures) or external (e.g., laws and regulations) standards used as base measures. |
| Balance Billing | When a provider bills a Medicaid enrollee for the difference between the provider’s charge and the allowed amount. |
| Balanced Budget Act | Refers to the Balanced Budget Act (BBA) of 1997; final rule issued June 14, 2002; effective August 13, 2002. The BBA is the comprehensive revision to Federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Part 438 et seq. |
| Behavioral Health and Substance Abuse Treatment Services (BHS) | An array of therapeutic and rehabilitation services provided in inpatient and outpatient psychiatric and community mental health settings to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance abuse disorder. Under this contract, the Department categorizes BHS as traditional and non-traditional services. Traditional Behavioral Health & Substance Abuse Treatment Services are defined as inpatient and outpatient behavioral health and substance abuse treatment services, including care coordination services that are covered by the Contractor under the terms of this contract. Non-Traditional Behavioral Health & Substance Abuse Treatment Services are defined as the subset of community mental health and rehabilitation services that are covered by the Department or its designee in accordance with the Department’s established criteria and guidelines. |
| Behavioral Health Service 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 that are currently carved out of managed care on a statewide basis for Title XIX Medicaid members and Title XXI FAMIS and FAMIS Plus members to include care coordination, provider management, and reimbursement of such behavioral health services. |
| Behavioral Therapy Services | Systematic interventions provided by licensed practitioners within the scope of practice, as defined under state law or regulations, and covered as remedial care under 42 CFR § 440.130(d) to individuals younger than 21 years of age in the individual’s home. Behavioral therapy includes, but is not limited to, applied behavior analysis (ABA). Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. |
| Benchmarking | A process through which standards and thresholds are developed through comparisons with others, standards, and best practices. In terms of quality benchmarking, the goal of a performance improvement system is to develop an assessment process that incorporates four basic comparisons with self, with others, with standards, and with best practices. |
| Budget Neutral | A standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted MCOs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program. |
| Business Associate | Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department’s capability for effective administration of the program. A Business Associate includes, but is not limited to, those applicable parties referenced in 45 CFR, §160.103. |
| Business Days | Means Monday through Friday, 830 AM to 500 PM, Eastern Standard Time, unless otherwise stated. |
| Capitation Payment | A payment the Department makes periodically to a Contractor on behalf of each member enrolled under a contract for the provision of medical services under the State Plan, regardless of whether the particular member receives services during the period covered by the fee. |
| Capitation Rate | The monthly amount, payable to the Contractor, per member, for all expenses incurred by the Contractor in the provision of contract services as defined herein. |
| Care Coordination | (also known as “Care Management) The Contractor’s responsibility of assessing and planning of services; linking the Member to services and supports; assisting the Member directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family individuals involved with the Member; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling. |
| Carved-Out Service(s) | The subset of Medicaid covered services for which the Contractor will not be responsible under this Contract. |
| Case Management | The process of identification of patient needs and the development and implementation of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner. |
| Centers for Medicare and Medicaid Services or CMS | The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act. |
| Childhood Obesity | In accordance with The Center for Health and Health Care in Schools, Childhood Obesity is defined as an age-specific Body Mass Index (BMI) that is greater than the ninety-fifth (95th) percentile. Children are considered at risk if their BMI-for-age is greater than the eighty-fifth (85th) percentile but less than the ninety-fifth (95th) percentile. |
| Children and Youth With Special Health Care Needs or “CYSHCN” | Children and youth with special needs that have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child’s age. These include, but are not limited to, the children in the eligibility categories of foster care and adoption assistance (aid category 076 and 072), youth who have aged out of the foster care system (Aid Category 70), children identified as Early Intervention (EI) participants, members identified as experiencing childhood obesity and others as identified through the Contractor’s assessment or by the Department. |
| Claim | An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-04 (or subsequent iterations of these forms). |
| Clean Claim | A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2) (B) and 1842(c) (2) (B) of the Social Security Act. |
| Client or Member or Participant | An individual having current Medicaid eligibility who shall be authorized by the Department to participate in the Medicaid or FAMIS program. |
| Cold-Call Marketing | Any unsolicited personal contact with a potential member by an employee, affiliated provider, or contractor of the entity for the purpose of influencing enrollment with such entity. |
| Common Core Formulary | A list of all drugs required to be covered by health plans, including those on the Preferred Drug List (PDL), for Medicaid members enrolled with fee-for- service, Medallion 4.0, and Commonwealth Coordinated Care Plus (CCC Plus) Managed Care programs. These drugs do not require Service Authorizations (SA) unless subject to additional clinical criteria. Health plans may add drugs to the therapeutic drug classes on the DMAS PDL/Common Core Formulary but cannot remove drugs. |
| Commonwealth Coordinated Care | The name the Department has given the program for the Medicare-Medicaid Financial Alignment Demonstration. The Demonstration provides Medicare and Medicaid covered services through an integrated care delivery system to individuals age 21 and over who are enrolled in Medicare Parts A, B, and D, and are also receiving full-benefit Medicaid (“dual eligible individuals”), including dual eligible individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) home-and-community-based services waiver program and those residing in nursing facilities (NFs). The Demonstration is being implemented in Central Virginia, Northern Virginia, Roanoke, Tidewater and Western/Charlottesville |
| Commonwealth Coordinated Care Plus (CCC Plus) Program | The Department’s mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from designated home and community-based services (HCBS) 1915(c) waivers. |
| Community Service Board (CSB) | A citizens' board established pursuant to Virginia Code §37.2-500 and §37.2-600 that provides mental health, intellectual disability and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases the term CSB also includes Behavioral Health Authority (BHA). |
| Complaint | See “grievance” definition. |
| Comprehensive Risk Contract | A risk contract between the Department and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services 1) Outpatient hospital services. 2) Rural health clinic services. 3) Federally Qualified Health Center (FQHC) services. 4) Other laboratory and X-ray services. 5) Nursing facility (NF) services. 6) Early and periodic screening, diagnostic, and treatment (EPSDT) services. 7) Family planning services. 8) Physician services. 9) Home health services. |
| Consumer Assessment of Healthcare Providers and Systems or CAHPS® | A consumer satisfaction survey developed collaboratively by Harvard, RAND, the Agency for Healthcare Research and Quality (AHRQ), the Research Triangle Institute, and Westat that has been adopted as the industry standard by NCQA and CMS to measure the quality of managed care plans. |
| Consumer-Directed (CD) Employee/Attendant | A person who is employed by an individual who is receiving services through the consumer-directed model or their representative to provide approved services (e.g., personal care), and who is exempt in Virginia from Workers’ Compensation. |
| Consumer-Directed (CD) Services | Service (personal care) for which the individual or his representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff. |
| Consumer-Directed (CD) Services Facilitator (SF) | The Medicaid enrolled provider who is responsible for supporting the Member or his representative, as appropriate, providing employee management training, and completing ongoing review activities as required by DMAS. |
| Contract | This signed and executed Medallion 4.0 program document resulting from the RFP, issued and awarded, including all attachments or documents incorporated by reference. |
| Contract Modifications or Contract Amendment | Any changes, modifications, or amendments to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations. |
| Contractor | 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. |
| Coordination of Benefits or COB | A method of integrating benefits payable under more than one form of health insurance coverage so that the covered member’s benefits from all sources do not exceed 100 percent of the allowable medical expenses. COB rules also establish which plan is primary (pays first) and which plan is secondary, recognizing that Medicaid is the payor of last resort. |
| Cost Avoidance | The application of a range of tools to identify and prevent inappropriate or medically unnecessary charges before they are actually paid. This may include service authorization, second surgical opinion, medical necessity review, and other pre-and post- payment /service reviews. |
| Cost Sharing | Co-payments paid by the member in order to receive medical services. |
| [COV Security Standards](https://www.vita.virginia.gov/policy--governance/itrm-policies-standards/) | Commonwealth of Virginia (COV) Information Technology Resource Management (ITRM) policies, standards, and guidelines that may be updated from time to time. A complete list can be located at <https://www.vita.virginia.gov/policy--governance/itrm-policies-standards/> |
| [Cover Virginia](http://www.coverva.org/) | Virginia’s telephonic customer service center and online portal providing statewide eligibility information and application assistance for Virginia’s Medicaid, FAMIS, Fee-for-Service, Department of Corrections, and other insurance options. Cover Virginia’s website www.coverva.org provides easy access to information about Virginia’s Medicaid and FAMIS programs, including eligibility and how to apply. Staff at the Cover Virginia statewide customer service center at 1-855-242-8282 provide confidential application assistance and program information. Individuals can apply, report changes, or renew coverage through Cover Virginia. |
| Covered Services | The subset of services for which the Contractor shall be responsible for covering under the program. |
| Credentialing | The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility to deliver covered services. |
| Credibility Adjustment | As defined in 42 CFR § 438.8, an adjustment to the Medical Loss Ratio (MLR) for a partially credible MCO to account for a difference between the actual and target MLRs that may be due to random statistical variation. |
| Cultural Competency | The ability of health care providers and health care organizations to understand and respond effectively to a patient’s cultural health beliefs, preferred languages, health literacy levels and communications needs. |
| Data Analysis | Tool for identifying potential payment errors and trends in utilization, referral patterns, formulary changes, and other indicators of potential fraud, waste, or abuse. Data analysis compares claim information and other related data to identify potential errors and /or potential fraud by claim, individually or in the aggregate. Data analysis is an integrated, on-going component of fraud detection and prevention activity. |
| Days | Business days, unless otherwise specified. |
| Department also referred to as DMAS | The Virginia Department of Medical Assistance Services. |
| Department of Health Professions (DHP) | Agency that issues licenses, registrations, certifications, and permits to healthcare practitioner applicants that meet qualifications established by law and regulation. In addition to the Board of Health Professions, the following applicable boards are included within the Department Board of Audiology and Speech- Language Pathology, Board of Counseling, Board of Dentistry, Board of Long-Term Care Administrators, Board of Medicine, Board of Nursing, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, and Board of Social Work. |
| Department of Medical Assistance Services (DMAS or Department) | The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children’s Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act. |
| Disease Management | System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. |
| Disenrollment | The process of changing enrollment from one MCO plan to another MCO or from managed care to fee-for-service. |
| Drug Efficacy Study Implementation or DESI | Designation indicating drugs for which DMAS will not provide reimbursement because the drugs have been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness. |
| Durable Medical Equipment or DME | Medical equipment, supplies, and appliances suitable for use in the home consistent with 42 CFR 440.70(b)(3) that treat a diagnosed condition or assist the individual with functional limitations. |
| Early and Periodic Screening, Diagnostic, and Treatment or EPSDT | Federal law (42 CFR § 441.50 et seq.) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts 1) EPSDT promotes the early and universal assessment of children’s healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member 2) EPSDT also compels state Medicaid agencies to cover for children, any additional health care services, products, or procedures that are coverable under the Federal Medicaid program, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination. All medically necessary services require service authorization. 3) For more information on the EPSDT services visit https://www.medicaid.gov/medicaid/benefits/epsdt/index.html |
| Early Intervention Assistive Technology Services | Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. |
| Early Intervention Individualized Family Service Plan (IFSP) | A written plan developed by the member’s interdisciplinary team for providing early intervention supports and services to eligible children and families that 1) Is based on evaluation for eligibility determination and assessment for service planning; 2) Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer- reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and 3) Is implemented as soon as possible once parental consent is obtained. The IFSP requires a physician signature for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). Medical necessity is established by the IFSP combined with physician certification and shall serve as the authorization for the identified early intervention services. No additional service authorizations shall be required for EI services. |
| Early Intervention or EI | Services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EI services are distinguished from similar rehabilitative services available through EPSDT to individuals aged three and older in that EI services are specifically directed towards children from birth to age three. EI services are not medically indicated for individuals aged three and above. |
| ED Care Coordination | Real-time communication and collaboration among hospital emergency departments, physicians, other health care providers, and health plan clinical and care management personnel to improve outcomes for populations with high utilization of EDs as required by state law through the Virginia Emergency Department Care Coordination Program. |
| Electronic Visit Verification or EVV | An electronic system that provides “real time” monitoring of a service provision, verifies that service visits occur, and documents the precise times service provision begins and ends. |
| Emergency Custody Order | An order, pursuant to §§ 37.2-800 through 37.2-847 (adults) and §§ 16.1-340 through 16.1-361 (minors) of the Code of Virginia, issued by a magistrate that requires any person in the magistrate’s judicial district who is incapable of volunteering or unwilling to volunteer for treatment, or in the case of a minor pursuant to §16.1-340, to be taken into custody and transported for an evaluation in order to assess the need for temporary detention order and to assess the need for hospitalization or treatment. |
| Emergency Medical Condition | A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. |
| Emergency Services | Those health care services that are rendered by participating or non- participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in Placing the client’s health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; Serious impairment to bodily functions; or, Serious dysfunction of any bodily organ or part. [42 CFR §438.114 (a) (i-iii)] |
| Employer of Record (EOR) | The individual who directs their own care and receives consumer-directed services from a CD attendant who is hired, trained, and supervised by the individual or the individual’s representative. |
| Encounter | Any covered or enhanced service received by a Member through the Contractor or its subcontractor. |
| Encounter Data | Data collected by the Contractor documenting all of the health care and related services provided to a member. These services include, but are not limited to, inpatient and outpatient medical and behavioral treatment services, professional services, home health, medical supplies or equipment, medications, community behavioral health, and transportation services. Encounter data is collected on an individual member level and includes the person’s Medicaid/FAMIS ID number. It also is specific in terms of the provider, the medical procedure, and the date the service was provided. DMAS and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring managed care plan’s performance and holding them accountable to specific standards for health care quality, access, and administrative procedures. |
| Encounter Processing System (EPS) | The DMAS Encounter Processing Solution (EPS) is a component module of the overall Medicaid Enterprise System (MES). The EPS is designed to fulfill all DMAS encounter data collection and validation needs. |
| Encounter Submission Calendar | The Department’s schedule for the Contractor to submit encounters. |
| Encryption | A security measure process involving the conversion of data into a format which cannot be interpreted by outside parties. |
| Enhanced Benefits or Services | Services offered by the Contractor to members in addition to services covered by this Contract. The Department will not pay for enhanced services. |
| Enrollee | A Medicaid or FAMIS beneficiary who is currently enrolled in an MCO, used interchangeably with member in this Contract. |
| Enrollee Encounter Data | Information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO. |
| Enrollment | The completion of approved enrollment forms by or on behalf of an eligible person and assignment of a member to an MCO by the Department in accordance with the terms of this Contract. |
| Enrollment Area | The counties and municipalities in which an eligible organization is authorized by the Commonwealth of Virginia, pursuant to a Contract, to operate as a Contractor and in which service capability exists as defined by the Commonwealth. |
| Enrollment Broker | An independent broker who enrolls members in the Contractor’s health plan and who is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to member education and enrollment, assistance with and tracking of member’s grievance resolution, and may include member marketing and outreach. |
| Enrollment Period | The time that a member is enrolled in a Department approved MCO during which they may not dis-enroll or change MCOs unless dis-enrolled under one of the conditions described in this Contract and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months. |
| Enrollment Report | The method by which the Department notifies the Contractor of members assigned to its health plan, as described in the Managed Care Technical Manual. |
| Every Reasonable Effort | This is Contractor-initiated action related to assessments, screenings, laboratory tests, immunizations, follow-up treatment or other services. Every reasonable effort shall include at a minimum a telephone call or mailed reminder either prior to the due date of each visit or upon learning that a visit has been missed and scheduling appointments for members. In the case of being notified of a missed appointment, a telephone call or mailed reminder for the missed appointment is required. In the case of EPSDT, if there is no response, a personal visit to urge the parent or guardian to take the child to his or her appointment is required. |
| Excluded Parties List System or EPLS | The General Services Administration (GSA) maintains the EPLS, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the EPLS on parties they have debarred or suspended as described above |
| Exclusion from Managed Care/ Exclusion from Medallion 4.0/ Exclusion from FAMIS | The removal of a member from the Medallion 4.0 and/or FAMIS Program on a temporary or permanent basis. |
| Expedited Appeal | The process by which an MCO must respond to an appeal by a member if a denial of care decision by an MCO may jeopardize life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor must respond as expeditiously as the member’s health condition requires, not to exceed the latter of three (3) business days from the initial receipt of the appeal, or three (3) business days from receipt of written certification from the MCO or treating medical professional that the member’s health condition requires expedited handling of the appeal. |
| External Appeal | An appeal, subsequent to the Contractor’s appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions. |
| External Quality Review or EQR | Analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that a MCO or their contractors furnish to Medicaid members, as defined in 42 CFR § 438.320. |
| External Quality Review Organization or EQRO | An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR § 438.358, or both. |
| Family Planning | Those necessary services that delay or prevent pregnancy. Coverage of such services shall not include services to treat infertility or services to promote fertility. |
| FAMIS Family Access to Medical Insurance Security Plan | A comprehensive health insurance program for Virginia’s children. FAMIS is administered by and is funded by the state and federal government. Also referred to as Title XXI or the state’s CHIP (Children’s Health Insurance Program). |
| FAMIS Appeal | After final review by the FAMIS managed care plan, there shall also be opportunity for final independent external review by the external quality review organization in accordance with 12VAC30-141-40 upon request by the enrollee. |
| FAMIS MOMS Members | Members who are uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level (plus a 5% disregard), and who are assigned and enrolled in the aid category of 05. Per 12 VAC 30-141, FAMIS MOMS are not subject to exemption from MCO participation (e.g., for being hospitalized at the time of MCO enrollment). |
| Federally Qualified Health Centers or FQHCs | Those facilities as defined in 42 CFR § 405.2401(b), as amended. |
| Federally Qualified HMO | A HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act. |
| Fee-for-Service | The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This method of reimbursement is not used by the Department to reimburse the Contractor under the terms of this Contract. |
| Financial Relationship | As defined in 42 CFR § 438.320, a financial relationship is (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or (2) A compensation arrangement with an entity. |
| Firewall | Software or hardware-based security system that controls the incoming and outgoing network traffic based on an applied rule set. A firewall establishes a barrier between a trusted, secure internal network and another network (e.g. the internet) that is not assumed to be secure and trusted. Firewall also includes physical security measures that establish barriers between staff, the public, work areas, and data to ensure information is not shared inappropriately or in violation of any applicable State or Federal laws and regulations. |
| Flesch Readability Formula | The formula by which readability of documents is tested as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974). |
| Former Foster Care Member | A former foster care youth is an individual who was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory and receiving Medicaid until discharge from foster care upon turning age 18 years or older, is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under Age 18 or SSI), and is under age 26 years. A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group. |
| Formulary | A list of drugs that the MCO has approved. Prescribing some of the drugs may require service authorization. The Department has developed a Preferred Drug List (PDL) that shall be a subset of the Contractor’s formulary that includes all the preferred drugs from the Department’s Preferred Drug List (PDL). |
| Foster Care | Pursuant to 45 CFR §1355.20, a “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.” Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is predicated upon the child being placed outside of the home and with an individual who has “placement and care” responsibility for the child. The term “placement and care” means that the Local Department of Social Services (LDSS) is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. Pursuant to the Affordable Care Act, Virginia must provide Medicaid coverage to additional foster care individuals (formerly Title IV- E or non-Title IV-E) when the following conditions occur the individual was under the responsibility of a Virginia-based foster care agency and receiving Medicaid until discharged from foster care upon turning twenty- one (21) years, the individual is not eligible for Medicaid in another mandatory Medicaid covered group, and the individual is under age 26 years. |
| Fostering Futures | Virginia’s program that implements provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages 18 to 21. The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source. |
| Fraud | Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. Fraud also includes any act that constitutes fraud under applicable Federal or State law. |
| Full Credibility | As defined in 42 CFR § 438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ratio (MLR) with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR |
| Generally Accepted Accounting Principles or GAAP | Uniform minimum standards of and guidelines to financial accounting and reporting as established by the Financial Accounting Standards Board and the Governmental Accounting Standards Board. |
| Grievance | In accordance with 42 CFR § 438.400, means an expression of dissatisfaction about any matter other than an “adverse action” or “adverse benefit determination.” Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s or provider’s rights. |
| Guardian | An adult who is legally responsible for the care and management of a minor child or another adult. |
| Health Care Home (Formally Patient Centered Medical Home) | A patient centered health care delivery system option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions to support the “whole-person” across the lifespan. |
| Health Care Services | All Medicaid and FAMIS services provided by an MCO under contract with the Department. |
| Health Insurance Portability & Accountability Act of 1996 or HIPAA | HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers; and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future. |
| Health Insurance Premium Payment (HIPP) Program | A DMAS administered Medicaid related premium assistance program(s) that may reimburse part, or a participant’s entire share, of employer sponsored group health insurance premiums for members who have employer sponsored group health insurance available to them through their own or their family member’s employment. Eligibility criteria currently include, but are not limited to the following 1) a member must be enrolled in full coverage Medicaid (be found eligible to meet either the categorically needy or medically needy and found eligible for a fully covered group); 2) the health plan must meet cost effectiveness evaluation; 3) must be enrolled in a health plan that meets the definition of an a “qualified employer sponsored plan”; and 4) must not be a plan with deductibles that are equal to or exceed IRS High Deductible Health Plan limits. |
| Health Insurance Premium Program (HIPP) for Kids | HIPP program for those Medicaid members under the age of 19 who are eligible for or enrolled in “qualified employer-sponsored coverage.” |
| Healthcare Effectiveness Data and Information Set (HEDIS) | Tool developed and maintained by the National Committee for Quality Assurance that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality. |
| Home and Community-Based Care Services or HCBS | A variety of home and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. |
| Homeless | In accordance with 42 U.S.C., 254b, a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. |
| Hospital or Health System | A facility that meets the requirements of 42 CFR § 482, as amended. |
| Indian | An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services. |
| Indian Health Care Provider | A health care program, including providers of contract health services (CHS), operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603). |
| Individualized Education Program or IEP | Means a written statement for a child receiving special education services that is developed, reviewed, and revised in a team meeting in accordance with (34 CFR §300.22). The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child’s educational needs. |
| Individualized Family Service Plan or IFSP | Individualized family service plan (IFSP) means a comprehensive and regularly updated statement specific to the child being treated containing, but not necessarily limited to treatment or training needs, measurable outcomes expected to be achieved, services to be provided with the recommended frequency to achieve the outcomes, and estimated timetable for achieving the outcomes. The IFSP is developed by a multidisciplinary team which includes the family, under the auspices of the local lead agency. |
| Individuals with Disabilities Education Act Early Intervention Services or IDEA-EIS | A program (as described in 20 U.S.C. § 1471 and 34 CFR § 303.12) administered by the Virginia Department of Behavioral Health and Developmental Services. Early Intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas physical, cognitive, communication, social or emotional, or adaptive development. |
| Informational Materials | Written communications from the Contractor to members that educates and informs about services, policies, procedures, or programs specifically related to Medicaid. |
| Initial Implementation | The first time a program or a program change is instituted in a geographical area by the Department. |
| Inquiry | An oral or written communication usually received by a Member Services Department or telephone helpline representative made by or on the behalf of a member that may be 1) questions regarding the need for additional information about eligibility, benefits, plan requirements or materials received, etc.; 2) provision of information regarding a change in the member’s status such as address, family composition, etc.; or 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction. |
| Institution for Mental Disease, or IMD | A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental disease. An IMD may be private or state- run. A State Institution for Mental Disease or State Mental Hospital is a hospital, psychiatric institute, or other institution operated by the DBHDS that provides care and treatment for persons with mental illness. |
| Intensive Outpatient Services | Services shall include the major psychiatric, psychological, and psycho-educational modalities individual and group counseling; family therapy; education about the effects of substance use disorder 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. |
| Intermediate Care Facility for Individuals with Intellectual Disabilities | Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) is a facility, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) in which care is provided to intellectually disabled individuals who are not in need of skilled nursing care, but who need more intensive training and supervision than would be available in a rooming, boarding home, or group home. Such facilities must comply with Title XIX standards, provide health or rehabilitative services, and provide active treatment to clients toward the achievement of a more independent level of functioning. |
| Internal Appeal | A request to the Contractor by a member, a member’s authorized representative or provider, acting on behalf of the member and with the member’s written consent, for review of a Contractor’s adverse benefit determination as defined in this Contract. The internal appeal is the only level of appeal with the Contractor and must be exhausted by a member or deemed exhausted according to 42 CFR § 438.408(c)(3) before the member may initiate a State fair hearing. |
| Investigation | A review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. DMAS reserves the right to expand upon any investigation. |
| Joint Legislative Audit and Review Commission (JLARC) | Conducts policy analysis, program evaluation, and oversight of state agencies on behalf of the Virginia General Assembly. The duties of the Commission are authorized by the Code of Virginia §30-58.1. |
| Laboratory | Any laboratory performing testing for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 CFR §§ 493.2 and 493.3, as amended. |
| Limited English Proficient (LEP) | In accordance with 42 CFR § 438.10, potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter. |
| List of Excluded Individuals and Entities or LEIE | When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider’s name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG website and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI). |
| Local Education Agency | A local public school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or the Virginia School for the Deaf and the Blind at Staunton. |
| Local Lead Agency | Local lead agency means an agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local Early Intervention system, as described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia . |
| Long-Stay Hospital or LSH | Hospitals that provide a slightly higher level of care than Nursing Facilities. The Department recognizes two facilities that qualify the individual for exemption as Long-Stay Hospitals: Lake Taylor Transitional Care Hospital (Norfolk) and Hospital for Sick Children Pediatric Center (Washington, DC). |
| Long-Term Acute Care Hospitals or LTAC | A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in treating patients with serious and often complex medical conditions. The Department recognizes these facilities as Acute Care Facilities. |
| Managed Care Organization or MCO | An organization which offers managed care health insurance plans (MCHIP), as defined by Code of Virginia § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in Va. Code § 38.2- 3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Medallion 4.0 members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 CFR § 438.116. |
| Managed Care Program | As defined in 42 CFR § 438.2, a managed care delivery system operated by a State as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act. |
| Managed Care Technical Manual or MCTM | A document developed by the Department that provides the technical specifications for the submission of encounters and other contract deliverables, including monthly, quarterly, annual, and other required reports from MCOs. In addition, it supplies technical information on enrollment and payment files, Department- generated files, and Departmental processes such as the processing of incarcerated members and the reconciliation of payments for newborn members. |
| Managing Employee | In accordance with 42 CFR 455 Subpart B, means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. |
| Marketing | Any communication, from an MCO to a Medicaid or FAMIS beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO's Medicaid or FAMIS product, or either to not enroll in or to dis-enroll from another MCO's Medicaid or FAMIS product. Marketing does not include communication to a Medicaid or FAMIS beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan. |
| Marketing Materials | Any materials that are produced in any medium, by or on behalf of an MCO, are used by the MCO to communicate with individuals, members, or prospective members, and can reasonably be interpreted as intended to influence the individuals to enroll or reenroll in that particular MCO and entity. |
| Marketing Services | Any communication, services rendered, or activities conducted by the Contractor or its subcontractors to its prospective members for the purpose of education or providing information that can reasonably be interpreted as intended to influence the member to enroll in that particular MCO’s Medicare, Medicaid, or FAMIS products. |
| Material Adjustment | As defined in 42 CFR § 438.2, an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices. |
| Medallion 4.0 | A statewide mandatory Medicaid program, approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver, which utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. |
| Medallion Care System Partnership or MCSP | An arrangement, such as a medical home, with the goal of improving health outcomes for Medicaid members whereby the Managed Care Organizations form partnerships and contractual arrangements tied to gain and/or risk sharing, performance-based incentives, and other Commonwealth-approved quality metrics and financial performance in an effort to increase participation of integrated provider health care delivery systems. |
| Medicaid | Medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. |
| Medicaid Covered Services | Services as defined in the Virginia State Plan for Medical Assistance or State regulations. |
| Medicaid Enterprise System or MES | The Department’s modernized technology system which will replace the current Medicaid Management Information System (MMIS). |
| Medicaid Fraud Control Unit | The unit established within the Office of the Attorney General to audit and investigate providers of services furnished under the Virginia State Plan for Medical Assistance, as provided for in the Code of Virginia § 32.1-320, as amended. |
| Medicaid Information Technology Architecture (MITA) | Initiative sponsored by the Center for Medicare and Medicaid Services (CMS) intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. The MITA Initiative is a national framework to support improved systems development and health care management for the Medicaid enterprise. MITA has a number of goals, including development of seamless and integrated systems that communicate effectively through interoperability and common standards. |
| Medicaid Management Information System or MMIS | The medical assistance and payment information system of the Virginia Department of Medical Assistance Services. |
| Medicaid Member | Any individual enrolled in the Virginia Medicaid program. |
| Medicaid Non-Covered Services | Services not covered by DMAS and, therefore, not included in covered services as defined in the Virginia State Plan for Medical Assistance or State regulations. |
| Medicaid Work also known as Medicaid Buy-In program | Medicaid Works allows working people with disabilities whose income is no greater than 80% Federal Poverty Level (FPL) to pay a premium to participate in the Medicaid program. |
| Medical Loss Ratio (MLR) Reporting Year | As defined in 42 CFR § 438.8, a period of twelve (12) months consistent with the rating period selected by the Department. |
| Medical Necessity or Medically Necessary | Appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. |
| Medically Complex | Individuals who have a complex medical or behavioral health condition and a functional impairment or an intellectual or developmental disability. |
| Medically Needy | Individuals who meet Medicaid covered group requirements but have excess income. A medically needy determination requires a resource test and includes pregnant women, children under the age of 18, foster care and adoption assistance, and those in Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Waivers (ICF/IIDs) up to age 21, Aged, Blind, Disabled (ABD) up to age 21. Parents and caretaker relatives do not qualify under medically needy. |
| Medicare Exclusions Database or MED | CMS maintains the MED as a way of providing exclusion information to its stakeholders, including State Medicaid agencies and Medicare contractors. Office of Inspector General (OIG) sends monthly updates of the LEIE to CMS. CMS uses the OIG updates to populate the MED (formerly Publication 69). Unlike the LEIE and the EPLS, the MED includes unique identifiers (e.g., SSNs, EINs, NPIs), but is available only to certain users to protect sensitive information. |
| Member | A person eligible for Medicaid or CHIP/FAMIS who is enrolled with an MCO Contractor to receive services under the provisions of this Contract. |
| Member Handbook | Document required by the Contract to be provided by the MCO to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections table of contents, member eligibility, choosing or changing an MCO, choosing or changing a PCP, making appointments and accessing care, member services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes. |
| Member Months | As defined in 42 CFR § 438.8, the number of months an enrollee or a group of enrollees is covered by an over a specified time period, such as a year. |
| Mental Health Case Management | Service to assist individuals who reside in a community setting in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct clinical or treatment services. |
| Mental Health Parity and Addiction Equality Act | A federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. |
| [Mental Health Professional](https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2400.1/) | In accordance with the Virginia Department of Health Professions (DHP), a Mental Health Professional is a person who by education and experience is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual’s achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development. Refer to <https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2400.1/> |
| Monitoring | The ongoing oversight of the provision of services to determine that services are administered according to the individual’s plan of care and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include, but are not limited to, telephone contact, observation, interviewing the individual and/or the individual’s family, as appropriate, and in person or by telephone, and/or interviewing service providers. |
| Monthly | For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month’s reporting period. For example, January’s monthly reports are due by February 15th; February’s are due by March 15th, etc. |
| National Committee for Quality Assurance (NCQA) | A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems. |
| National Practitioner Data Bank or NPDB | The NPDB, maintained by the Health Resources and Services Administration, is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. OIG reports exclusions to the NPDB monthly. Although the NPDB includes unique identifiers, to protect sensitive information it is available only to registered users whose identities have been verified. 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 or NPI | NPI is a national health identifier for all health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in this contract will be required to have and use an NPI. |
| Network Provider | Any provider, group of providers, or entity that has a network provider agreement with a MCO or a subcontractor, and receives Medicaid or CHIP/FAMIS funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP, or PAHP |
| Newborn Guarantee Coverage Period (Medallion 4.0) | The time period between the date of birth of a child whose mother is a Medicaid, FAMIS or FAMIS MOMS member with the Contractor until the last day of the third calendar month including the month of birth, unless otherwise specified by the Department. For example, a baby born any day in February will be enrolled with the Contractor until April 30. |
| No Credibility | As defined in 42 CFR § 438.8, a standard for which the experience of an MCO is determined to be insufficient for the calculation of a Medical Loss Ratio (MLR). An MCO that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements. |
| Non-Claims Costs | As defined in 42 CFR § 438.8, expenses for administrative services that are not Incurred claims (as defined in 42 CFR §438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 CFR §438.8(e)(3)); or licensing and regulatory fees, or Federal and State taxes (as defined in 42 CFR §438.8 (f)(2) of this section) |
| Non-Participating Provider | A health care entity or health care professional not in the Contractor’s participating provider network. |
| Notice | Means a written statement that meets the requirements of 42 CFR § 438.404. |
| Nursing Facility (NF)/Certified Nursing Facility | Any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the Code of Virginia, § 32.1-137. |
| Office Based Opioid Treatment Providers or Preferred OBOTs | Deliver addiction treatment services to members with moderate to severe opioid use disorders provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-130-5020). |
| Ombudsman | The independent State entity that will provide advocacy and problem-resolution support for Medallion 4.0 participants, and serve as an early and consistent means of identifying systemic problems. |
| Open Enrollment | The time frame in which members are allowed to change from one MCO to another, without cause, at least once every 12 months per 42 CFR § 438.56 (c)(2) and (f)(1). For Medallion 4.0 members, open enrollment timeframes are based upon the Department’s regional open enrollment effective date. Within sixty (60) days prior to the open enrollment effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within sixty (60) days of the open enrollment period shall remain in his or her current health plan selection until their next open enrollment effective date. |
| Outcomes | As defined in 42 CFR § 438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services. |
| Out-of-Network Coverage | Coverage provided outside of the established MCO network; medical care rendered to a member by a provider not affiliated with the Contractor or contracted with the Contractor. |
| Overpayment | As defined in 42 CFR § 438.2, any payment made to a network provider by a MCO to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO by a State to which the MCO is not entitled to under Title XIX of the Act. |
| PACE | The Program of All-inclusive Care for the Elderly. PACE provides the entire spectrum of health and long-term care services (preventive, primary, acute, and long-term care services) to their members without limit as to duration or dollars. |
| Partial Credibility | As defined in 42 CFR §438.8, a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ratio (MLR) but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR. |
| Party of Interest | Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or member of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual. |
| Pass-Through Payment | Any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes A specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of 42 CFR §438.6(a) for services and enrollees covered under the contract; a sub-capitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments. |
| Performance Incentive Award | A program instituted by the Department that rewards or penalizes managed care organizations with possible incentive payments based upon the quality of care received by Virginia’s Medicaid/CHIP members. |
| Person with Ownership or Control Interest | In accordance with 42 CFR 455 Subpart B, means a person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor’s capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor. |
| Personal Care Provider | A provider that renders personal care services to an eligible member in order to prevent or reduce institutional care, or, in the case of Local Education Agency-based services, in order to allow the child to participate in a free and appropriate public education. |
| Personal Care Services | Available through the EPSDT benefit and through Local Education Agency-Based Services for children under the age of 21. A range of support services necessary to enable the individual to remain at or return home rather than enter a nursing facility, or to participate in a free and appropriate public education. The services includes assistance with ADLs, IADLs, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition. Personal care services shall be provided by personal care aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model, by consumer-directed attendants under the CD model of service delivery, or as authorized by a student’s Individual Education Program plan delivered via Special Education and Related Services. |
| Person-Centered Planning | A process, directed by an individual or his or her family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired outcomes for the individual. |
| Pharmacy Benefit Manager (PBM) | An entity responsible for the provision and administration of pharmacy services. |
| Pharmacy Benefits Management | The administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals. |
| Physician Incentive Plan | Any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan member. |
| Post Stabilization Services | Covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member’s condition. |
| Post-Payment | Subjecting claims for services to evaluation after the claim has been adjudicated. This activity may result in claim reversal or partial reversal, and claim payment recovery. |
| Potential Enrollee | As defined in 42 CFR § 438.2, a Medicaid beneficiary who is subject to mandatory enrollment or who may voluntarily elect to enroll in a given MCO, but is not yet an enrollee of a specific MCO. |
| Potential Member | A Medicaid member who is subject to mandatory enrollment in a given managed care program. [42 C.F.R. § 438.10(a)] |
| Prepaid Ambulatory Health Plan (PAHP) | An entity that provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and Does not have a comprehensive risk contract. |
| Prepaid Inpatient Health Plan (PIHP) | An entity that 1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates. 2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) Does not have a comprehensive risk contract. |
| Pre-Payment | A review process conducted before a claim is paid to ensure the appropriate code was billed, the documentation supports the claim submitted, and/or the service was medically necessary. |
| Prevalent Non-English Language | A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient. |
| Previously Authorized | As described in 42 CFR § 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example: If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a “previously authorized service” that is being reduced. Conversely, “previously authorized” does not include the example whereby (1) the Contractor authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the Contractor. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not germane to continuation of benefit requirements for previously authorized services that are terminated, suspended or reduced. |
| Primary Care | As defined in 42 CFR § 438.2, all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the Department, to the extent the furnishing of those services is legally authorized in the State. |
| Primary Care Provider or PCP | A practitioner who provides preventive and primary medical care for eligible members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc. |
| Privacy | Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 CFR §§ 431.300 through 431.307, as well as relevant Virginia privacy laws. |
| Private Duty Nursing | Nursing care services available for children under age 21 under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services. |
| Program Integrity | The process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities. |
| Prospective Risk Adjustment | A methodology to account for anticipated variation in risk levels among contracted MCOs, PIHPs, or PAHPs that is derived from historical experience of the contracted MCOs, PIHPs, or PAHPs and applied to rates for the rating period for which the certification is submitted. |
| Protected Health Information or PHI | Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium. |
| Provider | As defined in 42 CFR § 438.2, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State. |
| Psychiatric Residential Treatment Facilities (PRTF) | Means the same as defined in 42 CFR 483.352 and are a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment. |
| Quality | As defined in 42 CFR § 438.320, as it pertains to external quality review, the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through 1) Its structural and operational characteristics; 2) The provision of services that are consistent with current professional, evidenced-based- knowledge; 3) Interventions for performance improvement. |
| Quality Compass, or NCQA Quality Compass | NCQA’s comprehensive national database of health plans’ HEDIS and CAHPS results, containing plan-specific, comparative and descriptive information on the performance of hundreds of managed care organizations. The database allows benefit managers, health plans, consultants, the media, and others to conduct a detailed market analysis by providing comprehensive information about health plan quality and performance. |
| Quality Improvement Program or QIP | A quality improvement program with structure and processes and related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, plans, and/or members. |
| Quarterly | For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each calendar quarter. |
| Quarters | Calendar quarters starting on January 1st, April 1st, July 1st, and October 1st. |
| Rate Cell | As defined in 42 CFR § 438.2, a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract. |
| Rating Period | A period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by § 438.7(a). |
| Readily Accessible | Electronic information and services which comply with modern accessibility standards such as Section 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions. |
| Reconsideration | A provider’s request for review of an adverse action as defined in this Contract. The Contractor’s reconsideration decision is a prerequisite to a provider filing an informal appeal to the DMAS Appeals Division. |
| Remand | The return of a case by the DMAS hearing office to the Contractor MCO for further review, evaluation, and action. |
| Retrospective Risk Adjustment | A methodology to account for variation in risk levels among contracted MCOs that is derived from experience concurrent with the rating period of the contracted MCOs subject to the adjustment and calculated at the expiration of the rating period. |
| Risk Adjustment | A methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of MCOs contracted with the State. |
| Rural Area | A census designated area outside of a metropolitan statistical area. |
| Rural Exception | A rural area as designated in the 1915(b) managed care waiver, pursuant to 1935(a)(3)(B) of the Social Security Act and 42 C.F.R. § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying members are mandated to enroll in the one available contracted MCO. |
| Rural Health Clinic | A facility as defined in 42 C.F.R. § 491.2, as amended. |
| Safe Sleep Virginia | Virginia Department of Social Services program designed to educate parents and caregivers regarding the steps they can take to prevent infant sleep-related death and to emphasize simple practices all Virginians can employ to provide a safe and healthy environment for infants during sleep. |
| Safety Net Providers | Providers that organize and deliver a significant level of healthcare and other related services to Medicaid, FAMIS, uninsured, and other vulnerable populations. |
| School Health Services | Are defined as 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 are reimbursed directly by DMAS. (Reference Section 7.5.A for coverage guidelines.) |
| Screening | Comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by the Department and as required by the Screenings and Assessments provisions of this Contract. |
| Sentinel Event | An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called “Sentinel” because they signal the need for immediate investigation and response. |
| [Serious Emotional Disturbance](http://www.dbhds.virginia.gov/) | Used to refer to children, age birth through seventeen (17), who have had a serious mental health problem diagnosed under the DSM or who exhibit all of the following problems in personality development and social functioning that have been exhibited over at least one year’s time, problems that are significantly disabling based upon the social functioning of most children of the child’s age, problems that have become more disabling over time, and service needs that require significant intervention by one or more agency (see <http://www.dbhds.virginia.gov/> for additional information). |
| Serious Mental Illness | Used to refer to individuals ages 18 and older, who have serious mental illness diagnosed under the DSM in the following major diagnostic categories: schizophrenias and other psychotic disorders, bipolar disorders, and major depressive disorders. |
| Service Authorization (SA)/Prior Authorization (PA) | The Department’s service authorization program for fee-for-service Medicaid and for carved-out services. A type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that claim is billed and processed for payment. Pre-payment review is often focused on controlling utilization of specific services by a pre-determination that the service is medically necessary for an individual. |
| Service Authorization Request | A managed care member’s request for the provision of a service. |
| Social Determinants | Economic and social conditions that affect health risk and outcomes. |
| Spread Pricing | The model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services. |
| Stabilized | As defined in 42 CFR § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the individual from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta. |
| State Fair Hearing | The Department’s evidentiary hearing process. Any “action” or appeal decision rendered by the MCO may be appealed by the member to the Department’s Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-380. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in 12 VAC 30-20-500 et. seq. |
| State Institution for Mental Disease or State-run IMD or State Mental Hospital | A hospital, psychiatric institute, or other institution operated by the Department of Behavioral Health and Developmental Services (DBHDS) that provides care and treatment for persons with mental illness. |
| State Plan for Medical Assistance or State Plan | The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid 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 that are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). However, the Contractor shall not require a Member to use a state plan substituted service/“in lieu of service” as a substitute for a state plan covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner. |
| Subcontract | A written contract between the Contractor and a third party, under which the third party performs any one or more of the Contractor’s obligations or functional responsibilities under this Contract. |
| Subcontractor | Any group or person that furnishes supplies or services to the Commonwealth, DMAS, on behalf of Supplier or another Subcontractor in performance of this Contract. |
| Substance Abuse | The use of drugs, without a compelling medical reason, or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the member. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care. |
| Substance Exposed Infants (SEIs) | Infants who experienced prenatal exposure to alcohol, tobacco, or other controlled substances. SEIs shall include children born with Neonatal Abstinence Syndrome (NAS). SEIs/NAS infants require unique medical, behavioral health and care coordination services in order to reach optimum health outcomes. |
| Substance Use/ Substance Use Disorder (SUD) | The use of drugs, without a compelling medical reason, or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the member. This care and treatment may include counseling, rehabilitation, medical, or psychiatric care. |
| Successor Law or Regulation | That section of Federal or State law or regulation which replaces any specific law or regulation cited in this Contract. The successor law or regulation shall be that same law or regulation if changes in numbering occur and no other changes occur to the appropriate cite. In the event that any law or regulation cited in this Contract is amended, changed or repealed, the applicable successor law or regulation shall be determined and applied by the Department in its sole discretion. The Department may apply any source of law to succeed any other source of law. The Department shall provide the Contractor written notification of determination of successor law or regulation. |
| System for Award Management or SAM or formerly EPLS | The General Services Administration (GSA) maintains the SAM, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the SAM on parties they have debarred or suspended as described above; Office of Inspector General (OIG) sends monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the SAM. The SAM does not include any unique identifiers; it provides only the name and address of excluded entities. If SAM users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion. |
| Telehealth | The use of telecommunications and other electronic information exchange to support remote or long-distance health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance, and it is not restricted to modalities that involved real-time, two-way interaction (see “Telemedicine” below). Telehealth incorporates technologies such as telephone, facsimile machines, electronic, email systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation. |
| Telemedicine | A service delivery model that uses real-time, two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the member to an enrolled provider approved to provide telemedicine services at a distant (remote) site. |
| Temporary Detention Order or TDO | An emergency custody order issued following sworn petition to any magistrate that authorized law enforcement to take a person into custody and transport that person to a facility designed on the order to be evaluated, where such person is believed to be mentally ill and in need of hospitalization or treatment pursuant to 42 CFR §441.150 and Code of Virginia §§ 16.1-340 and 340.1, et. seq. (minors) and §§ 37.2-808 through 810, et. seq. (adults). |
| Third-Party Liability | The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan. |
| Threshold | A pre-established level of performance that, when it is not attained, results in initiating further in-depth review to determine if a problem or opportunity for improvement exists. Failure of Supplierr to meet any threshold in the Contract may result in compliance actions. |
| Transmit | Means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission. |
| Trauma Informed Care | An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences (ACEs) have played in their lives. This approach also builds on member resiliency and strengths to address both the overall physical and emotional well-being of the individual. |
| Treatment Foster Care (TFC) Case Management (CM) | Serves children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. TFC case management focuses on a continuity of services, is goal directed and results oriented. |
| Urban Area | Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of “extended cities” according to the US Department of Commerce, Bureau of the Census. |
| Urgent Care | Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent care is appropriately provided in a clinic, physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition. |
| Urgent Medical Condition | A medical (physical, mental, or dental) condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected by a prudent layperson that possesses an average knowledge of health and medicine to result in 1) Placing the patient’s health in serious jeopardy; 2) Serious impairment to bodily function; 3) Serious dysfunction of any bodily organ or part; or 4) In the case of a pregnant woman, serious jeopardy to the health of the fetus. |
| Utilization Management | The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. |
| Validation | As defined in 42 CFR § 438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis. |
| Value-Added Network or VAN | A third party entity (e.g. vendor) that provides hardware and/or software communication services, which meet the security standards of telecommunication. |
| Value-Based Payment (VBP) | A broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures. Public and private payers use VBP strategies in an effort to drive improvements in quality and to slow the growth in health care spending. |
| Virginia Administrative Code (VAC) | Contains regulations of all of the Virginia State Agencies. |
| Virginia Department of Health Office of Emergency Medical Services (OEMS) | The governing state agency ensuring ambulance companies maintain employee, vehicle compliance, and licensing requirements. If OEMS finds the ambulance company out of compliance, OEMS is the governing authority that takes action. |
| Waste | The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified that the practice is inappropriate, may be considered fraud or abuse. |
| Withhold Arrangement | Any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement. |

# Appendix H – EQRO RFP List of Acronyms Used

|  |  |
| --- | --- |
| AA | Adoption Assistance |
| AAA | Area Agencies on Aging |
| ABD | Aged, Blind, and Disabled Population |
| ACA | Patient Protection and Affordable Care Act |
| ACIP | Advisory Committee on Immunization Practice |
| ADCC | Adult Day Care Center |
| 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 |
| 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 |
| CMHRS | Community Mental Health Rehabilitative Services |
| CMR | Comprehensive Medication Review |
| CMS | Centers for Medicare and Medicaid Services |
| CMS 1500 | Standard Professional Paper Claim Form |
| COB | Coordination of Benefits |
| 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 for Aging and Rehabilitative Services |
| DBA | Dental Benefits Administrator |
| DBHDS | Department of Behavioral Health and Developmental Services |
| DD | Developmental Disability |
| DDI | Design, Development, Implementation |
| 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 Related Grouping |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| DSMP | Diabetes Self-Management Program |
| D-SNP | Dual Eligible Special Needs Plan |
| DSP | Data Security Plan |
| DSS | Department of Social Services |
| ECO | Emergency Custody Order |
| EDI | Electronic Data Interchange |
| EI | Early Intervention |
| EMR | Emergency Medical Record |
| EN | Enteral Nutrition |
| EOC | Evidence of Coverage |
| 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 |
| F/EA | Fiscal/Employer Agent |
| FAMIS | Family Access to Medical Insurance Security |
| FAMIS Plus | Another name for Children’s Medicaid |
| FC | Foster Care |
| FFS | Fee-for-Service |
| FIPS | Federal Information Processing Standards |
| FOIA | Freedom of Information Act |
| FQHC | Federally Qualified Health Centers |
| FSWV | Far Southwest Virginia HALF – Halifax |
| FTE | Full-Time Equivalent |
| FTP | File Transfer Protocol |
| FY | Fiscal Year |
| GAAP | Generally Accepted Accounting Principles |
| HCBS | Home and Community-Based Care Services |
| HCPCS | Healthcare Common Procedure Coding System |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| 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 |
| I/T/U | Indian Tribe, Tribal Organization, or Urban Indian Organization |
| IADL | Instrumental Activities of Daily Living |
| IBNR | Incurred But Not Reported |
| ICF/IID | 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 |
| IMD | Institution for Mental Disease |
| IOP | Intensive Outpatient |
| ITOTS | **Infant and Toddler Online Tracking System (Early Intervention tracking system)** |
| LARC | Long Acting Reversible Contraception |
| LCSW | Licensed Clinical Social Worker |
| LDSS | Local Department of Social Services |
| LEA | Local Education Agency |
| 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 |
| LSWV | Lower Southwest Virginia SHSP – State Hospitals |
| LTAC | Long-Term Acute Care |
| LTSS | Long Term Services & Support |
| MA | Medicare Advantage |
| MAO | Medicare Advantage Organization |
| MATE | Medical Assistance to Employment |
| MCHIP | Managed Care Health Insurance Plans |
| MCO | Managed Care Organization |
| MCTM | Managed Care Technical Manual |
| MDS | Minimum Data Set |
| MEL | Medicare Exclusions List |
| MES | Medicaid Enterprise System |
| MFCU | Medicaid Fraud Control Unit |
| MHPAEA | Mental Health Parity Addiction Equality Act |
| MLTSS | Managed Long Term Services and Supports |
| MMHS | MCO Member Health Screening |
| MMIS | Medicaid Management Information System (also known as VAMMIS) |
| MMP | Medicare-Medicaid Plan |
| MOB | Matter of Balance |
| MOC | Model of Care |
| MOU | Memorandum of Understanding |
| 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 |
| NOVA | Northern Virginia |
| NPDB | National Practitioner Data Bank |
| NPI | National Provider Identifier |
| NQTL | Non-quantitative Treatment Limitations |
| 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 |
| Part C | Part C of the Individuals with Disability and Education Act (also known as Early Intervention) |
| PCP | Primary Care Provider |
| PDN | Private Duty Nursing |
| PDSA | Plan Do Study Act |
| PHI | Protected Health Information |
| PIP | Physician Incentive Plan |
| PIRS | Patient Intensity Rating Survey |
| PMP | Prescription Monitoring Program |
| PMV | Performance Measure Validation |
| POC | Plan of Care |
| PPE | Provider Preventable Event (refer to Provider Preventable Condition) |
| PRTF | Psychiatric Residential Treatment Facility |
| 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) |
| SAM | System for Award Management (formally known as Excluded Parties List System) |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SED | Serious Emotional Disturbance |
| SLP | Speech-Language Pathology |
| SMI | Serious Mental Illness |
| SPO | State Plan Options |
| SSI | Social Security Income |
| SSN | Social Security Number |
| SUD | Substance Use Disorder |
| TB | Tuberculosis |
| TBI | Traumatic Brain Injury |
| TDO | Temporary Detention Order |
| TFCCM | Treatment Foster Care Case Management |
| TGH | Therapeutic Group Home |
| TIDW | Tidewater |
| Title XIX | Medicaid |
| Title XXI | CHIP |
| TMJ | Temporomandibular Joint (disorder) |
| TNC | Transportation Network Company |
| TPL | Third-Party Liability |
| TPN | Total Parenteral Nutrition |
| TTY/TDD | Teletype/Telecommunication Device for the Deaf |
| U.S.C | United States Code |
| UAI | Uniform Assessment Instrument |
| UB-92 | Universal Billing 1992 claim form |
| UM | Utilization Management |
| USC | United States Code |
| USWV | Upper Southwest Virginia |
| 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 |
| WIC | Special Supplemental Nutrition Program for Women, Infants, and Children. |
| XYZ | Any Named Entity |

# Appendix I –External Quality Review Services Solution Requirements & Requirements Traceability Matrix (RTM)

As a part of this contract, Suppliers will complete the RTM. The RTM is formatted via headings/tabs which reflect the major roles and responsibilities of the Supplier components of the RFP. The RTM will become part of the final contract. For this solicitation, the RTM and required content must be completed for the proposal submission.

The RTM for the External Quality Review Services is provided in a Microsoft Excel file format, and it is included as an attachment to this RFP. Contractors shall complete the Requirements Traceability Matrix (RTM) provided in the Procurement Library and include in Response File # 3– Detailed Description of Proposed Solution(s).

# Appendix J- Contract Template

The Contract Template is provided in a Microsoft Word file format, and it is included as Exhibit J to this RFP in the Procurement Files.

# Appendix K – Enterprise Cloud Oversight Services (ECOS) Questionnaire (Sample)

## Appendix K – Enterprise Cloud Oversight Services (ECOS) Questionnaire (Sample)

The ECOS Questionnaire (Sample) s document is provided in a Microsoft Excel file format, and it is included as Appendix K to this RFP in the Procurement Files.

The Supplier acknowledges that by submitting a response to this RFP, that in the event that VITA determines the Supplier’s solution falls under the Commonwealth’s Enterprise Cloud Oversight Services (ECOS) process, that successful completion of the ECOS assessment process may be a condition of this RFP/contract prior to Supplier passing readiness review. Suppliers should prepare to submit an ECOS assessment and view the sample provided in Exhibit K, while developing proposals. Suppliers should promptly address any questions posed by VITA and the Department. In the event a successful VITA approved ECOS assessment cannot be completed in a reasonable time period prior to award, the Department may disqualify the Supplier from further consideration during the RFP evaluation/negotiations process. The Department may also elect to continue based its discretion and taking into account the Suppliers progress. For more information on the ECOS process, please see the following link: <https://www.vita.virginia.gov/services/catalog-services/enterprise-cloud-oversight-service/>

In the event the Supplier’s Solution is not determined to require an ECOS review, Supplier will still be required to undergo a DMAS-specific security compliance review of similar scope and breadth. The ECOS questionnaire may serve as the foundation for this review.

Similarly, the Cloud-specific terms contained in the Contract Template in Appendix J, will apply to the Supplier in the event the Solution goes through the ECOS process. Such terms may also apply to an externally hosted cloud solution overseen by DMAS. The Supplier’s ability to negotiate terms will be limited those contained in its proposal submission (via the form in Appendix E). All such requested edits to the Cloud-specific terms must be included with the Supplier’s initial proposal by track change redlines and comments in Appendix E. Please note that the terms will be included in the final negotiated contract, if applicable. Only exceptions or recommended language revisions submitted with your proposal will be considered during negotiations. Please note, exceptions or recommended language revisions to the indemnification and liability provisions contained within Appendix J will not be considered at this time. If your firm is selected to go forward into negotiations, you will be required to state any exceptions to any liability provisions contained in the Contract, at that time via email to the procurement officer.

If Supplier believes this section is or may be applicable to the Supplier’s solution, then a response to Appendix K, Attachment 1 should be included in Response File # 6 – Contracts and Appendix E. The response and total Solution proposed will be reviewed by VITA. This review will dictate the cloud terms and requirements in the final contract. Suppliers should price the Solution with the assumption these terms may apply to the Solution. There will be no further evaluation by DMAS after VITA’s review of the response and total Solution.

# Appendix L – Certification Regarding Lobbying

A Certification of Compliance with the Prohibition of Political Contributions and Gifts/Regarding Lobbying during the Procurement Process form is included as Appendix L to this RFP in the Procurement Files and should be completed by the Supplier and returned with the proposal.

# Appendix M – Proprietary/Confidential Information Identification Form

**Proprietary/Confidential Information Identification Form**

Trade secrets or proprietary information submitted by an Supplier shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Supplier must invoke the protections of §2.2-4342F of the *Code of Virginia*, in writing, either before or at the time the data or other material is submitted. The written notice must specifically identify the data or materials to be protected including the section of the proposal in which it is contained and the page numbers, and states the reasons why protection is necessary. The proprietary or trade secret material submitted must be identified by some distinct method such as highlighting or underlining and must include only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. In addition, a summary of such information shall be submitted on this form. The classification of an entire proposal document, line item prices, and/or total proposal prices as proprietary or trade secrets is not acceptable. If, after being given reasonable time, the Supplier refuses to withdraw such a classification designation, the proposal may be scored lower or eliminated from further consideration.

Name of Firm/ Supplier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, invokes the protections of § 2.2-4342F of the *Code of Virginia* for the following portions of my proposal submitted on \_\_\_\_\_\_\_\_\_\_\_\_.

Date

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note to Supplier: You may add rows as needed or change the layout for this page to landscape.*

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| **DATA/MATERIAL**  **TO BE PROTECTED** | **SECTION NO., &**  **PAGE NO.** | **REASON WHY PROTECTION IS**  **NECESSARY** |
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***To Be Completed by Contractor and Returned with Response Files #7.***

# Appendix N- Business Associate Agreement

A Business Associate Agreement (BAA) is required between the Supplier and DMAS prior to executing a final contract. The terms contained in the BAA are, at this time, non-negotiable.

The completed BAA will become an attachment to the Final Contract.