Contract

Between

United States Department of Health and Human Services

Centers for Medicare & Medicaid Services

In Partnership with

The Commonwealth of Virginia

Department of Medical Assistance Services

and

Humana Health Plan, Inc.

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This Contract, made on December 20, 2013, is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the Commonwealth of Virginia, acting by and through the Department of Medical Assistance Services (DMAS) and Humana Health Plan, Inc. (the Contractor). The Contractor's principal place of business is Enter principal place of business.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title IX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

WHEREAS, the Department of Medical Assistance (DMAS) is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and, the Code of Virginia § 32.1-325, et seq., designed to pay for medical, behavioral health, and long term services and supports (LTSS) for eligible beneficiaries;

WHEREAS, the Contractor is in the business of providing medical services, behavioral health services, and LTSS, and CMS and DMAS desire to purchase such services from the Contractor;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

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

Section 1. Definition of Terms

1.1. **Adverse Action** - (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; (iv) or denial in whole or in part of a payment for a covered service for an Enrollee; (v) the failure by the Contractor to render a decision within the required timeframes; or (vi) solely with respect to a MMP that is the only contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Service Area.

1.2. **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.

1.3. **Appeal** - An Enrollee's request for review of an Adverse Action of the Contractor in accordance with Section 2.14 of the Contract

1.4. **Behavioral Health Inpatient Services** - Services provided in a hospital setting to include inpatient medical/surgical/psychiatric.

1.5. **Behavioral Health Outpatient Services** - Services that are provided in the home or community setting and to Enrollees who are able to return home after care without an overnight stay in a hospital or other inpatient facility.

1.6. **Behavioral Health & Substance Abuse Treatment Services** - are defined as inpatient, outpatient and community mental health and rehabilitative services that are covered by the Commonwealth Coordinated Care Program.

1.7. **Capitated Financial Alignment Model ("the Demonstration")** - A model where a state, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.

1.8. **Capitation Payment** - A payment CMS and the State make periodically to a Contractor on behalf of each Enrollee enrolled under a contract for the provision of services within this Demonstration, regardless of whether the Enrollees receives services during the period covered by the payment. Any and all costs incurred by the Contractor in excess of a capitation payment shall be born in full by the Contractor.

1.9. **Capitation Rate** - the sum of the monthly capitation payments for Demonstration Year 1 (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of risk adjustment methodologies as described in Section 4.1.5 and 2) any payment adjustments as a result of the reconciliation described in Section 4.4. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

1.10. **Care Management** - A collaborative, person-centered process that assists Enrollees in gaining access to needed services. Includes assessing and planning of services; linking the Enrollee to services and supports identified in the Plan of Care (POC); working with the Enrollee directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family members involved with the Enrollee; making collateral contacts to promote the implementation of the Plan of Care and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the Enrollee and develops a supportive relationship that promotes the POC.

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

1.12. **Centers for Medicare & Medicaid Services (CMS)** - The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.13. **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.

1.14. **Community Service Board (CSB)/Behavioral Health Authority (BHA)** - A citizens' board established pursuant to Virginia Code §37.2-500 and §37.2-600 that provides mental health, intellectual disabilities and substance abuse 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).

1.15. **Commonwealth Coordinated Care (CCC)** - The program name for the Virginia Capitated Financial Alignment Model.

1.16. **Complaint** - A grievance.

1.17. **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** - Enrollee survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care.

1.18. **Consumer Direction - Consumer-directed (CD) model of services** - means the model of service delivery for which the waiver Enrollee or the Enrollee's employer of record, as appropriate, are responsible for hiring, training, supervising, and firing of the person or persons who actually render the services that are reimbursed by DMAS.

1.19. **Contract** - The participation agreement that CMS and DMAS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

1.20. **Contract Management Team (CMT)** - A group of CMS and DMAS representatives responsible for overseeing the contract management functions outlined in Section 2.2 of the Contract.

1.21. **Contract Operational Start Date** - The first date on which any enrollment into the Contractor's Medicare-Medicaid Plan (MMP) is effective.

1.22. **Contractor** - An entity approved by CMS and DMAS that enters into this Contract with CMS and DMAS in accordance with and to meet the purposes specified in this Contract.

1.23. **Cost Sharing** - Co-payments paid by the Enrollee in order to receive medical services.

1.24. **Covered Services** - The set of services to be offered by the Contractor.

1.25. **Cultural Competence** - Understanding those values, beliefs, and needs that are associated with the Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious background. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for Enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.

1.26. **Department of Medical Assistance Services (DMAS)** - The single state agency for the Medicaid program in Virginia; responsible for implementation and oversight of the Demonstration.

1.27. **Elderly or Disabled with Consumer Direction (EDCD) Waiver** - The CMS-approved §1915(c) waiver that covers a range of community support services offered to Enrollees who are elderly or who have a disability who would otherwise require a nursing facility (NF) level of care.

1.28. **Eligible Beneficiary** - An individual who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and are receiving full Medicaid benefits, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria.

1.29. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

1.30. **Emergency Services** - Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

1.31. **Enrollee** - Any Eligible Beneficiary who is actually enrolled with a Contractor.

1.32. **Enrollee Communications** - Materials designed to communicate plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

1.33. **Enrollee Medical Record** - Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.

1.34. **Enrollees with Special Health Care Needs** - Enrollees who have or are at increased risk to have chronic physical, developmental, or behavioral health condition(s) and require an amount or type of services beyond those typically required for individuals of similar age. These Enrollees may receive these services from an array of public and/or private providers across health, education and social systems of care.

1.35. **Enrollment** - The processes by which an Eligible Beneficiary is enrolled into the Contractor's Medicare-Medicaid Plan.

1.36. **Excluded Parties List System (EPLS)** - The System for Award Management (SAM) 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; OIG sends monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the EPLS. The EPLS does not include any unique identifiers; it provides only the name and address of excluded entities. If EPLS users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.

1.37. **Expedited Appeal** - The accelerated process by which a Contractor must respond to an appeal by an Enrollee if a denial of care decision by a Contractor may jeopardize life, health or ability to attain, maintain or regain maximum function.

1.38. **External Appeal** - An appeal, subsequent to the Contractor appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions or the Medicare process for Medicare-based adverse decisions.

1.39. **External Quality Review Organization (EQRO)** - An independent entity that contracts with the Commonwealth and evaluates the access, timeliness, and quality of care delivered by managed care organizations to their Medicaid Enrollees.

1.40. **Federally-Qualified Health Center (FQHC)** - an entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(1)(2)(B).

1.41. **First Tier, Downstream and Related Entity** - An individual or entity that enters into a written arrangement with the Contractor, acceptable to CMS and DMAS, to provide administrative or health care services of the Contractor under this Contract.

1.42. **Fiscal/Employer Agent** - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 which has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of program Enrollees who are receiving consumer directed services.

1.43. **Flesch-Kincaid Readability Formula** - The formula by which readability of documents is tested as set forth in Rudolf Flesch (1949, as revised 1974) and developed by J. Peter Kincaid (1975).

1.44. **Grievance** - Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Enrollee's rights, as provided for in 42 C.F.R. § 438.400.

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

1.46. **Health Outcomes Survey (HOS)** - Enrollee survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.47. **Health Plan Management System (HPMS)** - A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.48. **Health Risk Assessment (HRA)** - A comprehensive assessment of an Enrollee's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs.

1.49. **Home and Community-Based Services (HCBS) Waiver** - A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (NF) placement.

1.50. **Interdisciplinary Care Team (ICT)** - A team of professionals that collaborate, either in person or through other means, with the Enrollee to develop and implement a Plan of Care that meets their medical, behavioral, long term care and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the Enrollee's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

1.51. **List of Excluded Individuals and Entities (LEIE)** - When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; 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 Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

1.52. **Long Term Services and Supports (LTSS)** - A variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

1.53. **Marketing, Outreach, and Enrollee Communications** - Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 CFR 422.2260.

1.54. **Medicaid Management Information System (MMIS)** - The medical assistance and payment information system of the Virginia Department of Medical Assistance Services.

1.55. **Medically Necessary or Medical Necessity** - Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y. Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an Enrollee's condition consistent with standards of medical practice and in accordance with Medicaid policy (12 VAC 30-130-600). Furthermore, as defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Virginia Medicaid.

1.56. **Medicare-Medicaid Coordination Office** - Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.57. **Medicare-Medicaid Plan (MMP)** - For purposes of this Demonstration, a product offered by the Contractor who has entered into a contract with CMS and DMAS to participate in the CCC.

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

1.59. **Medicare** - Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.60. **Medicare Advantage** - The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.

1.61. **Medicare Waiver** - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.

1.62. **Medicaid Waiver** - Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act.

1.63. **Minimum Data Set (MDS)** - Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for NF residents to return to community settings.

1.64. **Money Follows the Person (MFP)** - Demonstration project designed to create a system of long-term services and supports that better enable individuals to transition from certain LTC institutions into the community. To participate in MFP, individuals must: 1) have lived for at least 90 consecutive days in a NF, an intermediate care facility for persons with mental retardation, a long-stay hospital licensed in Virginia, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof; and 2) move to a qualified community-based residence. Individuals may participate in MFP for up to twelve (12) months. Individuals enrolled in MFP will be excluded from the Demonstration.

1.65. **Ombudsman** – The independent State entity that will provide advocacy and problem-resolution support for CCC participants, and serve as an early and consistent means of identifying systemic problems with the Demonstration.

1.66. **Opt Out** - A process by which an Enrollee can choose not to participate in the Demonstration.

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

1.68. **Passive Enrollment** - An enrollment process through which an eligible individual is enrolled by DMAS (or its authorized agent) into a Contractor's plan, when not otherwise affirmatively electing one, following a minimum 60-day advance notification that includes the opportunity to make another enrollment decision, or opt out of the Demonstration, prior to the effective date.

1.69. **Patient Pay** - When an Enrollee's income exceeds an allowable amount, he or she must contribute toward the cost of their LTC services. This contribution, known as the patient pay amount, is required for Enrollees residing in a NF and for those receiving EDCD Waiver services. Patient pay is required to be calculated for every Enrollee receiving NF or waiver services, although not every eligible Enrollee will end up having to pay each month.

1.70. **Plan of Care (POC) -** A plan, primarily directed by the Enrollee, and family members of the Enrollee as appropriate, with the assistance of the Enrollee's Interdisciplinary Care Team to meet the medical, behavioral, long term care and supports, and social needs of the Enrollee.

1.71. **Post-Stabilization Care Services** - Covered services related to the Enrollee's underlying condition that are provided after an Enrollee's Emergency Medical Condition has been Stabilized and/or under the circumstances described in 42 CFR 438.114(e).

1.72. **Pre-Admission Screening (PAS) -** The process to: (i) evaluate the functional, nursing, and social supports of Enrollees referred for long-term services and supports; (ii) assist Enrollees in determining needed services; (iii) evaluate whether community services are available to meet the Enrollees' needs; and (iv) refer Enrollees to the appropriate provider for Medicaid-funded facility or home- and community-based care.

1.73. **Pre-Admission Screening (PAS) Team** - The entity or entities contracted with DMAS that is responsible for performing Pre-Admission screening pursuant to the Code of Virginia § 32.1-330.

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

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

1.76. **Program of All-Inclusive Care for the Elderly (PACE)** - A capitated benefit for frail elderly authorized by the Balanced Budget Act 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE is a three-way partnership between the Federal government, the Commonwealth of Virginia, and the PACE organization.

1.77. **Provider Appeal (Medicaid Only)** - An appeal to DMAS filed by a service provider that has already provided a Medicaid-based service and has received a denial, in whole or part, regarding payment or authorization for the Medicaid-based service. A service provider must exhaust the Contractor's internal Reconsideration process for providers as a prerequisite to filing an appeal to DMAS. A provider, with written authorization from an Enrollee, may also file an appeal with DMAS on behalf of an Enrollee for a Medicaid-based service that the provider has not yet rendered. A provider must exhaust the Contractor's internal appeal process for Enrollee's as a prerequisite to filing an appeal to DMAS.

1.78. **Provider Contract** - An agreement between a MMP and a provider which describes the conditions under which the provider agrees to furnish covered services to Enrollees under this Contract. All provider contract templates for Medicaid-funded services between the Contractor and a provider must be approved by DMAS.

1.79. **Provider Network** - A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty providers, behavioral health/substance abuse providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor.

1.80. **Provider Preventable Condition** - A condition that (1) meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 C.F.R. 447.26(b); and/or (2)a hospital acquired condition or a condition occurring in any health care setting that has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the beneficiary, and is auditable. DMAS' policy regarding Provider Preventable Conditions is set out in 12 VAC 30-70-201 and 12 VAC 30-70-221.

1.81. **Quality Improvement Organization (QIO)** - As set forth in § 1152 of the Social Security Act and 42 C.F.R. Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.

1.82. **Quality Improvement Strategic Work Plan** - A quality improvement plan designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target providers, the Contractor, and/or Enrollees.

1.83. **Readiness Review** - Prior to entering into a three-way contract with DMAS and CMS, the Contractor will undergo a readiness review. The readiness review will evaluate each Contractor's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare- and Medicaid-covered medically necessary services. CMS and DMAS will use the results to inform their decision of whether the Contractor is ready to participate in the Demonstration. At a minimum, each readiness review will include a desk review and potentially a site visit to the Contractor's headquarters.

1.84. **Reconsideration** - Contractor's internal appeal process for providers.

1.85. **Service Area** - The specific geographic area of Virginia designated in the CMS HPMS, and as referenced in Appendix J, for which the Contractor agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the Contractor.

1.86. **Services Facilitator** - The person who is responsible for supporting the waiver individual and the individual's family/caregiver or Employer of Record (EOR) (person responsible for directing the care of the individual), as appropriate, by ensuring the development and monitoring of the consumer directed services POC, providing employee management training, and completing ongoing review activities as required for consumer directed personal care and respite services.

1.87. **Solvency** - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by DMAS and agreed to by CMS.

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

1.89. **State Fair Hearing** - DMAS' evidentiary hearing process. Medicaid-based adverse actions upheld in whole or in part by the Contractor's appeals process may be appealed by the Enrollee to the Department of Medical Assistance Services' Appeals Division. The Contractor's appeal process is a prerequisite to filing for a State Fair Hearing with the Department of Medical Assistance Services. DMAS conducts evidentiary hearings in accordance with regulations at 42 C.F.R. § 431, Subpart E, 12 VAC30-110-10 through 12VAC 30-110-370, and § 2.2-4027 et seq. of the Virginia Code.

1.90. **Store and Forward** - Used in Telehealth, when pre-recorded images, such as X-rays, video clips and photographs are captured and then forwarded to and retrieved, viewed, and assessed by a provider at a later time. Some common applications include (1) tele-dermatology where digital pictures of a skin problem are transmitted and assessed by a dermatologist; (2) tele-radiology where x-ray images are sent to and read by a radiologist; and, (3) tele-retinal imaging where images are sent to and evaluated by an ophthalmologist to assess for diabetic retinopathy.

1.91. **Targeted Case Management (TCM)** - Medicaid-funded State Plan case management service provided by private providers for Enrollees with substance use disorders or developmental disabilities and by Community Services Boards/Behavioral Health Authorities for Enrollees with behavioral health disorders or intellectual disabilities. TCM encompasses both referral/transition management and clinical services such as monitoring, self-management support, medication review and adjustment. In circumstances where individuals receive TCM services through the Medicaid State Plan, care management provided by the Contactor and TCM provider shall be collaborative with clearly delineated responsibilities and methods of sharing important information between the Contractor and the TCM provider. TCM is separate from "care management" as defined in this Contract; however, the two programs shall work in concert for individuals receiving both services.

1.92. **Telehealth** - The real time or near real time two-way transfer of data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. This is also referred to as telemedicine.

1.93. **Transition Report** - Reports that display service authorizations and claims data for individuals transitioning from fee-for-service to the Commonwealth Coordinated Care (CCC) program and from one CCC MMP to another.

1.94. **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.

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

1.96. **Virginia Uniform Assessment Instrument (UAI)** - The standardized multidimensional questionnaire that is completed by a Pre-Admission Screening Team that assesses an individual's psychosocial, physical health, mental health, and functional abilities to determine if an individual meets level of care criteria for LTSS funded through Medicaid. Please see the definition of the Pre-Admission Screening Team.

1.97. **Vulnerable Subpopulations** - Shall include, at a minimum:

- Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver;
- Individuals with intellectual/developmental disabilities;
- Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury);
- Individuals with physical or sensory disabilities;
- Individuals residing in nursing facilities;
- Individuals with serious and persistent mental illnesses;
- Individuals with end stage renal disease; and
- Individuals with complex or multiple chronic conditions.

Section 2. Contractor Responsibilities

2.1. General

2.1.1. Through the Capitated Financial Alignment Model initiative, CMS and DMAS will work in partnership to offer Eligible Beneficiaries the option of enrolling in a Contractor's participating plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and DMAS Covered Services for Enrollees.

2.1.2. Contractor Requirements for State Operations

2.1.2.1. Licensure

2.1.2.1.1. The Contractor shall obtain and retain at all times during the period of this Contract a valid license issued with Health Maintenance Organization Lines of Authority by the State Corporation Commission and comply with all applicable terms and conditions set forth in the *Code of Virginia* §§ 38.2-4300 through 38.2-4323, 14 VAC 5-210-10 et seq. and any and all other applicable laws of the Commonwealth of Virginia, as amended.

2.1.2.2. Certification

2.1.2.2.1. Pursuant to § 32.1-137.1 through § 32.137.7 *Code of Virginia*, and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner of the Office of Licensure and Certification.

2.1.2.3. Accreditation

2.1.2.3.1. The Contractor must report to DMAS any deficiencies noted by the National Committee for Quality Assurance (NCQA) for any of the Contractor's Medicare and/or Medicaid product lines within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

2.1.2.4. Mergers and Acquisition

2.1.2.4.1. In addition to the requirements at 42 C.F.R. § 422 Subpart L, if the Contractor has NCQA accreditation, the Contractor must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify DMAS and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.) for any of the Contractor's Medicare and/or Medicaid product lines within thirty (30) calendar days.

2.1.3. Compliance and Program Integrity

The Contractor must, to the satisfaction of CMS and DMAS:

2.1.3.1. Comply with all provisions set forth in this Contract.

2.1.3.2. Comply with all applicable provisions of federal and state laws, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that variances from these requirements are provided in the Memorandum of Understanding (MOU) signed by CMS and DMAS for this initiative.

2.1.3.3. Comply with Other Laws. No obligation imposed herein on the Contractor shall relieve the Contractor of any other obligation imposed by law or regulation, including, but not limited to the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by DMAS or CMS. DMAS and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation. DMAS or CMS will inform the Contractor of any such report unless the appropriate agency to which DMAS or CMS has reported requests that DMAS or CMS not inform the Contractor.

2.1.3.4. Comply with all aspects of the joint Readiness Review.

2.1.3.5. Develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. 455. The compliance

program must, at a minimum, include written policies, procedures and standards of conduct that:

2.1.3.5.1. Articulate the Contractor's commitment to comply with all applicable federal and state standards;

2.1.3.5.2. Describe compliance expectations as embodied in the standards of conduct;

2.1.3.5.3. Implement the operation of the compliance program;

2.1.3.5.4. Provide guidance to employees and others on dealing with potential compliance issues;

2.1.3.5.5. Identify how to communicate compliance issues to appropriate compliance personnel;

2.1.3.5.6. Describe how potential compliance issues are investigated and resolved by the Contractor; and

2.1.3.5.7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.

2.1.3.6. Program Integrity (PI). The Contractor must have a comprehensive PI Plan to detect, correct and prevent fraud, waste, and abuse.

2.1.3.6.1. The PI Plan must define how the Contractor will adequately identify and report suspected fraud, waste and abuse by Enrollees, by network providers, by First Tier, Downstream, and Related Entities, and by the Contractor.

2.1.3.6.1.1. The Contractor shall refer Enrollees and Providers of suspected fraud and abuse, to DMAS within forty-eight (48) hours of discovery and before initial investigation.

2.1.3.6.1.2. The Contractor shall establish written policies for all employees of the Contractor and any agent of the Contractor, which provide detailed information about False Claims as required in 42 U.S.C § 1396(a)(68) and the Contractor's policies for detecting and preventing fraud, waste and abuse.

2.1.3.6.1.3. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, VA Code §§ 8.01-216.1 through 8.01-216.19.

2.1.3.6.2. The PI Plan must be submitted to DMAS annually as described in Section 2.1.3.7.

2.1.3.6.3. The Contractor shall have a process for assessment of all claims for fraudulent activity by Enrollees and providers through utilization of computer software or through periodic audits of medical records.

2.1.3.7. Program Integrity Plan

2.1.3.7.1. The Contractor shall submit electronically to DMAS each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report will include the following:

2.1.3.7.1.1. Number of cases by providers and Enrollees investigated with resolution;

2.1.3.7.1.2. Provider/Enrollee name;

2.1.3.7.1.3. Source of complaint;

2.1.3.7.1.4. Type of provider;

2.1.3.7.1.5. Date case was opened;

2.1.3.7.1.6. Reason(s) for initiating case;

2.1.3.7.1.7. Date case was cleared (if applicable);

2.1.3.7.1.8. Findings;

2.1.3.7.1.9. Corrective action taken;

2.1.3.7.1.10. Financial summary; and

2.1.3.7.1.11. Recovery action taken/completed.

2.1.3.7.2. The Contractor shall provide to DMAS, on March 30th of each contract year commencing March 30, 2015, an annual summary of prior year activities and results.

2.1.3.7.3. DMAS shall share fraudulent provider activity with the Contractor on a quarterly basis.

2.1.3.8. Compliance Officer

2.1.3.8.1. The Contractor shall designate a compliance officer, who must meet the requirements at 42 C.F.R. § 422.503(b)(4)(vi)(B), and may also serve as the project manager in accordance with the requirements at 2.2.2.1, and a compliance committee, accountable to senior management, to coordinate with DMAS and CMS on any fraud, waste or abuse case. The Contractor may identify different contacts for Enrollee fraud, waste and abuse, network provider fraud, waste and abuse, First Tier, Downstream and Related Entity fraud, waste and abuse, and Contractor fraud, waste and abuse.

2.1.3.9. Program Integrity Lead

2.1.3.9.1. The Contractor shall designate a PI lead that will represent and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, and pre and post claim edits, prior authorization review, and any other fraud activities and outcomes.

2.1.3.10. Program Integrity Collaborative

2.1.3.10.1. The Contractor must be aware and actively be involved with state, federal, and CMS initiatives of PI.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS and DMAS, or its designee, will conduct a Readiness Review of each Contractor, which must be completed successfully, as determined by CMS and DMAS, prior to the Contract Operational Start Date.

2.2.1.2. CMS and DMAS Readiness Review Responsibilities

2.2.1.2.1. CMS and DMAS or its designee will conduct a Readiness Review of each Contactor that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and enrollment of beneficiaries into the Contractor's MMP. CMS and DMAS or its designee will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.8;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing, in accordance with Section 2.12);

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix D;

2.2.1.2.2.4. Care management capabilities, in accordance with Section 2.6.3;

2.2.1.2.2.5. Content of Provider Contracts, including any Provider Performance Incentives, in accordance with Sections , 2.6.3.2, 5.1.7 and Appendix D;

2.2.1.2.2.6. Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and Utilization Management strategies, in accordance with Section 2.11.5;

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.13 and 2.14;

2.2.1.2.2.9. Fraud and abuse and program integrity policies and procedures, in accordance with Section 2.1.3;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.20;

2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.22, including IT testing and security assurances.

2.2.1.2.3. No individual shall be enrolled into the Contractor's MMP unless and until CMS and the DMAS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.4. CMS and DMAS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.5. CMS or DMAS may, at its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date if the Contractor fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DMAS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DMAS do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DMAS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor must demonstrate to CMS and DMAS's satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DMAS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. Project manager. The Contractor shall employ a qualified individual to serve as the project manager of its Capitated Financial Alignment model. The project manager shall be located in an operations/business office within the Commonwealth of Virginia. The project manager shall be dedicated to the Contractor's program and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program, such as rate negotiations for the MMP program, claims payment, and provider relations/contracting. The project manager shall be able to make decisions about the program and policy issues. The project manager shall act as liaison between the Contractor, CMS, and DMAS, and has responsibilities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the Request for Proposals (RFP) and approved by CMS and DMAS;

2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities, including but not limited to coordinating with the Contractor's quality management director, medical director, and behavioral health clinician;

2.2.2.1.4. Ensure that Enrollees receive written notice of any significant change in the manner in which Covered Services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;

2.2.2.1.5. Receive and respond to all inquiries and requests made by CMS and DMAS in time frames and formats specified by CMS and DMAS;

2.2.2.1.6. Meet with representatives of CMS or DMAS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;

2.2.2.1.7. Ensure the availability to CMS and DMAS, upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, utilization management, Provider Network management, and Benefit Coordination;

2.2.2.1.8. Represent the Contractor at the DMAS and CMS meetings;

2.2.2.1.9. Coordinate requests and activities among the Contractor, all subcontractors, CMS, and DMAS;

2.2.2.1.10. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DMAS; and

2.2.2.1.11. Meet with CMS and DMAS at the time and place requested by CMS and the DMAS if either CMS or DMAS or both, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. On an annual, and ad hoc basis when changes occur, or as directed by DMAS and CMS, the Contractor shall submit to the CMT an overall organizational chart that includes senior and mid-level managers. The Contractor shall describe the interdepartmental structures and processes to support the operation and management of its CCC line of business. For all organizational charts, the Contractor shall indicate any staff vacancies and

provide a timeline for when such vacancies are anticipated to be filled. For all employees, by functional area, the Contractor shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to DMAS upon request.

2.2.3.2. If any Demonstration specific services and activities are provided by a First Tier, Downstream or Related Entity, the Contractor shall submit the organizational chart of the First Tier, Downstream or Related Entity which clearly demonstrates the relationship with the First Tier, Downstream or Related Entity and the Contractor's oversight of the First Tier, Downstream or Related Entity.

2.2.3.3. For MMP key management positions, including but not limited to the Contractor's chief executive officer, if applicable, chief medical officer/medical director, pharmacy director, behavioral health clinical director, director of long term services and supports, ADA compliance director, chief financial officer, chief operating officer, senior manager of clinical services, quality manager, claims director, information technology (IT) director, project manager, and key contact, the Contractor shall immediately notify the CMT whenever the position becomes vacant and notify DMAS when the position is filled and by whom; and

2.2.3.4. The Contractor shall submit to DMAS a listing of its board of directors as of the Contract Operational Start Date and an updated listing of its board of directors whenever any changes are made.

2.3. Eligibility and Enrollment Responsibilities

2.3.1. Eligibility

2.3.1.1. CMS and DMAS shall have sole responsibility for determining the eligibility of an Enrollee for Medicare- and Medicaid- funded services. CMS and DMAS shall have sole responsibility for determining enrollment in the Contractor's MMP.

2.3.2. Eligible Populations

2.3.2.1. The Contractor shall cover all full-benefit Eligible Beneficiaries, including those who are:

2.3.2.1.1. Age 21 and older at the time of enrollment;

2.3.2.1.2. Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits. This includes individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities (NF); and,

2.3.2.1.3. Residing in a CCC area.

2.3.2.2. DMAS shall exclude Enrollees who meet at least one of the exclusion criteria listed below:

2.3.2.2.1. Individuals under age 21.

2.3.2.2.2. Individuals who are required to "spend down" income in order to meet Medicaid eligibility requirements.

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

2.3.2.2.3.1. Qualified Medicare Beneficiaries (QMBs);

2.3.2.2.3.2. Special Low Income Medicare Beneficiaries (SLMBs);

2.3.2.2.3.3. Qualified Disabled Working Individuals (QDWIs); or,

2.3.2.2.3.4. Qualifying Individuals (QIs).

2.3.2.2.3.5. These individuals may receive Medicaid coverage for the following: Medicare monthly premiums for Part A, Part B, or both (carved-out payment); coinsurance, copayment, and deductible for Medicare-allowed services; Medicaid-covered services, including those that are not covered by Medicare.

2.3.2.2.4. Individuals who are inpatients in state mental hospitals, including but not limited to those listed below:

2.3.2.2.4.1. Catawba Hospital,

2.3.2.2.4.2. Central State Hospital,

2.3.2.2.4.3. Eastern State Hospital,

2.3.2.2.4.4. HW Davis Medical Center,

2.3.2.2.4.5. Northern Virginia Mental Health Institution,

2.3.2.2.4.6. Piedmont Geriatric Hospital,

2.3.2.2.4.7. Southern Virginia Mental Health Institution,

2.3.2.2.4.8. Southwestern State HM&S,

2.3.2.2.4.9. Southwestern VA Mental Health Institution

2.3.2.2.4.10. Western State HM&S, and

2.3.2.2.4.11. Western State Hospital

2.3.2.2.5. Individuals who are residents of State Hospitals, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDs), Residential Treatment Facilities, or long stay hospitals. Note that dual eligible individuals residing in NFs will be enrolled in the Demonstration.

2.3.2.2.6. Individuals who are participating in federal home and community based waiver programs other than the EDCD Waiver (e.g., Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology Assisted Waiver, and Alzheimer's Assisted Living waivers).

2.3.2.2.7. Individuals enrolled in a hospice program. Individuals receiving hospice services at the time of enrollment will be excluded from the Demonstration. If an individual enters a hospice program while enrolled in the Demonstration, he/she will be disenrolled from the Demonstration. However, Contractor shall refer these individuals to the EDCD Waiver pre-admission screening team for additional LTSS options.

2.3.2.2.8. Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration. However, an Enrollee who develops ESRD while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out. If he/she opts out, the Enrollee cannot opt back into the Demonstration.

2.3.2.2.9. Individuals with other comprehensive group or individual health insurance coverage, other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).

2.3.2.2.10. Individuals who have a Medicaid eligibility period that is less than three months.

2.3.2.2.11. Individuals who have a Medicaid eligibility period that is only retroactive.

2.3.2.2.12. Individuals enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

2.3.2.2.13. Individuals enrolled in the Money Follows the Person (MFP) Program.

2.3.2.2.14. Individuals residing outside of the Demonstration areas.

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

2.3.2.2.16. Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH participants may enroll in the Demonstration if they choose to disenroll from IAH.

2.3.2.3. MMP Enrollees that subsequently meets one or more of these criteria during enrollment shall be excluded from MMP participation as appropriate.

2.3.3. General Enrollment

2.3.3.1. DMAS will begin opt-in Enrollment prior to the initiation of Passive Enrollment. During this period, Eligible Beneficiaries may choose to enroll into a particular MMP. Eligible Beneficiaries who do not select a MMP or who do not opt out of the Demonstration will be assigned to a MMP during Passive Enrollment.

2.3.3.1.1. Phase I (Central Virginia and Tidewater): The first effective Enrollment date for this initial opt-in period is scheduled for no earlier than April 1, 2014.

2.3.3.1.2. Phase II (Western/Charlottesville, Northern Virginia, and Roanoke): The first effective Enrollment date for this initial opt-in period is scheduled for no earlier than June 1, 2014.

2.3.3.2. Enrollments received up to five (5) days before the end of the month will be effective on the first calendar day of the following month, The Contractor is responsible for providing and paying for Covered Services as of the effective Enrollment date of each Enrollee, even if the Contractor is not notified of an Enrollee's Enrollment into Contractor's MMP until after such Enrollee's effective Enrollment date.

2.3.3.2.1. Enrollment requests, including requests to change among MMPs, received the last five (5) days before the end of the month will be effectuated the first of the second month following the request.

2.3.3.3. DMAS may conduct Passive Enrollment during the term of the Contract to assign Eligible Beneficiaries who do not select a MMP, Opt Out of the Demonstration or are newly eligible.

2.3.3.3.1. For Phase I (Central Virginia and Tidewater), Passive Enrollment to the Contractor will begin no sooner than July 1, 2014, and DMAS will provide notice of Passive Enrollments at least sixty (60) days prior to the effective dates to Eligible Beneficiaries, and will accept Opt- Out requests prior to the effective date of Enrollment.

2.3.3.3.2. For Phase II (Western/Charlottesville, Northern Virginia, and Roanoke), Passive Enrollment to the Contractor will begin no sooner than October 1, 2014, and DMAS will provide notice of Passive Enrollments at least sixty (60) days prior to the effective dates to Eligible Beneficiaries, and will accept Opt- Out requests prior to the effective date of Enrollment.

2.3.3.3.3. DMAS will apply the following intelligent methodology to assign Eligible Beneficiaries to a MMP.

2.3.3.3.3.1. The intelligent assignment algorithm will consider Enrollees' previous Medicare managed care Enrollment and historic utilization of certain provider types. At a minimum, Enrollees will be pre-assigned with the following considerations in the following order of priority: 1) Enrollees in a NF will be pre-assigned to a MMP that includes the Enrollee's NF in its network; 2) Enrollees in the EDCD Waiver will be assigned to a MMP that includes the Enrollee's current adult day health care provider in its network; 3) if more than one MMP's network includes the NF or adult day health provider used by an Enrollee, he/she will be assigned to the MMP with which they have previously been assigned in the past six (6) months. If they have no history of previous MMP assignment, he/she will be assigned to a MMP in which their NF or ADHC provider participates; 4) Enrollees will be pre-assigned to a MMP (searching for Medicare) with whom they have previously been assigned within the past six (6) months. After initial start date, the intelligent assignment will look for the Enrollee's previous MMP.

2.3.3.3.4. CMS and DMAS may stop Passive Enrollment to a Contractor if the Contractor does not meet reporting requirements necessary to maintain Passive Enrollment as set forth by CMS and DMAS.

2.3.3.3.5. Enrollments and disenrollments will be processed through DMAS or its authorized agent. DMAS or its authorized agent will then submit Passive Enrollment transactions sixty (60) days in advance of the effective date, to the CMS Medicare Advantage Prescription Drug (MARx) enrollment system directly or via a third-party CMS designates to receive such transactions, and DMAS or its authorized agent will receive notification on the next daily transaction reply report. The Contractor will then receive enrollment transactions through DMAS or its authorized agent. The Contractor will also use the third-party CMS designates to submit additional Enrollment-related information to MARx, and receive files from CMS.

2.3.3.3.6. The Contractor must have a mechanism for receiving timely information about all Enrollments in the Contractor's MMP, including the effective Enrollment date, from CMS and DMAS systems.

2.3.3.3.7. The Contractor shall accept for Enrollment all Eligible Beneficiaries, as described in Section 3.2. The Contractor shall accept for Enrollment all Eligible Beneficiaries identified by DMAS at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

2.3.3.3.8. Upon instruction by DMAS, its authorized agent may not provide new Enrollments within six (6) months (or less) of the end date of the Demonstration, unless the Demonstration is renewed or extended.

2.3.3.3.9. DMAS and CMS will monitor Enrollments and Passive Enrollment auto-assignments to all MMPs and may make adjustments to the volume and spacing of Passive Enrollment periods based on the capacity of the Contractor, and of MMPs in aggregate, to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the Contractor will be subject to any capacity determinations, including but not limited to, those documented in the CMS and DMAS final readiness review report and ongoing monitoring by CMS and DMAS.

2.3.4. Enrollee Materials

2.3.4.1. For Passive Enrollments, the Contractor shall send the following materials thirty (30) days prior to the Enrollee's effective date of coverage:

2.3.4.1.1. An MMP-specific Summary of Benefits for those offered Passive Enrollment (this document is not required for opt-in enrollments). Providing the Summary of Benefits, which is considered marketing material normally provided prior to the individual making an Enrollment request, ensures that those who are offered Passive Enrollment have a similar scope of information as those who opt-in.

2.3.4.1.2. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the MMP.

2.3.4.1.3. A combined provider and pharmacy directory that includes providers of all Demonstration-covered services.

2.3.4.1.4. Proof of health insurance coverage so that the Enrollee may begin using MMP services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

2.3.4.1.4.1. NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the State-specific Demonstration marketing guidelines. The proof of coverage may be in the form of an Enrollee ID card, the Enrollment form, and/or a notice to the Enrollee. As of the effective date of Enrollment, the Contractor's systems should indicate active membership.

2.3.4.2. For Passive Enrollment, the MMP must send the following no later than the last calendar day of the month prior to the effective date of coverage:

2.3.4.2.1. A single ID card for accessing all covered services under the MMP.

2.3.4.2.2. An enrollee handbook (evidence of coverage) to ensure that the individual has sufficient information about MMP benefits to make an informed decision prior to the enrollment effective date.

2.3.4.3. For the individuals who opt into the Demonstration, the Contractor shall provide the following materials no later than ten (10) calendar days from receipt of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:

2.3.4.3.1. A comprehensive integrated formulary

2.3.4.3.2. A combined provider and pharmacy directory

2.3.4.3.3. A single ID card

2.3.4.3.4. An enrollee handbook (evidence of coverage)

2.3.4.3.5. NOTE: For opt-in Enrollment requests received late in the month, see §30.4.2 of the enrollment guidance (After the effective date of Enrollment) for more information.

2.3.4.4. For all Enrollments, regardless of how the Enrollment request is made, the Contractor must explain:

2.3.4.4.1. The charges for which the prospective Enrollee will be liable (e.g., coinsurance for Medicaid benefits in MMP, if applicable; LIS copayments for Part D covered drugs), if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).

2.3.4.4.2. The prospective Enrollee's authorization for the disclosure and exchange of necessary information between the Contractor, state, and CMS.

2.3.4.4.3. The requirements for use of the Contractor's network providers. The state, or Contractor as appropriate, must also obtain an acknowledgment by the individual that he/she understands that care will be received through designated providers except for emergency services and urgently needed care. For individuals enrolled through Passive Enrollment, taking no action to decline Passive Enrollment, is considered to be the required acknowledgement. The potential for financial liability if it is found that the individual is not entitled to Medicare Part A and Part B and enrolled in Medicaid at the time coverage begins and he/she has used plan services after the effective date.

2.3.4.4.4. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the Contractor has not yet provided the ID card).

2.3.4.5. After the Effective Date of Enrollment

2.3.4.5.1. CMS recognizes that in some instances the DMAS (or its authorized agent, if DMAS delegates any notifications to the authorized agent) will be unable to provide the materials and required notifications to new Enrollees prior to the effective date, as required in §30.4.1 of the Enrollment guidance. These cases will generally occur when an opt-in Enrollment request is received late in a month with an effective date of the first of the next month. In these cases, DMAS or its authorized agent still must provide the Enrollee all materials described in §30.4.1 of the Enrollment guidance no later than 10 calendar days after receipt of the completed Enrollment request. Additionally, the Contractor is also strongly encouraged to call these new Enrollees as soon as possible (within 3 calendar days) to provide the effective date, the information necessary to access benefits and to explain the MMP rules. The Enrollee's coverage will be active on the effective date regardless of whether or not the Enrollee has received all the information by the effective date. It is expected that all of the items outlined in §30.4.1 of the Enrollment guidance will be sent prior to the effective date for Passive Enrollment.

2.3.5. Disenrollment

2.3.5.1. The Contractor shall:

2.3.5.1.1. Have a mechanism for receiving timely information about all disenrollments from the MMP, including the effective date of disenrollment, from CMS and DMAS or its authorized agent. All disenrollment-related transactions will be performed by the DMAS or its authorized agent. Enrollees can elect to disenroll from the MMP or the Demonstration at any time and enroll in another MMP, a Medicare Advantage plan, PACE; or may elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with the Virginia Medicaid State Plan and any waiver programs (if eligible). Disenrollments received by DMAS or its authorized agent, or by CMS or its contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.5.1.2. Be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.5.1.3. Notify DMAS or its authorized agent of any individual who is no longer eligible to remain enrolled in the MMP per CMS Enrollment guidance, in order for DMAS or its authorized agent to disenroll the Enrollee. This includes where an Enrollee remains out of the Service Area or for whom residence in the MMP Service Area cannot be confirmed for more than six consecutive months.

2.3.5.1.4. Not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status, unless they enter a hospice program, or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation, to the CMT to disenroll an Enrollee, for cause, for the following reason:

2.3.5.1.4.1. The Enrollee's continued Enrollment seriously impairs the Contractor's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

2.3.5.1.4.2. DMAS and CMS through the CMT will determine when and if the Contractor's request to terminate the Enrollment of an Enrollee will be granted based on the criteria in Section 2.3.5.1.4 above. DMAS and CMS will develop a process to evaluate disenrollment requests for Enrollees whose continued Enrollment seriously impairs the Contractor's ability to furnish services to this Enrollee or other Enrollees. If DMAS and CMS determine that the Contractor too frequently requests termination of Enrollment for Enrollees, DMAS and CMS reserve the right to deny such requests and require the Contractor to initiate steps to improve the Contractor's ability to serve such Enrollees.

2.3.5.2. To support DMAS' and CMS' evaluation of a Contractor's requests for involuntary disenrollment, the Contractor shall:

2.3.5.2.1. In all cases, document what steps the Contractor has taken to locate and engage the Enrollee, and the impact of or response to each attempt;

2.3.5.2.2. Provide a monthly report to the CMT of all Enrollees who have not participated in either the Health Risk Assessment (HRA) or the care planning process or both, and whether this is because the Contractor could not locate or engage the Enrollee, because the Enrollee declined, or for another reason;

2.3.5.2.3. Transfer Enrollee medical record information promptly to the new MMP or DMAS fee-for-service contractor or provider as appropriate upon disenrollment of the Enrollee from the Demonstration or at the Enrollee's request to transfer to another MMP in accordance with 2.7.5.3; and

2.3.5.2.4. Notify DMAS if the Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

2.3.6. Initial Enrollee Contact and Orientation

2.3.6.1. Provide an orientation, to Enrollees, within thirty (30) calendar days of the initial date of Enrollment. The orientation shall include:

2.3.6.1.1. Materials and a welcome call;

2.3.6.1.2. For Enrollees without a current primary care provider (PCP) identified at the time of Enrollment, assisting the Enrollee to identify and if desired retain their current PCP or choose a PCP.

2.3.6.1.3. The Contractor may assign an in-network PCP at Enrollment if the Enrollee's PCP is not included in the Provider Network. The Enrollee may continue to see the out-of-network PCP during the 180 day continuity of care period, regardless of Contractor assignment of PCP. The Enrollee must be clearly informed of this right during the welcome call.

2.3.6.1.4. Working with the Enrollee to schedule a HRA (see Section 2.7); and

2.3.6.1.5. Any pre-enrollment materials specified in Section 2.19 that, due to a late month Enrollment request, were not provided prior to the time of Enrollment.

2.3.6.2. For Enrollees with a current PCP that is not in-network and refuses to become a network provider or enter into a single-case out-of-network agreement where applicable (see Section 2.8.1.12), assist the Enrollee to choose a PCP if he or she does not want to utilize the PCP assigned during Enrollment.

2.3.6.3. Make available to family members, caregivers, and designated representatives, as appropriate, any Enrollment and orientation materials upon request and with consent of the Enrollee;

2.3.6.4. For Enrollees for whom written materials are not appropriate, provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations;

2.3.6.5. Notify its Enrollees:

2.3.6.5.1. That translations of written information are available in Prevalent Languages;

2.3.6.5.2. That oral interpretation services are available for any language spoken by Enrollees and Eligible Beneficiaries free of charge;

2.3.6.5.3. How Enrollees can access oral interpretation services;

2.3.6.5.4. How Enrollees can access non-written materials described in Section 2.3.6.4 above; and

2.3.6.5.5. How Enrollees can make a standing request to receive all future notifications and communication in a specified Alternate Format.

2.3.6.6. Ensure that all orientation materials are provided in a manner and format that may be easily understood, including providing written materials in Prevalent Languages and oral interpretation services when requested.

2.3.6.7. The Contractor shall ensure that documents for its Enrollees, such as the Enrollee handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it achieves at or below a 6th grade reading level using the Flesch-Kincaid Readability Formula. The document must set forth the Flesch-Kincaid reading level and certify compliance with this standard. (These requirements shall not apply to language that is mandated by federal or state laws, regulations or agencies.) Additionally, the Contractor shall ensure that written Enrollee material is available in Alternate Formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited.

2.3.6.8. The Contractor must make available Enrollee handbooks in languages other than English when five (5) percent of the Contractor's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by CCC regions and will only affect handbooks distributed in the affected region.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services will be managed and coordinated by the Contractor through the Interdisciplinary Care Team (ICT) (see Section 2.6.2).

2.4.2. The Contractor will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's POC, as appropriate to address the Enrollee's needs.

2.4.3. The Contractor may use and reimburse for Telehealth for Medicare and Medicaid services as an innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions. The Contractor shall also encourage the use of Telehealth to promote community living and improve access to behavioral health services.

2.4.3.1. The Contractor may use Telehealth in both rural and urban settings. Requests for consultation and/or follow up visits will be generated by the primary care provider or hospital provider of record. The decision to participate in a telemedicine encounter will be at the discretion of the Enrollee and/or their authorized representative(s), for which informed consent must be provided, and all Telehealth activities shall be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS program requirements as defined in Appendix B. Covered services include:

2.4.3.1.1. Store and Forward Applications: The Contractor may also reimburse for Store and Forward Applications, including:

2.4.3.1.1.1. Tele-dermatology

2.4.3.1.1.2. Tele-radiology

2.4.3.1.1.3. Tele-retinal imaging to assess for diabetic retinopathy

2.4.3.1.2. Remote Patient Monitoring: The Contractor may also have the ability to cover remote patient monitoring, especially for Enrollees with one or more chronic conditions, such as congestive heart failure, cardiac arrhythmias, diabetes, pulmonary diseases or the need for anticoagulation. Examples of remote patient monitoring activities include transferring vital signs such as weight, blood pressure, blood sugar, and heart rate.

2.4.3.1.3. Specialty Consultative Services: The Contractor may also have the ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the Enrollee's primary care physician.

2.4.3.2. Telehealth Providers and Settings

2.4.3.2.1. The following Providers may utilize covered Telehealth services: physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors, licensed marriage and family counselors, and licensed substance abuse practitioners.

2.4.3.2.2. Telehealth may also be used in home based settings for individuals receiving hospice care or home dialysis and who are determined to be homebound (as defined for purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A)(i))

2.4.3.2.3. In addition the above Provider types, covered Telehealth services may be provided at the following sites: office of licensed independent practitioners including dentists, rural health clinics, federally qualified health centers, critical access hospitals, hospitals, nursing facilities, certified outpatient rehabilitation facilities, freestanding dialysis facilities, health department clinics, and community service boards and mental health clinics.

2.4.4. Under the Demonstration, skilled nursing level of care may be provided in a long term care facility without a preceding acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.

2.4.5. The Contractor must provide the full range of Covered Services. If either Medicare or Virginia Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program. The Contractor may not limit or deny services to Enrollees based on Medicare or Virginia Medicaid providing a more limited range of services than the other program.

2.5. Excluded Services

2.5.1. The following services will be carved out from this Contract and will be provided in fee-for-service as described below.

2.5.1.1. Targeted Case Management Services (TCM), and

2.5.1.2. Dental services not otherwise listed below. The Contractor will be responsible for medically necessary procedures, including but not limited to, the following:

2.5.1.2.1. CPT codes billed for dental services performed as a result of a dental accident;

2.5.1.2.2. Medically necessary procedures, including but not limited to: preparation of the mouth for radiation therapy, maxillary or mandibular frenectomy when not related to a dental procedure, orthognathic surgery to attain functional capacity, and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.

2.5.1.2.3. The Contractor must cover anesthesia and hospitalization for medically necessary dental services.

2.5.1.2.4. At their option, the Contractor may cover additional certain dental services for Enrollees.

2.5.1.3. Case management services for participants of auxiliary grants (although not widely used (this service is included as part of the annual reassessment screening process for assisted living recipients), this service will be provided under fee-for-service).

2.6. Care Delivery Model

2.6.1. Primary Care

2.6.1.1. The PCP must:

2.6.1.1.1. Provide primary medical services, including acute and preventive care;

2.6.1.1.2. Manage, in coordination with the ICT, an Enrollee's medical situations;

2.6.1.1.3. Oversee, in coordination with the ICT, an Enrollee's use of specialists and inpatient care; and,

2.6.1.1.4. Refer the Enrollee, in coordination with the ICT and in accordance with the Contractor's policies, to network providers, as medically appropriate.

2.6.2. Interdisciplinary Care Team (ICT)

2.6.2.1. The Contractor shall arrange for each Enrollee, in a manner that respects the needs and preferences of the Enrollee, the formation and operation of an ICT. The Contractor shall ensure that each Enrollee's care (e.g., medical, behavioral health, substance use, LTSS and social needs) is integrated and coordinated within the framework of an ICT and that each ICT member has a defined role appropriate to his/her licensure and relationship with the Enrollee. The Enrollee shall be encouraged to identify individuals that he/she would like to participate on the ICT. The

ICT will be person-centered, built on the Enrollee's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.6.2.2. The ICT shall consist of the Enrollee and/or their authorized representative and at least the following staff:

2.6.2.2.1. PCP;

2.6.2.2.2. Behavioral health clinician, if indicated;

2.6.2.2.3. Care manager;

2.6.2.2.4. LTSS provider, if indicated;

2.6.2.2.5. Targeted case manager, if applicable (if an Enrollee is receiving TCM services, the Contractor shall include the targeted case manager as a member of the Enrollee's ICT);

2.6.2.2.6. Pharmacist, if indicated;

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

2.6.2.3.1. Registered Nurse;

2.6.2.3.2. Specialist clinician;

2.6.2.3.3. Other professional and support disciplines, including social workers, community health workers, and qualified peers;

2.6.2.3.4. Family members;

2.6.2.3.5. Other informal caregivers;

2.6.2.3.6. Advocates; and,

2.6.2.3.7. State agency or other case managers.

2.6.2.4. The Contractor shall:

2.6.2.4.1. Recruit, select, train, manage, and employ or contract with appropriate and qualified personnel, including PCPs, behavioral health clinicians, care managers, and LTSS providers, and will maintain staffing levels necessary to perform its responsibilities under the Contract;

2.6.2.4.2. Document that all members of the ICT outlined in 2.6.2.2. have participated in required training (initially and on an annual basis) on the person-centered process planning processes, cultural competence, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training, as specified by DMAS and CMS; and,

2.6.2.4.3. Ensure that the ICT is accessible to the Enrollee, including by providing alternatives to office visits, including, as appropriate, home visits, e-mail and telephone contact.

2.6.2.4.4. Have a mechanism to identify Enrollees that meet the state criteria for Enrollees with Special Health Care Needs, and have policies and procedures for granting these identified individuals direct access to a specialist.

2.6.2.5. The ICT shall:

2.6.2.5.1. Be led by a care manager, or designee appointed by the care manager as necessary to cover in their absence.

2.6.2.5.2. Participate, as appropriate, in HRAs and reassessments.

2.6.2.5.3. With the Enrollee and/or Enrollee's designated representative, if any, and with all the appropriate ICT members, including the Enrollee, develop a POC, that includes treatment goals (medical, functional, and social) and measure progress and success in meeting those goals (see Section 2.7.4).

2.6.2.5.4. On an ongoing basis, coordinate, consult with and advise acute, specialty, LTSS, and behavioral health providers about care plans and clinically appropriate interventions;

2.6.2.5.5. Promote independent functioning of the Enrollee and providing services in the most appropriate, least restrictive environment;

2.6.2.5.6. Document and comply with advance directives about the Enrollee's wishes for future treatment and health care decisions;

2.6.2.5.7. Maintain the Enrollee Medical Record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee.

2.6.2.5.8. Communicate with other ICT members regarding the medical, functional, and psychosocial condition of Enrollees.

2.6.2.5.9. Communicate with the Enrollee and, in accordance with the Enrollee's preferences, the Enrollee's family members and caregiver(s), if any, about the Enrollee's medical, social, and psychological needs on a monthly basis to include a phone call or face-to-face meeting, depending upon the Enrollee's needs and preferences.

2.6.2.5.10. Document changes in the Enrollees' condition(s) in the Enrollee's Medical Record consistent with documentation polices established by the Contractor.

2.6.3. Care Management

2.6.3.1. The Contractor shall offer person-centered care management functions to all Enrollees. All Enrollees shall have access to the following supports depending on their needs and preferences; however, care management for Vulnerable Subpopulations must include:

2.6.3.1.1. A single, toll-free point of contact for all questions;

2.6.3.1.2. Ability to develop, maintain and monitor the POC;

2.6.3.1.3. Timely appointments for all referred services;

2.6.3.1.4. Communication and education regarding available services and community resources;

2.6.3.1.5. Assistance developing self-management skills to effectively access and use services.

2.6.3.1.6. Assurance that Enrollees receive needed medical and behavioral health services, preventative services, medications, LTSS, social services and enhanced benefits; this includes setting up appointments, in-person contacts as appropriate, strong working relationships between care managers and physicians; evidence-based Enrollee education programs, and arranging transportation as needed;

2.6.3.1.7. Monitoring of functional and health status;

2.6.3.1.8. Seamless transitions of care across specialties and settings;

2.6.3.1.9. Assurance that Enrollees with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options;

2.6.3.1.10. Connecting Enrollees to services that promote community living and help avoid premature or unnecessary NF placements;

2.6.3.1.11. Coordinating with social service agencies (e.g. local departments of health, social services, and Community Services Boards (CSBs)/Behavioral Health Authorities (BHA)) and refer Enrollees to state, local, and other community resources; and,

2.6.3.1.12. Working with NFs to promote adoption of evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services beyond the scope of the NF benefit.

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

2.6.3.2. The Contractor shall coordinate with entities that currently perform case management (i.e. CSBs). The Contractor shall contract with entities that offer support services to Enrollees in the Demonstration.

2.6.3.2.1. These partnerships/contracts may include the use of medical homes sub-capitation, shared savings, and performance incentives.

2.6.3.2.2. Entities can include, but are not limited to adult day care centers, and nursing facilities.

2.6.3.2.3. The Contractor must also demonstrate coordination with existing care management services to avoid duplication.

2.6.3.3. Contractor shall contract with behavioral health homes (BHHs) appropriate for Enrollees with serious and persistent mental illness (SPMI) using CSBs/BHAs as BHHs in collaboration with the Contractor if the Enrollee chooses a BHH. The BHHs shall collectively serve as a comprehensive behavioral health management program that integrates physical and behavioral health services and that has the staff and resources to improve health care delivery, including the ability to rapidly respond to acute episodes for Enrollees with severe mental illnesses.

2.6.3.4. Eligible Beneficiaries with intellectual or developmental disabilities that live in nursing facilities may enroll in the Contractor's MMP. For these

individuals, the Contractor's ICT will work with the CSBs and the Department of Behavioral Health and Developmental Services to successfully transition the Enrollee into the community if appropriate. If the Enrollee transitions into the Intellectual Disability (ID) or Individual and Family Developmental Disability Support (DD) Waivers, the Enrollee will be disenrolled from the Demonstration. If the Enrollee transitions to the EDCD Waiver, the Enrollee will remain in the Demonstration. The Enrollee CSB case manager shall participate as a part of the Contractor's ICT to monitor their service needs.

2.6.4. Care manager Roles and Responsibilities

2.6.4.1. The Contractor must establish its own written qualifications for a care manager that at a minimum meet the qualifications listed below. The Contractor is responsible for the appropriate training for the care manager and verifying that training or any certifications remain current. The Contractor must have policies in place to address non-compliance with training by care managers. The Contractor's care managers' caseload requirements and staffing ratios must be appropriate for the needs of the population as reflected in Contractor's policies and procedures and are subject to DMAS and CMS approval.

2.6.4.2. The care manager must:

2.6.4.2.1. Act as the single point of contact for an Enrollee to the Contractor and the ICT, however, other organizational staff is available for the member;

2.6.4.2.2. At a minimum, have a bachelor's degree or be a Registered Nurse (RN), licensed in Virginia with at least one year of experience working as a RN. The care manager must have demonstrated ability to communicate with Enrollees who have complex medical needs and may have communication barriers. The care managers also must have experience navigating resources and computer systems to access information.

2.6.4.3. As a leader of the ICT, execute the following responsibilities:

2.6.4.3.1. Participating in HRA for care planning;

2.6.4.3.2. Ensuring that ICT meetings and conference calls are held periodically;

2.6.4.3.3. Monitoring the provision of services, including outcomes, assessing appropriate changes or additions to services, and making necessary referrals, as needed for the Enrollee; and

2.6.4.3.4. Ensuring that appropriate mechanisms are in place to receive Enrollee input, complaints and grievances, and secure communication among relevant parties.

2.6.5. Consumer Direction

2.6.5.1. EDCD Waiver Enrollees shall be offered choice of a consumer directed model when the need for personal or respite care is identified.

2.6.5.2. Contract with Fiscal/Employer Agent (F/EA)

2.6.5.2.1. The Contractor shall contract with DMAS' designated Fiscal/Employer Agent (F/EA) to provide the following services to EDCD Waiver Enrollees who choose consumer direction of eligible waiver services:

2.6.5.2.1.1. Criminal background checks for consumer directed employees, with appropriate follow-up and communication to appropriate individuals; and

2.6.5.2.1.2. Payroll expenses for authorized hours actually worked by consumer directed employees, inclusive of employer share of state and federal taxes net Patient Pay.

2.6.5.2.2. The F/EA withholds Patient Pay amounts from employees' checks. The Contractor's payments for payroll to the F/EA shall reflect (be net of) the Patient Pay amount.

2.6.5.2.2.1. The Contractor shall not be liable for any failure, error, or omission by the F/EA related to the F/EA's verification of worker qualifications.

2.6.5.2.2.2. DMAS shall pay the F/EA the administrative fees specified in the contract between DMAS and the F/EA. The contract between DMAS and the F/EA outlines the responsibilities of the F/EA reimbursed by DMAS.

2.6.5.2.3. Claims Submission and Payment

2.6.5.2.3.1. The Contractor shall provide payment to the F/EA for authorized eligible EDCD Waiver services provided by consumer-directed employees at the DMAS rate for the consumer-directed services, which includes applicable payroll taxes.

2.6.5.2.3.2. The Contractor shall process and pay claims in accordance with the contract between the F/EA and the Contractor. Regardless of how the Contractor pays the F/EA, the payment cycle for payroll, including pay dates, shall be the same as DMAS implements for its FFS population. The Contractor shall have the ability to provide, via electronic interface with the F/EA, eligibility information and service authorizations in a manner and format acceptable to the F/EA and DMAS.

2.6.5.2.3.3. The Contractor shall establish a process that allows for the efficient exchange of all relevant Enrollee information between the Contractor and the F/EA, including but not limited to eligibility, Patient Pay obligation and frequency of Patient Pay withholding and service authorization status in a file format acceptable to the F/EA.

2.6.5.2.3.4. The Contractor shall develop and forward to the F/EA a new authorization for consumer directed services when the following occur: a change in the number of service units, or the frequency or duration of service delivery, including the provision of a new service through consumer direction or termination of a service through consumer direction.

2.6.5.2.4. Payroll Reconciliation: The Contractor's contract with the F/EA shall include:

2.6.5.2.4.1. A process to reconcile both estimated with actual payroll and tax expenses as well as actual payroll expenditures to amounts billed (actual pay rates and taxes compared to billable rates). The reconciliation process will provide financial controls and enable accurate and timely adjustments and refunds i.e. amounts due to/from the F/EA and Contractor for overpaid employer taxes, employee FICA refunds, unclaimed property, bank and tax penalties and interest incurred on the F/EA payroll bank account and tax filings; and other needed adjustments as specified in the F/EA contract with DMAS). This process must be developed and implemented in accordance with the Contractor's contract with the F/EA.

2.6.5.2.4.2. A system, policies and procedures, timelines, and internal controls for investigation and resolution of uncashed or cancelled (voided) checks as required by §55-210.1 - §55-210.30 of the *Code of Virginia*.

2.6.5.2.4.3. A process for notifying Contractor staff, EDCD Waiver Enrollees, and Services Facilitators of issues related to consumer-directed employee qualifications, including, background checks on consumer-directed employees and outlining appropriate follow-up regarding findings, as appropriate;

2.6.5.2.4.4. The Contractor shall provide education and training to the F/EA and its staff and subcontracted Services Facilitators (as applicable) regarding key requirements of this Contract and the contract between the Contractor and the F/EA.

2.6.5.2.4.5. The Contractor shall conduct initial education and training to the F/EA and its staff at least thirty (30) days prior to implementation of CCC regions covered by this Contract. This education and training shall include, but not be limited to, the following:

2.6.5.2.4.5.1. The role and responsibilities of the care manager, including as it relates to Enrollees electing to participate in consumer direction;

2.6.5.2.4.5.2. The F/EA's responsibilities for communicating with the Contractor, Enrollees, representatives, consumer-directed employees and DMAS, and the process by which to do this;

2.6.5.2.4.5.3. Customer service requirements;

2.6.5.2.4.5.4. The F/EA's role and responsibility in implementing the Contractor's PI plan described in 2.1.3.6;

2.6.5.2.4.5.5. The Contractor's Enrollee complaint and appeal processes.

2.6.5.2.4.5.6. The Contractor shall provide ongoing F/EA education, training and technical assistance as deemed necessary by the Contractor or DMAS in order to ensure compliance with this Contract between the Contractor and the F/EA.

2.6.5.3 The Contractor shall provide to DMAS a monthly report, in an electronic format acceptable to DMAS, which includes Enrollee level data of monthly consumer-directed payroll activity. The payroll report must be submitted by the 15th day of the month following the report month. DMAS will identify and notify the Contractor of the required data elements.

2.6.6. Health Promotion and Wellness Activities

2.6.6.1. The Contractor must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behaviors in the Medicare-Medicaid population. Interpreter services must be available for Enrollees who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to the following:

2.6.6.1.1. Chronic condition self-management;

2.6.6.1.2. Smoking cessation;

2.6.6.1.3. Nutrition; and,

2.6.6.1.4. Prevention and treatment of alcohol and substance abuse.

2.6.6.2. On an annual basis, the Contractor shall provide DMAS with a report summarizing all health promotion and wellness and Enrollee incentive programs used by the Contractor to encourage active Enrollee participation in health and wellness activities to both improve Enrollee health and control costs.

2.7. Health Risk Assessments and Plans of Care

2.7.1. Identification Strategy

2.7.1.1. The Contractor shall develop and implement an identification strategy that uses a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information as appropriate, that will consider medical, behavioral health, substance use, and LTSS needs. Criteria and thresholds must be established by the Contractor and must be used to prioritize the timeframe by which Enrollees will receive timely HRAs in accordance with the requirements outlined below.

2.7.2. Health Risk Assessment

2.7.2.1. The Contractor shall provide each Enrollee with a timely HRA (see 0) completed by the Contractor's Care Management team. All HRA tools must be approved by DMAS prior to use and conducted in a location that meets the needs of the Enrollee. HRAs will encompass social, functional, medical, behavioral, cognitive, LTSS, wellness and prevention domains, as well as the Enrollees' strengths and goals, need for any specialists and the plan for Care Management and coordination. Each element of the HRA, including a description of the LTSS and other covered services to be provided until the next POC review, will be reflected in the Individualized

POC, and the ICT will ensure that all relevant aspects of the Enrollee's care are addressed in a fully integrated manner on an ongoing basis.

2.7.2.2. Relevant and comprehensive data sources, including the Enrollee, providers, family/caregivers, etc., shall be used by the Contractor. Results of the assessment will be used to confirm the appropriate stratification level for the Enrollee and as the basis for developing the POC.

2.7.2.3. During Demonstration Year 1 (which encompasses both CY 2014 and CY 2015), the Contractor must complete a HRA for all Enrollees meeting any of the following criteria no later than sixty (60) days from the individual's Enrollment date:

2.7.2.3.1. Individuals enrolled in the EDCD Waiver;

2.7.2.3.2. Individuals with intellectual/developmental disabilities;

2.7.2.3.3. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);

2.7.2.3.4. Individuals with physical or sensory disabilities;

2.7.2.3.5. Individuals residing in nursing facilities;

2.7.2.3.6. Individuals with serious and persistent mental illnesses;

2.7.2.3.7. Individuals with end stage renal disease; and,

2.7.2.3.8. Individuals with complex or multiple chronic conditions.

2.7.2.4. During the first year of the Demonstration, the Contractor must complete a HRA within ninety (90) days of Enrollment for all other Enrollees.

2.7.2.5. The Contractor must conduct HRAs for individuals enrolled in the EDCD Waiver and for Enrollees residing in nursing facilities face-to-face. The Contractor must incorporate pertinent information from the MDS into HRAs for individuals residing in nursing facilities.

2.7.2.6. During subsequent years of the Demonstration, the Contractor must complete HRAs within thirty (30) days of Enrollment for individuals enrolled in the EDCD Waiver and within sixty (60) days of Enrollment for all other Enrollees. The Contractor must conduct the HRAs for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities face-to-face. The Contractor must incorporate the MDS into HRAs for individuals residing in nursing facilities.

2.7.3. Level of Care (LOC) Determinations

2.7.3.1. Incorporation into POC

2.7.3.1.1. Initial LOC determinations for individuals enrolled in or seeking Enrollment in the EDCD Waiver or NF admission will be conducted by Pre-Admission Screening (PAS) Team entities using the Uniform Assessment Instrument (UAI). For Enrollees that have been enrolled in the EDCD Waiver or admitted to a NF prior to enrolling in the Demonstration, DMAS will send information collected from the UAI to the Contractor as part of the transition report. For Enrollees that have LOC determinations completed after enrolling in the Demonstration, the UAI information shall be submitted to the Enrollee's MMP. The Contractor will use information obtained from the UAI in the development of the Enrollee's POC.

2.7.3.1.2. For new NF or EDCD Waiver admissions, the Contractor shall submit admission documentation using the approved process and forms to DMAS and the local Department of Social Services (LDSS) within two (2) business days of the start of EDCD Waiver services.

2.7.3.1.3. When EDCD Waiver Enrollees enter a NF, inpatient rehabilitation, or do not receive EDCD Waiver services for thirty (30) consecutive days, the Contractor shall submit EDCD Waiver discharge information to DMAS and the LDSS within two (2) business days using the approved process and forms.

2.7.3.2. Reassessment

2.7.3.2.1. The Contractor must conduct annual LOC reassessments for EDCD Waiver Enrollees according to the requirements below.

2.7.3.2.2. The Contractor must communicate the annual LOC reassessment data and results within thirty (30) calendar days of the reassessment.

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

2.7.3.2.4. EDCD Waiver Enrollees

2.7.3.2.4.1. The Contractor must ensure that LOC annual reassessments are conducted timely for EDCD Waiver Enrollees. This would include when an Enrollee experiences a triggering event such as hospitalization or a significant change in health or functional status, but no later than within 365 days after the last annual assessment/reassessment.

2.7.3.2.4.2. The Contractor will need to conduct annual face-to-face assessments for continued eligibility for the EDCD Waiver.

2.7.3.2.4.3. The LOC annual reassessment must include all the elements on the DMAS 99-C LOC Review Instrument for individuals who are in the EDCD Waiver who have a change in status (available at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal).

2.7.3.2.4.4. LOC annual reassessments for EDCD Waiver Enrollees shall be performed by providers with the following qualifications: (i) a Registered Nurse licensed in Virginia with at least one (1) year of experience as an RN or (ii) an individual who holds at least a bachelor's degree in a health or human services field and has at least two (2) years of experience working with individuals who are elderly or have disabilities, or both.

2.7.3.2.5. Nursing Facility (NF) Residents

2.7.3.2.5.1. The Contractor must work with the NF to coordinate annual reassessment (functional) for continued NF placement, including the incorporation of all MDS guidelines/timeframes for quarterly and annual assessments and POC development.

2.7.4. Plan of Care (POC)

2.7.4.1. The Contractor shall develop a person-centered, culturally competent POC for each Enrollee that is tailored to the Enrollee's needs and preferences in the timeframes specified in 0. The Contractor must engage each Enrollee in ongoing development of their POC. The Contractor will ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process that includes the POC development. The Contractor shall develop a process that will incorporate but not duplicate TCM for applicable Enrollees.

2.7.4.2. Enrollees shall be encouraged to direct and actively engage in the POC development process and shall have the authority to determine who is included in the process, consistent with the requirements of section 2.6.2.2. The Contractor shall develop and maintain the POC and make the POC or

information related to the POC accessible to providers and Enrollees as needed and upon request. Information shall be secured for privacy and confidentiality in accordance with the Enrollee's permission. On initial POC development, the care manager shall gather advance directive information. This includes educating the Enrollee about advance directives, and obtaining any advance directive documentation and filing them in the Enrollee's file. The status of advance directives should be reviewed at annual reassessments and with a significant change in condition.

2.7.4.3. The Enrollee or their representative as appropriate must review and sign the initial POC and all subsequent revisions. In the event the Enrollee refuses to sign the POC, the Contractor shall:

2.7.4.3.1. Document in detail the specific reasons why the individual refuses to sign the POC;

2.7.4.3.2. Document actions taken by the care manager to address the Enrollee's concerns;

2.7.4.3.3. Clearly document the Enrollee's agreement with the POC or documentation that the individual has been provided a copy of Grievance rights if the Enrollee expresses dissatisfaction with any aspect of the POC or process and Appeal rights if the Enrollee is not in agreement with the services (service, quantity, frequency, duration, etc.) included in the POC; and

2.7.4.3.4. The Contractor shall attempt to obtain the Enrollee's signature on the POC and shall document all efforts to do so.

2.7.4.4. The Enrollee or their representative as appropriate will have access to the initial POC and all subsequent revisions. through their assigned Care Coordinator and member portal

2.7.4.5. The Contractor shall ensure that each POC is reviewed, monitored, and modified by the care manager, or designee in their absence, during contact with the Enrollee and as the Enrollee's health status changes.

2.7.4.6. During the first year of the Demonstration, the Contractor must ensure that POC for all Enrollees are completed within ninety (90) days of Enrollment. During subsequent years of the Demonstration, the Contractor must ensure that POCs are conducted within the following timeframes:

2.7.4.6.1. Within thirty (30) days of Enrollment for EDCD Waiver Enrollees;

2.7.4.6.2. Within sixty (60) days of Enrollment for Vulnerable Subpopulations(excluding EDCD Waiver Enrollees); and,

2.7.4.6.3. Within ninety (90) days of Enrollment for all other Enrollees.

2.7.4.7. The Contractor must honor all existing POCs and prior authorizations (PAs) as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare until the authorizations ends or 180 days from Enrollment, whichever is sooner. For EDCD Waiver Enrollees, the Contractor shall develop and implement the POC no later than the end date of any existing PA. If the existing PA end-date is within thirty (30) days of Enrollment into the MMP, the Contractor may elect to automatically extend the authorization (unchanged) for up to thirty (30) days from the date of Enrollment to allow time for the HRA and POC to be developed.

2.7.4.8. The Contractor will develop a process for obtaining NF MDS data and incorporating that information into the POC as applicable.

2.7.4.9. The Contractor must ensure that Enrollees in NFs who wish to move to the community have a valid pre-admission screening in order to access LTSS. If appropriate, Enrollees will be given the choice of a referral to the Money Follows the Person (MFP) Program. If the individual enrolls in the MFP Program, he/she will be disenrolled from the Demonstration.

2.7.4.10. The Contractor must develop a process for addressing health, safety (including minimizing risk), and welfare of the Enrollee in the POC.

2.7.4.11. The POC will contain the following:

2.7.4.11.1. Prioritized list of Enrollee's concerns, needs, and strengths;

2.7.4.11.2. Attainable goals, outcome measures, and target dates selected by the Enrollee and/or caregiver;

2.7.4.11.3. Strategies and actions, including interventions and services to be implemented and the person(s)/providers responsible for specific interventions/services and their frequency;

2.7.4.11.4. Progress noting success, barriers or obstacles;

2.7.4.11.5. Enrollee's informal support network and services;

2.7.4.11.6. Back up plans as appropriate (for EDCD Waiver Enrollees using personal care and respite services) in the event that the scheduled provider(s) is unable to provide services;

2.7.4.11.6.1. Each EDCD Waiver Enrollee must have a viable back-up plan in case the personal care or respite care aide is unable to work as expected or terminates employment without prior notice. The POC shall outline back-up plan provisions for all services requiring a back-up plan, either by the provision of waiver services or through other means (e.g. a family member, neighbor or friend willing and available to assist the Enrollee, etc.). The arrangement for Enrollees to provide back-up is the responsibility of the waiver Enrollee and family, and individuals who will provide back-up shall be identified in the POC. The Contractor shall assist Enrollees in identifying and selecting individuals or agencies that will be identified as the viable back-up method. Back up measures may include, but are not limited to, natural supports in the community, additional consumer-directed employees, or agency-directed resources. Waiver Enrollees who do not have viable back-up plans shall not be eligible for waiver services until viable back-up plans have been developed.

2.7.4.11.6.2. If an individual does not receive waiver services for any reason for thirty (30) consecutive days, then DMAS must be notified in writing within two (2) business days to determine if waiver Enrollment should be terminated.

2.7.4.11.7. Identified needs and plan to access community resources and non-covered services;

2.7.4.11.8. Enrollees must be given the choice of;

2.7.4.11.8.1. Waiver versus institution.

2.7.4.11.8.2. If waiver is chosen, the choice between services available under the waiver, the choice between service delivery method (consumer directed or agency directed when applicable) and

2.7.4.11.9. Choice of providers within the Provider Network

2.7.4.11.10. Elements included in the DMAS-97AB form, (which can be downloaded from https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.

2.7.4.12. The Contractor must ensure that reassessments and POC reviews are conducted:

2.7.4.12.1. By the POC anniversary for Vulnerable Subpopulations(excluding EDCD Waiver Enrollees and NF residents) and all other Enrollees;

2.7.4.12.2. By POC anniversary, not to exceed 365 days for EDCD Waiver Enrollees(must be face-to-face); and,

2.7.4.13. The Contractor must follow MDS guidelines/timeframes for quarterly and annual POC development for NF residents.

2.7.4.14. The Contractor must ensure that POC are revised based on triggering events, such as hospitalizations or significant changes in health or functional status.

2.7.5. Continuity of Care

2.7.5.1. The Contractor must develop policies and procedures to ensure continuity of care for all Enrollees as follows:

2.7.5.1.1. The Contractor must provide or arrange for all Medically Necessary services, whether by sub-contract or by single-case agreement in order to meet the needs of the Enrollee.

2.7.5.1.2. A process for accepting from DMAS and utilizing an Enrollee's Medical Records, claims histories, and PAs. The process shall require the Contractor to, at a minimum:

2.7.5.1.2.1. Ensure that there is no interruption of Covered Services for Enrollees;

2.7.5.1.2.2. Accept the transfer of all medical records and care management data, as directed by DMAS; and

2.7.5.1.2.3. Accept the transfer of all administrative documentation, as directed by DMAS, including but not limited to:

2.7.5.1.2.3.1. Provider fraud investigations;

2.7.5.1.2.3.2. Grievances and Appeals;

2.7.5.1.2.3.3. Quality management plan; and

2.7.5.1.2.3.4. Quality improvement project records;

2.7.5.1.3. For pregnant Enrollees:

2.7.5.1.3.1. If a pregnant Enrollee enrolls with the Contractor, the Enrollee may choose to remain with her current provider of obstetrical and gynecological services until six (6) weeks after delivery of the child, even if such provider is not in the Contractor's Provider Network;

2.7.5.1.3.2. The Contractor is required to cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six (6) weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network; and

2.7.5.1.3.3. If a pregnant Enrollee would like to select a new provider of obstetrical and gynecological services within the Contractor's Provider Network, the Enrollee may do so.

2.7.5.2. The Contractor must allow Enrollees to maintain their current providers (including out-of-network providers) for 180 days from Enrollment for new Enrollees into the CCC. The Contractor must also allow Enrollees to maintain their preauthorized services as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare for the duration of the PA or for 180 days from Enrollment for new Enrollees into the CCC, whichever is sooner, except for individuals residing in a NF at the date of Enrollment into the Demonstration. Individuals in NFs at the time of Enrollment may remain in the NF as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different NF or return to the community.

2.7.5.3. The Contractor will transfer PA, assessment, POC, and other pertinent information necessary to assure continuity of care to another MMP or to DMAS or its designated Contractor for Enrollees that choose to Opt Out or transfer to another MMP. The information shall be provided no later than ten (10) calendar days from receipt of the notice of disenrollment to the Contractor and no later than the effective date of transfer in the method and format specified by DMAS and CMS.

2.7.5.4. The Contractor must allow Enrollees to maintain their current providers (including out of network providers) for 30 days from Enrollment for Enrollees who transfer from another MMP. The Contractor must also allow Enrollees to maintain their preauthorized services as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare for the duration of the PA or for 30 days from Enrollment, for Enrollees who transfer from another MMP, whichever is sooner, except for individuals residing in a nursing facility at the date of enrollment into the MMP. Individuals in nursing facilities at the time of Enrollment may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

2.7.5.5. If, as a result of the development of the POC, or the HRA, the Contractor proposes modifications to the Enrollee's prior authorized services, the Contractor must provide written notification to the Enrollee about and an opportunity to Appeal the proposed modifications, as outlined in Section

2.14 of this Contract. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable.

2.7.5.6. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D and Medicaid drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require PA or step therapy under the Contractor's Utilization Management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.7.6. Discharge Planning Participation

2.7.6.1. The Contractor shall implement policies and procedures that (1) ensure timely and effective treatment and discharge planning; (2) establish the associated documentation standards; (3) involve the Enrollee; and (4) begin on the day of admission. Treatment and discharge planning shall include at least:

2.7.6.1.1. Identification and assignment of a facility based care manager for the Enrollee. This staff member shall be involved in the establishment and implementation of treatment and discharge planning;

2.7.6.1.2. Notification and participation of the Enrollee's ICT in discharge planning, coordination, and re-assessment as needed;

2.7.6.1.3. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;

2.7.6.1.4. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards;

2.7.6.1.5. Identification of barriers to aftercare, and the strategies developed to address such barriers;

2.7.6.1.6. Assurance that inpatient and 24-hour diversionary behavioral health providers provide a discharge plan following any behavioral health admission to ICT members;

2.7.6.1.7. Ensure that Enrollees who require medication monitoring will have access to such services within fourteen (14) business days of discharge from a behavioral health inpatient setting;

2.7.6.1.8. Make best efforts to ensure a smooth transition to the next service or to the community; and,

2.7.6.1.9. Document all efforts related to these activities, including the Enrollee's active participation in discharge planning.

2.7.6.2. During the transition period referenced above, the Contractor may change an Enrollee's existing provider only in the following circumstances:

2.7.6.2.1. Enrollee requests a change;

2.7.6.2.2. The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid;

2.7.6.2.3. The Contractor, CMS, or DMAS identify provider performance issues that affect an Enrollee's health and welfare; or

2.7.6.2.4. The provider is excluded under state or federal exclusion requirements.

2.7.6.3. During the time period set forth in Section 2.7.5 above the Contractor will maintain the Enrollee's current providers at the Medicare or Medicaid FFS rate and honor PAs issued prior to Enrollment for the specified time period.

2.7.6.4. The Contractor must reimburse an out-of-network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. §405.400 respectively, at the Medicare or Medicaid FFS payment levels for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS payment level applies. Enrollees maintain balance billing protections. In no event shall Contractor be required to pay the out-of-network provider in excess of the amount such provider would have received from Medicare and/or the state plan for providing the same services if the Enrollee was not enrolled in the Demonstration, but rather enrolled in Medicare and the state plan.

2.8. Provider Network

2.8.1. General

2.8.1.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and DMAS to ensure adequate access to medical, behavioral health, pharmacy, and long-term services and supports providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A). The Contractor must notify the CMT of any significant Provider Network changes immediately, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.8.1.2. The Contractor shall not require as a condition of participation/contracting with providers in their CCC network to also participate in the Contractor's other lines of business (e.g., commercial managed care network). However, this provision would not preclude a Contractor from requiring their managed care (Commercial, Medicare, etc.) network providers to participate in their CCC Provider Network.

2.8.1.3. The Contractor shall not require as a condition of participation/contracting with providers in its Provider Network a provider's terms of panel participation with other MMPs.

2.8.1.4. The Contractor shall not require as a condition of participation/contracting with providers that the provider shall not contract with other MMPs.

2.8.1.5. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.8.1.6. The Contractor shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network. The Contractor will submit annually the appropriate certification checklist on its efforts to contract with Small, Women-owned, and Minority-owned (SwaM) Businesses (see Appendix K).

2.8.1.7. The Contractor must demonstrate to DMAS, including through submission of reports as may be requested by DMAS, use of Alternative Payment Methodologies (APMs) that will advance the delivery system innovations inherent in this model, incentivize quality care, and improve health outcomes for Enrollees. APMs shall be reviewed and approved by CMS and DMAS prior to implementation. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111, Sec. 1860D-11(i).

2.8.1.8. APMs or methods are defined as, methods of payment that are not solely based on fee-for-service reimbursements; provided that, APMs may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements; provided further, that APMs may include fee-for-service payments, which are settled or reconciled with a bundled or global payment.

2.8.1.9. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq.

2.8.1.10. The Contractor shall establish, maintain and monitor a network, that is sufficient to provide adequate access to all Covered Services under the

Contract, taking into consideration the cultural and ethnic diversity and demographic characteristics, communication requirements, and health needs of specific Medicare-Medicaid populations:

2.8.1.10.1. The anticipated number of Enrollees;

2.8.1.10.2. The expected utilization of services, and care needs;

2.8.1.10.3. The number and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;

2.8.1.10.4. The number of network providers who are not accepting new patients; and

2.8.1.10.5. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.

2.8.1.11. The Contractor shall make reasonable efforts to contact out-of-network providers, within the first 180 days of an Enrollee's membership in the Contractor's MMP, such providers and prescribers which are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-network providers. New Enrollees into CCC may continue to receive services from previous providers during the initial continuity of care period (180 days), Enrollees who transfer from another MMP may continue to receive services from previous providers for 30 days. Enrollees may continue to receive services from previous providers during the initial continuity of care period (180 days). If the provider does not join the network, or if the Enrollee does not select a new in-network provider by the end of the 180-day period, the Contractor shall choose one for the Enrollee (with the exception of NF residents who may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different NF or return to the community). See Section 2.10.3 for out of network reimbursement requirements.

2.8.1.11.1. The Contractor may assign an in-network PCP at Enrollment and shall inform the Enrollee that he or she may continue to see an existing PCP during the 180 or 30 day continuity of care period. The Enrollee shall have the right to request a change in in-network PCP at any time, whether assigned by the Contractor or chosen by the Enrollee.

2.8.1.12. The Contractor must also offer single-case agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network and 2) currently serving Enrollees, under the following circumstances:

2.8.1.12.1. The Contractor's network does not have an otherwise qualified network provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;

2.8.1.12.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

2.8.1.12.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.8.1.13. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, individuals with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a visual or hearing impairment.

2.8.1.14. The Contractor shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations. All such written communications shall be subject to review at DMAS' and CMS' discretion.

2.8.1.15. The Contractor shall ensure that multilingual network providers and, to the extent that such capacity exists within the Contractor's Service Area, all network providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist network providers to meet these obligations.

2.8.1.16. The Contractor shall ensure that network providers and interpreters/translators are available for those who are Deaf, visual or hearing-impaired within the Contractor's Service Area.

2.8.1.17. The Contractor shall ensure that its network providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities), and other special populations served under the Contract.

2.8.1.18. If the Contractor declines to include individuals or groups of providers in its Provider Network, the Contractor must give the affected providers written notice of the reason for its decision.

2.8.1.19. The Contractor shall not include in its provider contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages network providers from participating as network or non-network providers in any Provider Network other than the Contractor's Provider Network(s).

2.8.1.20. The Contractor shall not establish selection policies and procedures for providers that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.8.1.21. The Contractor shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs.

2.8.1.22. The Contractor shall ensure that its network providers have a strong understanding of disability, and recovery and resilience cultures.

2.8.1.23. At the Enrollee's request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.

2.8.2. Provider Qualifications and Performance

2.8.2.1. Written Provider Protocols: The Contractor must have written protocols in the following areas:

2.8.2.1.1. Credentialing, re-credentialing, certification, and performance appraisal processes that demonstrate that all members of the Provider Network maintain current knowledge, ability, and expertise in the service or specialty in which they practice. Providers must meet board certification, continuing education, and other requirements, as appropriate. The Contractor shall demonstrate to CMS and DMAS, by reporting annually that all providers within the Contractor's Provider Network are credentialed according to Section 2.9.2.1.4 of the Contract. The protocol must also include: Enrollee Complaints and Appeals; results of quality reviews; Utilization Management information; and Enrollee surveys;

2.8.2.1.2. Practice guidelines, in accordance with 42 C.F.R. § 438.236 and 42 C.F.R. § 422.202(b);

2.8.2.1.3. Continuing education programs for ICTs, medical providers, behavioral health providers and LTSS providers to ensure they are knowledgeable about and sensitive to the health care needs of Enrollees. Education must also be provided about quality management activities and requirements;

2.8.2.1.4. Provider profiling activities, defined as multi-dimensional assessments of a provider's performance. The Contractor must use such measures in the evaluation and management of each component of the Provider Network on at least an annual basis. At a minimum, the Contractor must address the following:

2.8.2.1.4.1. Mechanisms for detecting both underutilization and overutilization of services;

2.8.2.1.4.2. Performance measures on structure, process, and outcomes of care;

2.8.2.1.4.3. Interdisciplinary team performance, including resolution of service plan disagreements;

2.8.2.1.4.4. Enrollee experience and perceptions of service delivery; and.

2.8.2.1.4.5. Timely access.

2.8.2.1.4.6. A revocation process or other specified remedies for providers whose performance is unacceptable in one or more of the areas noted in Section 2.8.2.1.1 above. For serious Complaints involving medical provider errors, the Contractor must take immediate corrective action and file reports of corrections made with CMS and DMAS within three (3) business days of the Complaint.

2.8.2.2. Primary Care Provider Qualifications: A PCP must be:

2.8.2.2.1. A Primary Care Physician who is

2.8.2.2.1.1. Licensed by the Commonwealth of Virginia;

2.8.2.2.1.2. A Family Practice, Internal Medicine, General Practice, OB/GYN, or Geriatrics practitioner; or

2.8.2.2.1.3. Specialists who perform primary care functions including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments and other similar community clinics; and

2.8.2.2.1.4. In good standing with the federal Medicare and federal/state Medicaid (DMAS) program.

2.8.2.2.2. Other providers

2.8.2.2.2.1. A Nurse Practitioner who is licensed by the Commonwealth of Virginia, performing within the scope of licensure; and

2.8.2.2.2.2. A Physician Assistant who is licensed by the Commonwealth of Virginia, performing within the scope of licensure.

2.8.3. Subcontracting Requirements

2.8.3.1.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.8.3.1.2. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities and shall subject them to formal review according to a periodic schedule established by the state, consistent with industry standards or state MCO laws and regulations. First Tier, Downstream and Related Entities are required to meet the same federal and state financial and program reporting requirements as the Contractor. The Contractor is required to evaluate any potential contractor prior to delegation, pursuant to 42 C.F.R. § 438.20. Additional information about subcontracting requirements is contained in Appendix D.

2.8.3.1.3. The Contractor must:

2.8.3.1.3.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.8.3.1.3.2. Contract only with qualified or licensed providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix D.

2.8.4. Reporting of Serious Reportable Events

2.8.4.1. Serious reportable events include but are not limited to:

2.8.4.1.1. Deaths (unexpected, suicide, or homicide);

2.8.4.1.2. Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function);

2.8.4.1.3. Infectious disease outbreaks;

2.8.4.1.4. Pressure ulcers that are unstageable or are Staged III and IV;

2.8.4.1.5. Traumatic injuries (including third degree burns over more than 10 percent of the body) that result in death, require hospitalization, or result in a loss of function;

2.8.4.1.6. Restraint use that results in death, hospitalization, or loss of function;

2.8.4.1.7. All elopements in which an Enrollee with a documented cognitive deficit is missing for 24 hours or more;

2.8.4.1.8. Media-related event. Any report of which the Contractor is aware that presents a potentially harmful characterization of the MMP or CCC Program.

2.8.5. Non-Payment and Reporting of Provider Preventable Conditions

2.8.5.1. The Contractor agrees to take such action as is necessary in order for DMAS to comply with and implement all federal and state laws, regulations, policy guidance, and Virginia policies and procedures relating to the identification, reporting, and non-payment of provider preventable conditions, including 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

2.8.5.2. As a condition of payment, the Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. §§ 434.6(a)(12), 438.6(f)(2), and 447.26, and guidance and be consistent with DMAS regulations, including 12 VAC 30-70-201 and 12 VAC 30-70-221 procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

2.8.5.2.1. The Contractor shall not pay a provider for a Provider Preventable Condition.

2.8.5.2.2. The Contractor shall require, as a condition of payment from the Contractor, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or DMAS.

2.8.5.2.3. The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee.

2.8.5.2.4. A Contractor may limit reductions in provider payments to the extent that the following apply:

2.8.5.2.4.1. The identified Provider Preventable Condition would otherwise result in an increase in payment.

2.8.5.2.4.2. The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.

2.8.5.2.5. The Contractor shall ensure that its non-payment for Provider Preventable Conditions does not prevent Enrollee access to services.

2.8.6. Non-Payment and Reporting of Preventable Hospital Readmisssions

2.8.6.1. As directed by DMAS, and in consultation with CMS, the Contractor shall develop and implement a process for ensuring non-payment or recovery of payment for preventable hospital readmissions. Such process shall be, to the extent feasible, consistent with minimum standards and processes developed by DMAS.

2.8.6.2. The Contractor shall report all identified Provider Preventable Conditions in a form and format specified by DMAS within seven (7) calendar days from occurrence.

2.8.7. Provider Profiling

2.8.7.1. The Contractor must conduct profiling activities for PCPs, behavioral health Providers, LTSS providers, and, as directed by DMAS, specialty providers, at least annually. As part of its quality activities, the Contractor must submit to DMAS by December 31 of each year for review and approval prior to its use the methodology to identify which and how many providers to profile and to identify measures to use for profiling such providers.

2.8.7.2. Provider profiling activities must include, but are not limited to:

2.8.7.2.1. Developing provider-specific reports that include a multi-dimensional assessment of a provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

2.8.7.2.2. Establishing provider, group, or regional benchmarks for areas profiled, where applicable, including Contractor-specific benchmarks, if any;

2.8.7.2.3. Providing feedback to providers regarding the results of their performance and the overall performance of the Provider Network; and

2.8.7.2.4. Designing and implementing quality improvement plans for providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests, including referral of these providers to the network management staff for education and technical assistance and reporting results annually to DMAS.

2.8.7.2.5. The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers. The Contractor shall:

2.8.7.2.5.1. Establish provider-specific quality improvement goals for priority areas in which a provider or providers do not meet established Contractor standards or improvement goals;

2.8.7.2.5.2. Develop and implement incentives, which may include financial and non-financial incentives, to motivate providers to improve performance on profiled measures;

2.8.7.2.5.3. Conduct on-site visits to network providers for quality improvement purposes; and

2.8.7.2.5.4. At least annually, measure progress on the Provider Network and individual providers' progress, or lack of progress, towards meeting such improvement goals.

2.8.7.2.6. The Contractor shall maintain regular, systematic reports, in a form and format approved by DMAS, of the above-mentioned provider profiling activities and related Quality Improvement activities pursuant to Section 2.17. Moreover, the Contractor shall submit to DMAS, upon request, such reports or information that would be contained therein. The Contractor shall also submit summary results of such Provider profiling and related quality improvement activities as a component of its annual evaluation of the QM/QI program.

2.8.8. Provider Education and Training: The Contractor must:

2.8.8.1. Inform its Provider Network about its service delivery model and Covered Services, flexible benefits, excluded services (carved-out) and , policies, procedures, and any modifications to these items;

2.8.8.2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;

2.8.8.3. Inform its Provider Network about the procedures and timeframes for Enrollee Complaints and Enrollee Appeals, per 42 C.F.R. § 438.414;

2.8.8.4. Inform its Provider Network about its quality improvement efforts and the providers' role in such a program;

2.8.8.5. Inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals;

2.8.8.6. Ensure that all providers receive proper education and training regarding the CCC program to comply with this Contract and all applicable federal and state requirements. The Contractor shall offer educational and training programs that cover topics or issues including, but not limited to, the following:

2.8.8.6.1. Eligibility standards, eligibility verification, and benefits;

2.8.8.6.2. The role of DMAS (or its authorized agent) regarding Enrollment and disenrollment;

2.8.8.6.3. Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;

2.8.8.6.4. ADA compliance, accessibility and accommodations;

2.8.8.6.5. The rights and responsibilities pertaining to

2.8.8.6.5.1. Grievance and appeals procedures and timelines; and

2.8.8.6.5.2. Procedures for reporting fraud, waste, neglect and abuse;

2.8.8.6.6. References to Medicaid and Medicare manuals, memoranda, and other related documents;

2.8.8.6.7. Payment policies and procedures including information on no balance billing;

2.8.8.6.8. PCP training on identification of and coordination of LTSS and behavioral health services;

2.8.8.6.9. Cultural competencies;

2.8.8.6.10. Person-centered planning processes taking into consideration the specific needs of subpopulations of Enrollees;

2.8.8.6.11. Billing instructions which are in compliance with CCC's encounter data submission requirements; and,

2.8.8.6.12. Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

2.8.8.7. Train its medical, behavioral, and LTSS providers on disability literacy, including, but not limited to the following information:

2.8.8.7.1. Various types of chronic conditions prevalent within the target population;

2.8.8.7.2. Awareness of personal prejudices;

2.8.8.7.3. Legal obligations to comply with the ADA requirements;

2.8.8.7.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;

2.8.8.7.5. Types of barriers encountered by the target population;

2.8.8.7.6. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model;

2.8.8.7.7. Use of evidence-based practices and specific levels of quality outcomes; and

2.8.8.7.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.

2.9. Network Management

2.9.1. General Requirements

2.9.1.1. The Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, independent living philosophy, cultural competence, integration and cost effectiveness. The management strategy shall address all providers. At a minimum, such strategy shall include:

2.9.1.1.1. A system for utilizing network provider profiling and benchmarking data to identify and manage outliers;

2.9.1.1.2. A system for the Contractor and network providers to identify and establish improvement goals and periodic measurements to track network providers' progress toward those improvement goals;

2.9.1.1.3. Conducting on-site visits to network providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

2.9.1.1.4. Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services;

2.9.1.2. Establish and conduct an ongoing process for enrolling in their Provider Network willing and qualified providers that meet the Contractor's requirements and with whom mutually acceptable provider contract terms, including with respect to rates, are reached.

2.9.1.3. Operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its plans' Service Areas are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.9.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.9.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.9.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.

2.9.1.4. Maintain and distribute a provider manual(s), which includes specific information about Covered Services, non-covered services, and other requirements of the Contract relevant to provider responsibilities. The Contractor shall submit an updated provider manual(s) to DMAS annually

and such updated provider manual(s) shall be distributed to providers annually and made available to providers on the Contractor's website; provided, however, after initial submission, if there are no substantial changes to the provider manual in a given year, then the Contractor is not required to submit a copy to DMAS but shall certify to DMAS that there are no substantial changes.

2.9.1.4.1. The provider manual(s) shall include, but not be limited to, the following information:

2.9.1.4.1.1. Enrollee rights and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;

2.9.1.4.1.2. Provider responsibilities, as a member of the ICT;

2.9.1.4.1.3. That Enrollees may file a Grievance with the Contractor if the provider violates any Enrollee rights and the steps the Contractor may take to address any such Grievances;

2.9.1.4.1.4. Enrollee Privacy matters;

2.9.1.4.1.5. Provider responsibility for assisting Enrollees with interpreter services;

2.9.1.4.1.6. Provider obligation to accept and treat all Enrollees regardless of race/ethnicity, age, English proficiency, sexual orientation, health status, or disability;

2.9.1.4.1.7. General rules of provider-Enrollee communications;

2.9.1.4.1.8. Covered Services lists; provider obligation to make Enrollees aware of available clinical options and all available care options;

2.9.1.4.1.9. Permissible provider marketing activities;

2.9.1.4.1.10. An explanation that providers may not charge Enrollees or the Contractor for any service that

2.9.1.4.1.10.1. That is not a Medically Necessary Covered Service or non-covered service;

2.9.1.4.1.10.2. For which there may be other Covered Services or non-covered services that are available to meet the Enrollee's needs; and

2.9.1.4.1.10.3. Where the provider did not explain items 2.9.1.4.1.10.1 and 2.9.1.4.1.10.2, that the Enrollee will not be liable to pay the provider for the provision of any such services.

2.9.1.4.1.11. Information on advance directives, as defined in 42 C.F.R. § 489.102, and pursuant to 42 C.F.R. § 422.128;

2.9.1.4.1.12. The Contractor's authority to audit the presence of advance directives in medical records;

2.9.1.4.1.13. Services that need PCP referrals or prior authorization;

2.9.1.4.1.14. Full explanation of new Enrollee's right to the initial continuity-of-care period;

2.9.1.4.1.15. Enrollee rights to access and correct medical records information;

2.9.1.4.1.16. The process through which the Contractor communicates updates to policies (for providers and First tier, Downstream and Related Entities);

2.9.1.4.1.17. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

2.9.1.4.1.18. Protocols for transitioning Enrollees from one provider to another;

2.9.1.4.1.19. Protocols for communication and coordination between members of the Enrollee's ICT, including access to electronic health records or Care Management portals;

2.9.1.4.1.20. Coordination between behavioral health providers and PCPs;

2.9.1.4.1.21. Steps a provider must take to request disenrollment of an Enrollee from his/her panel;

2.9.1.4.1.22. Enrollee's Appeal rights;

2.9.1.4.1.23. Internal Appeals as pre-requisites;

2.9.1.4.1.24. Information on the Contractor's process for an internal Appeal following an Adverse Action, including an Enrollee's right to use a provider as an Appeal representative;

2.9.1.4.1.25. Provider's Appeal rights when denied payment in whole or part, authorization for a delivered service or when audited;

2.9.1.4.1.26. The provider's inability to charge the Enrollee for denied services;

2.9.1.4.1.27. Information on the policy against balance billing; and

2.9.1.4.1.28. Mechanism by which providers must report fraud, waste, and abuse.

2.9.1.5. Maintain a protocol that shall facilitate communication to and from providers and the Contractor, and which shall include, but not be limited to, a provider newsletter and periodic provider meetings;

2.9.1.6. Except as otherwise required or authorized by CMS, DMAS or by operation of law, ensure that providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and

2.9.1.7. Work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Strategic Work Plan and all other requirements of this Contract.

2.9.1.8. Perform an annual review to assure that the health care professionals under contract with the First Tier, Downstream, and Related Entities are qualified to perform the services covered under this contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license.

2.9.1.9. Require its providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455.

2.9.2. Proximity Access Requirements

2.9.2.1. The Contractor must demonstrate annually that its Provider Network meets the following standards:

2.9.2.1.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html);

2.9.2.1.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. §423.120;

2.9.2.1.3. For services for which Medicaid is the traditional primary payer (including LTSS and community mental health and substance abuse services), each Enrollee shall have a choice of at least two (2) providers of each service type located within no more than thirty (30) minutes travel time from any Enrollee in urban areas unless the Contractor has a DMAS-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions. The Contractor shall ensure that each Enrollee shall have a choice of at least two (2) providers of each service type located within no more than sixty (60) minutes travel time from any Enrollee in rural areas unless the Contractor has a DMAS approved alternative time standard. CMS and DMAS will monitor access to care and the prevalence of needs indicated through Enrollee assessments, and, based on those findings, may require that the Contractor initiate further network expansion over the course of the Demonstration.

2.9.2.1.4. For providers of overlap services that may be subject to either Medicaid or Medicare network requirements, the stricter of any applicable standards will apply.

2.9.3. Provider Credentialing, Recredentialing, and Board Certification

2.9.3.1. General Provider Credentialing

2.9.3.1.1. The Contractor shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§ 422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention and exclusion of providers and meet, at a minimum, the requirements below.

2.9.3.1.2. The Contractor shall submit such policies and procedures annually to DMAS, if amended, and shall demonstrate to DMAS, by reporting annually that all providers within the Contractor's Provider Network are credentialed according to such policies and procedures.

2.9.3.1.3. The Contractor shall:

2.9.3.1.3.1. Designate and describe the department(s) and person(s) at the Contractor's organization who will be responsible for provider credentialing and re-credentialing;

2.9.3.1.3.2. Maintain appropriate, documented processes for the credentialing and re-credentialing of licensed physician providers and all other licensed or certified providers who participate in the Contractor's Provider Network to perform the services agreed to under this contract. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the NCQA and relevant state regulations, including regulations at 12 VAC 5-408-170;

2.9.3.1.3.3. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted as appropriate for initial credentialing;

2.9.3.1.3.4. Maintain a documented re-credentialing process which shall occur at least every three years (thirty six months) and shall take into consideration various forms of data including, but not limited to, grievances, results of quality reviews utilization management information, and Enrollee satisfaction surveys;

2.9.3.1.3.5. The Contractor's standards for licensure and certification shall be included in its participating Provider Network contracts with its network providers which must be secured by current subcontracts or employment contracts.

2.9.3.1.3.6. Upon notice from DMAS or CMS, not authorize any providers terminated or suspended from participation in the Virginia Medicaid Program, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition:

2.9.3.1.3.6.1. The Contractor shall comply with requirements detailed at 42 C.F.R. § 455.436, requiring the Contractor to, at a minimum, check the Department of Health Professions website at least twice per month for its Providers, OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) (the successor to the Excluded Parties List System (EPLS)) for its providers at least monthly, before contracting with the provider, and at the time of a provider's credentialing and recredentialing;

2.9.3.1.3.6.2. If a provider is terminated or suspended from the Virginia Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a state or federal licensing action, the Contractor shall terminate, suspend, or decline a provider from its network as appropriate.

2.9.3.1.3.6.3. The Contractor shall notify CMS and DMAS within seven (7) calendar days, via the CMT, when it terminates, suspends, or declines a provider from its network because of fraud, integrity, or quality;

2.9.3.1.3.7. Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901;

2.9.3.1.3.8. Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

2.9.3.1.3.9. Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

2.9.3.1.3.10. Search and do not contract with the names of parties disclosed during the credentialing and recredentialing process in the DHP, OIG LEIE, MED, and SAM exclusion or debarment databases, and parties that have been terminated from participation under Medicare or another state's Medicaid program;

2.9.3.1.3.11. Obtain disclosures from all network providers and applicants and consistent with 42 C.F.R. 455 Subpart B [42 CFR 455.104, 455.105, 455.106], and as required by 42 C.F.R.§ 1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DMAS in accordance with this Contract, including this Section, and relevant state and federal laws and regulations; and

2.9.3.1.3.12. Notify CMS and DMAS at least on a quarterly basis when a provider fails credentialing or re-credentialing because of a program integrity or adverse action reason, and shall provide related and relevant information to CMS and DMAS as required by CMS, DMAS or state or federal laws, rules, or regulations.

2.9.3.1.3.13. Include the consideration of performance indicators obtained through the Quality Improvement Plan (QIP), utilization management program, grievance and appeals system, and Enrollee satisfaction surveys in the Contractor's recredentialing process.

2.9.3.2. Board Certification Requirements

2.9.3.2.1. The Contractor shall maintain a policy with respect to board certification for PCPs and specialty participating in the Provider Network,

2.9.3.3. Behavioral Health Provider Network

2.9.3.3.1. In addition to those requirements described above, the Contractor shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of behavioral health providers. The Contractor shall have an adequate network of behavioral health and substance abuse providers to meet the needs of the population, including their community mental health rehabilitative service needs. Examples of these types of providers include, but are not limited to, psychiatrists, clinical psychologists, licensed clinical social workers, outpatient substance abuse treatment providers, and residential substance abuse treatment providers for pregnant women, etc. Providers of Medicaid covered behavioral health services must have the appropriate licensure and qualifications as outlined in DMAS' Community Mental Health Rehabilitative Services Manual found at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

2.9.4. Primary Care Provider (PCP) Network

2.9.4.1. The Contractor shall monitor and annually report to DMAS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds 10%, the Contractor shall submit an explanation for the turnover rate to DMAS. DMAS may subsequently request a business plan addressing the turnover rate for DMAS review and approval.

2.9.4.2. The Contractor shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in order to address opportunities for Enrollee education about the benefits of developing a consistent, long term patient-doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for any BHS may be indicated, including situations where the Contractor suspects drug seeking behavior.

2.9.5. Emergency Services Programs (ESPs)

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

2.9.5.2. The Contractor shall negotiate provider agreements with emergency care providers to ensure prompt and appropriate payment for Emergency

Services. Such network provider agreements shall provide a process for determining a true and actual emergency.

2.9.6. Long Term Services and Supports (LTSS) Providers

2.9.6.1. The Contractor's Provider Network must offer a selection of LTSS (NF and EDCD Waiver) service providers that meets Enrollee needs and preferences and satisfies the time and distance requirements outlined in Section 2.9.2.1.3.

2.9.6.2. The Contractor shall ensure that waiver service providers in their networks meet, at a minimum, DMAS provider qualifications and have received proper certification and/or training to perform the specific waiver or NF services for which they are contracted. Provider qualification requirements for NF services and services provided under the EDCD Waiver may be found at the following regulatory and DMAS manual cites (if the citation changes, DMAS will notify the Contractor in writing):

2.9.6.2.1. Adult Day Health Care

2.9.6.2.1.1. Regulation: (12-30-120-940(B)); (12-30-120-940(C)) and 12 VAC 40-60-10 et seq (Licensing regulations) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-940

2.9.6.2.1.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.2. Agency Directed Personal Care

2.9.6.2.2.1. Regulation: (12-30-120-950(D)) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-950

2.9.6.2.2.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.3. Agency Directed Respite Care

2.9.6.2.3.1. Regulation: (12-30-120-960(D)) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-960

2.9.6.2.3.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.4. Personal Emergency Response System (PERS)

2.9.6.2.4.1. Regulation: (12-30-120-970(D)) and (12-30-120-970(E)) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-970

2.9.6.2.4.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.5. Consumer Directed Services (Service Facilitation)

2.9.6.2.5.1. Regulation: (12-30-120-980(D)) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980

2.9.6.2.5.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.6. Consumer Directed Services (Personal Care Aide)

2.9.6.2.6.1. Regulation: (12-30-120-980(D)(10) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-120-980

2.9.6.2.6.2. EDCD Manual: Chapter II https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.6.2.7. Nursing Facility

2.9.6.2.7.1. Regulation: (12 VAC 30-60-300) http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-60-300

2.9.6.2.7.2. Nursing Facility Manual: (Chapter II) https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual

2.9.7. Family Planning Provider Network. Subject to Appendix A hereof, the Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by a network or out-of-network provider.

2.9.7.1. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.9.8. Nursing Facility Sanctions Tracking Process

2.9.8.1. DMAS is charged with the responsibility of issuing sanctions to NFs that are not in compliance with Medicare and Medicaid licensure and certification standards. DMAS tracks the NFs based upon information provided to them by the Virginia Department of Health (VDH) – Office of

Licensure and Certification (OLC). There are time standards associated with when sanctions are imposed and the resulting actions that must be taken by DMAS.

2.9.8.2. The Contractor shall work with DMAS in the event that sanctions are issued to any NF participating in the Contractor's Provider Network.

2.9.9. Elderly or Disabled with Consumer Directed Services Provider Termination Process:

2.9.9.1. DMAS is charged with the responsibility of issuing termination notices to waiver service providers for failure to meet the requirements of participation in the Medicaid program. DMAS works with the provider and the individuals served by the provider to ensure a smooth transition from the terminated provider to a new provider chosen by the individual. The time frames associated with this process vary depending upon the circumstances associated with the termination.

2.9.9.2. The Contractor shall work with DMAS in the event that a termination of provider agreement is issued to a waiver service provider participating in the Contractor's Provider Network.

2.9.10. Elderly or Disabled with Consumer Directed Services Waiver Record Seizure Process

2.9.10.1. On occasion, EDCD waiver records may be seized by law enforcement agencies due to investigations. If an agency is subject to seizure of records, then DMAS will notify the Contractor of such seizure once DMAS is notified.

2.9.10.2. The Contractor shall work with DMAS in the event that a waiver service provider participating in the Contractor's Provider Network experiences a seizure of records.

2.10. Provider Payment

2.10.1. Payment to Medicaid Covered Service Providers

2.10.1.1. The Contractor shall:

2.10.1.1.1. Process clean claims from providers of Medicaid covered services (e.g., NFs, LTSS, community behavioral health) within fourteen (14) days of receipt of the clean claim. This does not apply to LTC pharmacies within a NF.

2.10.1.1.2. Pay home health and EDCD waiver service providers no lower than the current FFS Medicaid rate or a different negotiated rate as mutually agreed to by the provider and the Contractor.

2.10.1.1.3. Pay NFs no less than the Medicaid rate for Medicaid covered days. DMAS will publish Medicaid rates by nursing home based on the most recent settled rates inflated to the Contract period and adjusted for changes in case mix. During the Demonstration, DMAS may modify the NF reimbursement methodology so that facility rates will be adjusted by acuity using Resource Utilization Groups. Contractor must be able to accommodate the new payment methodology, unless an alternate reimbursement methodology is agreed upon by contracted NFs. The Contractor shall meet these requirements during the Demonstration.

2.10.1.1.4. .

2.10.1.2. The Contractor shall notify DMAS and CMS 45 days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations. Any expenses incurred by DMAS and CMS or its contractors to adapt to the Contractor's claims processing operational changes (including but not limited to costs for site visits) shall be borne by the Contractor.

2.10.1.3. The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least sixty (60%) percent of claims received from providers are submitted electronically.

2.10.1.4. The Contractor must pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the Code of Virginia. Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the Contractor's receipt of proof of loss to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This shall also apply to retroactive denials or adjustments of a claim or portion of a claim not in accordance with this agreement. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

2.10.1.5. To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid specific nursing facility, home health, or HCBS waiver service providers, and as identified by DMAS, and these rate adjustments are incorporated into the Demonstration capitation payment rates during the Contract period, where required by DMAS and/or regulation, the Contractor is required to increase its reimbursement to

providers at the same percentage as Medicaid's increase as reflected in the revised fee-for- service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by DMAS. The DMAS shall make every reasonable effort to provide at least 90 days advance notice of such increases. The Contractor shall provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format. A copy of such notification shall be provided to DMAS 60 days before the Contractor's mailing of such notice or as soon as practicable if DMAS provides less than ninety (90) day notice to the Contractor.

2.10.1.6. Under 1932 (b) of the SSA the Contractor must establish an internal grievance procedure by which providers under contract may challenge the Contractor's decisions including, but not limited to, the denial of payment for services.

2.10.2. FQHCs Reimbursements

2.10.2.1. The Contractor shall ensure that its payments to FQHCs for services to Enrollees are no less than the sum of:

2.10.2.1.1. The level and amount of payment that the Contractor would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and

2.10.2.1.2. The difference between 80% of the Medicare FFS rate for that FQHC and the Medicaid PPS amount for that FQHC, where the Medicaid PPS amount exceeds 80% of the Medicare rate.

2.10.3. Out of Network Reimbursement Rules.

2.10.3.1. The Contractor must reimburse an out-of-network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the prevailing Medicare or Medicaid FFS payment levels for that service.

2.10.3.2. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which Contractors shall pay Out of Network providers the amount that would have been paid by Medicare and/or DMAS if the Enrollee was not enrolled in the Demonstration, but rather enrolled in Medicare and the State's Medicaid program, regardless of the setting and type of care for authorized out-of-network services..

2.10.4. Primary Care Payment Rates

2.10.4.1. As directed by the DMAS, the Contractor shall set payment rates for primary care services provided by eligible providers in accordance with Section 1202 of the ACA and 42 U.S.C. § 1396a(13)(C), and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. Notwithstanding the generality of the foregoing, the Contractor shall, in accordance with 42 C.F.R. § 438.6(c)(5)(vi), for payments for primary care services in calendar year 2014 furnished to Enrollees under 42 C.F.R. Part 447, subpart G:

2.10.4.1.1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 C.F.R. Part 447, subpart G; and

2.10.4.1.2. Provide documentation to the DMAS, sufficient to enable Department to ensure that Provider payments are made as required by this Section 2.10.4.

2.11. Enrollee Access to Services

2.11.1. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract. Services shall be available twenty-four (24) hours a day, seven (7) days a week when medically necessary.

2.11.1.2. Offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS providers that meet CMS and DMAS standards as provided for in Section 2.8;

2.11.1.3. All urgent and symptomatic office visits must be available to Enrollees within twenty-four (24) hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention;

2.11.1.4. All nonsymptomatic office visits must be available to Enrollees within thirty (30) calendar days;

2.11.1.5. Network providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

2.11.1.6. Reasonably accommodate persons and shall ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities as they are to an individual without disabilities. The Contractor and its network providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that

accommodates the needs of its Enrollees. The Contractor shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.6.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.6.2. Providing interpreters or translators for Enrollees who are Deaf and hard of hearing and those who do not speak English;

2.11.1.6.3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:

2.11.1.6.3.1. Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments;

2.11.1.6.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.6.3.3. Reading notices and other written materials to individuals upon request;

2.11.1.6.3.4. Assisting individuals in filling out forms over the telephone;

2.11.1.6.3.5. Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means;

2.11.1.6.3.6. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf; and

2.11.1.6.3.7. Providing individualized forms of assistance.

2.11.1.6.3.8. Ensuring safe and appropriate physical access to buildings, services and equipment;

2.11.1.6.3.9. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies;

2.11.1.6.3.10. Identifying to DMAS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute, and annually update, a work plan to achieve and maintain ADA compliance.

2.11.1.7. When a PCP or any medical, behavioral health or long-term services and supports provider is terminated from the Contractor's Provider Network or leaves the network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DMAS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.11.1.8. When the Food and Drug Administration determines a drug to be unsafe, the Contractor shall remove it from the formulary immediately. The Contractor must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) calendar days after the removal, to each Enrollee with a current or previous prescription for the drug. The Contractor must also make a good faith effort to call, within three (3) calendar days, each Enrollee with a current or previous prescription for the drug; a good faith effort must involve no fewer than three (3) phone call attempts at different times of day.

2.11.1.9. If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them in network. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.11.1.10. The Contractor shall annually report in writing on its use of out-of-network providers to meet Enrollee's necessary medical service needs.

2.11.1.11. The Contractor shall have the capacity to meet the needs of the linguistic groups in its Service Area. The following must be available:

2.11.1.11.1. The provision of care, including twenty-four (24) hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

2.11.1.11.1.1. Trained to translate in a medical setting;

2.11.1.11.1.2. Fluent in English; and

2.11.1.11.1.3. Fluent in the Enrollee's language;

2.11.1.11.2. Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS.

2.11.2. The Contractor is not responsible for services obtained outside the Commonwealth except under any of the following circumstances:

2.11.2.1. Necessary emergency or post-stabilization services,

2.11.2.2. Family planning where it is a general practice for Enrollees in a particular locality to use medical resources in another state

2.11.2.3. The required services are medically necessary and not available in-network and within the Commonwealth.

2.11.2.4. While the Contractor is honoring a transition of care plan, another MMP, or DMAS until services can be safely and effectively transitioned to a provider in the Contractor's network within the Commonwealth.

2.11.2.5. Further, direct and indirect payments to out-of-country individuals and/or entities are prohibited pursuant to Section 6505 of the Affordable Care Act and State Medicaid Director Letter (SMD# 10-026).

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care Services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions as defined in 42 C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Family planning services;

2.11.3.1.5. Out-of-area renal dialysis services; and

2.11.3.1.6. Prescription drugs as required in Appendix E.

2.11.4. Authorization of Services: In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.4.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor and any First Tier, Downstream, or Related Entities shall:

2.11.4.1.1. Have in place and follow written policies and procedures;

2.11.4.1.2. Have in place procedures to allow Enrollees to initiate requests for provision of services;

2.11.4.1.3. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and

2.11.4.1.4. Consult with the requesting provider when appropriate.

2.11.4.2. The Contractor shall ensure that a PCP and a behavioral health provider are available twenty-four (24) hours a day for timely authorization of Medically Necessary services, including, if necessary, the transfer of an Enrollee who presented to an emergency department with an Emergency Medical Condition which has been Stabilized, unless there are clear policies and procedures in place to ensure these activities are appropriately handled after hours at no risk to the Enrollee (medical, financial or otherwise). The Contractor's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and substance abuse services.

2.11.4.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.4.4. The Contractor shall assure that all behavioral health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for

demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.4.5. The Contractor shall ensure that decision makers on grievances and Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.11.4.5.1. A denial of an Appeal based on lack of medical necessity.

2.11.4.5.2. A grievance or Appeal regarding denial of expedited resolutions of an Appeal.

2.11.4.5.3. Any grievance or Appeal involving clinical issues.

2.11.4.6. The Contractor must notify the requesting provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 2.14, and must:

2.11.4.6.1. Be produced in a manner, format, and language that can be easily understood;

2.11.4.6.2. Be made available in Prevalent Languages, upon request; and

2.11.4.6.3. Include information, in the most commonly used languages about how to request translation services and Alternate Formats.

2.11.4.7. The Contractor must make authorization decisions in the following timeframes:

2.11.4.7.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.4.7.1.1. The Enrollee or the provider requests an extension, or

2.11.4.7.1.2. The Contractor can justify (to the satisfaction of DMAS and/or CMS upon request) that:

2.11.4.7.1.2.1. The extension is in the Enrollee's interest; and

2.11.4.7.1.2.2. There is a need for additional information where:

2.11.4.7.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.4.7.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.4.7.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.4.7 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.4.7.2.1. The Enrollee or the provider requests an extension; or

2.11.4.7.2.2. The Contractor can justify (to DMAS and/or CMS upon request) that:

2.11.4.7.2.3. The extension is in the Enrollee's interest; and

2.11.4.7.2.4. There is a need for additional information where:

2.11.4.7.2.5. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.4.7.2.6. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.4.7.3. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

2.11.5. Utilization Management/Authorization Program Description

2.11.5.1. The Contractor's Utilization Management (UM) programs shall comply with CMS requirements and timeframes for historically Medicare primary paid services in addition to the requirements for historically Medicaid primary paid services.

2.11.5.2. The Contractor must have a written UM program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long-term care services. The Contractor's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The program shall demonstrate that Enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees. The program shall reflect the standards for utilization management from the most current NCQA Standards when applicable. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, provider profiles.

2.11.5.3. In accordance with 42 C.F.R. § 438.210, any decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease. Additionally the Contractor and its First Tier, Downstream, and Related Entities are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee. The Contractor shall notify the requesting provider, and give the Enrollee written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

2.11.5.4. The following timeframe for decision requirements apply to service authorization requests, per 42 C.F.R. § 438.210:

2.11.5.4.1. Standard Authorization Decisions

2.11.5.4.1.1. For standard authorization decisions, the Contractor shall provide the decision notice as expeditiously as the Enrollee's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

2.11.5.4.1.1.1. The Enrollee or the provider requests extension; or

2.11.5.4.1.1.2. The Contractor justifies to DMAS and CMS upon request that the need for additional information per 42 C.F.R. § 438.210. (d)(1)(ii) is in the Enrollee's interest.

2.11.5.4.2. Expedited Authorization Decisions

2.11.5.4.2.1. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.

2.11.5.4.2.2. The Contractor may extend the three (3) business days turnaround time frame by up to fourteen (14) calendar days if the Enrollee requests an extension or the Contractor justifies to DMAS and CMS a need for additional information and how the extension is in the Enrollee's interest.

2.11.5.4.2.3. If the Contractor delegates responsibilities for UM to a First Tier, Downstream or Related Entity, the contract must have a mechanism in place to ensure that these standards are met by the First Tier, Downstream or Related Entity. The UM plan shall be submitted annually to DMAS and upon revision.

2.11.5.4.2.4. The Contractor shall assume responsibility for all Covered Services authorized by DMAS, CMS or a previous MMP, which are rendered after the Enrollment effective date.

2.11.5.4.3. Behavioral Health Service Authorization Policies and Procedures: The Contractor shall:

2.11.5.4.3.1. Review and update annually, at a minimum, the behavioral health clinical criteria and other clinical protocols that the Contractor may develop and utilize in its clinical case reviews and care management activities. Submit any modifications to DMAS annually for review and approval. In its review and update process, the Contractor shall consult with clinical experts either within its own clinical and medical staff or medical consultants outside of the Contractor's organization, who are familiar with standards and practices of mental health and substance use treatment in Virginia. Contractor shall ensure that clinical criteria are based on current research, relevant quality standards and evidence-based models of care.

2.11.5.4.3.2. Review and update annually and submit for DMAS approval, at a minimum, its behavioral health Services authorization policies and procedures.

2.11.5.4.3.3. Develop and maintain Behavioral Health Inpatient Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

2.11.5.4.3.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission for acute care, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week; access to a reviewer and response to a request for authorization is within established timeliness standards aligned with the level of urgency of the request, ensuring the safety of an Enrollee at all times;

2.11.5.4.3.3.2. A plan and a system in place to direct Enrollees to the least restrictive environment and the least intensive yet the most clinically appropriate service to safely and adequately treat the Enrollee;

2.11.5.4.3.3.3. A process to render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within three (3) hours, and within one (1) business day for non-emergency inpatient authorization and in writing within twenty-four (24) hours of all admissions;

2.11.5.4.3.3.4. Processes to ensure safe placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed and to avoid delay of onset of treatment to minimize risk to Enrollee;

2.11.5.4.3.3.5. A system to provide concurrent clinical reviews for continued stay in Behavioral Health Inpatient Services. Contractor to monitor Medical Necessity for the clinical need for continued stay, and progress toward and achievement of Behavioral Health Inpatient Services treatment goals and objectives;

2.11.5.4.3.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans based on updated clinical reports of Enrollee's status and response to existing treatment plan; and

2.11.5.4.3.3.7. Processes to ensure that treatment and discharge needs are addressed at the time of initial authorization and concurrent review, and that treatment planning includes coordination with the PCP and other service providers, such as community-based mental health services providers, as appropriate.

2.11.5.4.3.4. Develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

2.11.5.4.3.4.1. Policies and procedures to authorize Behavioral Health Outpatient Services for initial and ongoing requests for outpatient care;

2.11.5.4.3.4.2. Policies and procedures to authorize Behavioral Health Outpatient Services based upon behavioral health clinical criteria, based on current research, relevant quality standards and evidence-based models of care; and,

2.11.5.4.3.4.3. Review and update annually, at a minimum, and submit for DMAS approval its Behavioral Health Outpatient Services policies and procedures.

2.11.6. Authorization of LTSS

2.11.6.1. The Contractor must develop an authorization process for the LTSS listed in Appendix B.

2.11.6.2. At a minimum, the Contractor's authorization of LTSS must comply with DMAS' fee-for-service authorization criteria (available at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for those Covered Services. However, the Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the POC determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the POC, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS.

2.11.7. Services for Specific Populations

2.11.7.1. As appropriate, the Contractor shall coordinate with social service agencies (e.g., local departments of health and social services) and refer Enrollees to the following programs, to include, but not be limited to:

2.11.7.1.1. The Department of Behavioral Health and Developmental Services (DBHDS);

2.11.7.1.2. The Virginia Department for the Deaf and Hard of Hearing (VDDHH);

2.11.7.1.3. The Virginia Department for the Blind and Vision Impaired (DBVI);

2.11.7.1.4. The Virginia Department for Aging and Rehabilitative Services (DARS);

2.11.7.1.5. The Virginia Department of Health Professions;

2.11.7.1.6. The Virginia Department of Social Services (DSS); and

2.11.7.1.7. The Virginia Department of Health.

2.11.7.2. The Contractor shall deliver preventative health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by CMS or DMAS or, where there are no CMS or DMAS guidelines, in accordance with nationally accepted standards of practice.

2.11.7.3. The Contractor shall deliver prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by CMS or DMAS or, where there are no CMS or DMAS guidelines, in accordance with nationally accepted standards of practice.

2.11.7.4. The Contractor shall provide family planning services as follows:

2.11.7.4.1. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any family planning provider and include services and supplies for individuals of childbearing age which delay or prevent pregnancy, but do not include services to treat infertility or to promote fertility.

2.11.7.4.2. Ensure that all Enrollees do not need PA in order to receive such family planning services;

2.11.7.4.3. The Contractor may not restrict an Enrollee's choice of provider for family planning services, drugs, supplies, or devices.

2.11.7.4.4. The Contractor must cover family planning services, including drugs, supplies and devices by network and out-of-network providers.

2.11.7.4.5. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in this Section;and out-of-network; and

2.11.7.4.6. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:

2.11.7.4.6.1. All methods of contraception, including family planning services, drugs, supplies, or devices

2.11.7.4.6.2. Sterilizations including vasectomy, tubal ligation and contraceptive implants

2.11.7.4.6.3. Counseling regarding HIV, sexually transmitted infections, and risk reduction practices; and

2.11.7.4.6.4. If Enrollees become pregnant, provide referrals for the following: prenatal care, foster care or adoption.

2.11.7.5. The Contractor shall provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery system, the Contractor shall respect the privacy of Enrollees. The Contractor shall comply with Section 5.2 regarding compliance with laws and regulations relating to confidentiality and privacy.

2.11.8. Emergency and Post-stabilization Care Coverage

2.11.8.1. The Contractor shall cover and pay for Emergency Services in accordance with 2.10.3.

2.11.8.2. The Contractor shall not deny payment for treatment for an Emergency Medical Condition, pursuant to 42 C.F.R § 438.114.

2.11.8.3. The Contractor shall not deny payment for treatment of an Emergency Medical Condition if a representative of the Contractor instructed the Enrollee to seek Emergency Services.

2.11.8.4. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms, pursuant to 42 C.F.R. § 438.114(d).

2.11.8.5. The Contractor shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

2.11.8.6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose or Stabilize the specific condition.

2.11.8.7. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining if the Enrollee's Emergency Medical Condition has been Stabilized and the Enrollee may be transferred or discharged, as applicable. The Contractor shall cover and pay for post-stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).

2.11.9. Availability of Services

2.11.9.1. 24-Hour Coverage

2.11.9.1.1. The Contractor must provide a twenty-four (24) hour-per-day, seven (7) days-per-week toll-free system with access to a registered nurse who:

2.11.9.1.1.1. Has immediate access to the Enrollee Medical Record;

2.11.9.1.1.2. Is able to respond to Enrollee questions about health or medical concerns;

2.11.9.1.1.3. Has the experience and knowledge to provide clinical triage;

2.11.9.1.1.4. Is able to provide options other than waiting until business hours or going to the emergency room; and,

2.11.9.1.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge.

2.11.10. Access to Services for Emergency Medical Conditions and Urgent Care. The Contractor shall:

2.11.10.1.1. Have a Provider Network to ensure access to twenty-four (24) hour emergency services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.2. Have a process established to notify the PCP or ICT (or the designated covering physician) of an Emergency Medical Condition within one (1) business day after the Contractor is notified by the provider.

2.11.10.1.3. Have a process to notify the PCP or ICT of required Urgent Care within one (1) business day of the Contractor being notified.

2.11.10.1.4. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee Medical Record no more than eighteen (18) hours after the PCP or ICT is notified, and a full report of the services provided within two (2) business days.

2.11.10.1.5. Pay the provider or reimburse the Enrollee, in the fee-for-service amount that would have been paid by Medicare and/or DMAS, if services are obtained out of network for Emergency Medical Conditions. This must be done within sixty (60) calendar days after the claim has been submitted. The Contractor must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

2.11.10.1.6. Cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c). The Contractor may not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R § 438.114(a) of the definition of Emergency Medical Condition.

2.11.10.1.7. Ensure that an Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

2.11.10.2. The Contractor's Provider Network must comply with the Emergency Medical Treatment and Labor Act (EMTALA), which requires;

2.11.10.2.1. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b).

2.11.10.2.2. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

2.11.10.2.3. The Contractor's contracts with its providers must clearly state the provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

2.11.11. Linguistic Competency

2.11.11.1. The Contractor must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

2.11.12. Access for Enrollees with Disabilities

2.11.12.1. The Contractor and its Providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The Contractor and its Providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility. Physical and telephone access to services must be made available for individuals with disabilities and fully comply with the ADA. The Contractor must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the Contractor. The Contractor must have policies and procedures in place demonstrating a commitment accommodating the physical access and flexible scheduling needs of Enrollees, in compliance with the ADA. This includes the use of TTY/TDD devices for the Deaf and hard of hearing, qualified American Sign Language interpreters and alternative cognitively accessible communication for persons with cognitive limitations.

2.11.13. Access to Alternative Settings (Community-Based)

2.11.13.1. The Contractor will have significant flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.

2.12. Enrollee Services

2.12.1. Enrollee Service Representatives (ESRs)

2.12.1.1. The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Eligible Beneficiaries, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;

2.12.1.1.2. Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternate Formats;

2.12.1.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, TTY, or through an alternative language device or telephone translation service;

2.12.1.1.4. Inform callers that interpreter services are free.

2.12.1.1.5. Be knowledgeable about Virginia Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;

2.12.1.1.6. Be available to Enrollees to discuss and provide assistance with resolving Enrollee Complaints;

2.12.1.1.7. Have access to the Contractor's Enrollee database, and an electronic provider and pharmacy directory.

2.12.1.1.8. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;

2.12.1.1.9. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.1.10. Demonstrate sensitivity to culture, including disability culture and the independent living philosophy;

2.12.1.1.11. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at or below 6th grade reading level, and individualized guidance from ESRs to ensure materials are understood;

2.12.1.1.12. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.1.13. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.12.1.1.14. Ensure that ESRs make available to Enrollees and Eligible Beneficiary, upon request, information concerning the following:

2.12.1.1.14.1. The identity, locations, qualifications, and availability of providers;

2.12.1.1.14.2. Enrollees' rights and responsibilities;

2.12.1.1.14.3. The procedures available to an Enrollee and provider(s) to challenge or appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Actions (denials);

2.12.1.1.14.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternate Formats;

2.12.1.1.14.5. Information on all Covered Services and other available services or resources (e.g., state agency services) either directly or through referral or authorization;

2.12.1.1.14.6. The procedures for an Enrollee to change plans or to Opt Out of the Demonstration; and

2.12.1.1.14.7. Additional information that may be required by Enrollees and Eligible Beneficiaries to understand the requirements and benefits of the MMP.

2.12.2. Enrollee Service Telephone Responsiveness

2.12.2.1. There are five (5) call center requirements for the Contractor:

2.12.2.1.1. General customer service (8:00 am-8:00 pm, seven (7) days a week. Alternative technologies may be used on Saturdays, Sundays, and federal holidays);

2.12.2.1.2. Coverage determinations (8:00 am-6:00 pm, Monday through Friday);

2.12.2.1.3. Nurse hotline (24/7);

2.12.2.1.4. Care management support (24/7) [Enrollees shall be able to access information regarding all Covered Services during these times]; and,

2.12.2.1.5. Pharmacy Technical Support Line (Hours of operation for technical support cover all hours for which any network pharmacy is open, seven (7) days a week.)

2.12.2.2. Informational calls to Contractor's call centers that become sales/enrollment calls at the proactive request of the beneficiary must be transferred to DMAS' authorized agent.

2.12.2.3. The Contractor's ESR's must answer 80% of all Enrollee telephone calls within 30 seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the IVR system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five (5) percent. The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Coverage Determinations and Appeals Call Center Requirements

2.12.3.1. The Contractor must operate a toll-free call center with live Enrollee service representatives available to respond to providers and Enrollees for information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

2.12.3.2. The Contractor is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call centers.

2.12.3.3. The call centers must operate during normal business hours and never less than from 8:00 a.m. to 6:00 p.m., Monday through Friday as outlined in Section 2.12.2 above.

2.12.3.4. The Contractor must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations /redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours.

2.12.3.5. Voicemail may be used outside of normal business hours provided the message:

2.12.3.5.1. Indicates that the mailbox is secure;

2.12.3.5.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, Enrollee identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.12.3.5.3. For coverage determination calls (including exceptions requests) related to Part D, articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.12.3.5.4. For Appeals calls, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

2.12.3.5.4.1. Note that only requests for expedited appeals via State Fair Hearings may be submitted orally via telephone.

2.12.4. Enrollee Advisory Committee

2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.12.4.1.1. Meets at least quarterly throughout the Demonstration beginning second quarter of CY 2014.

2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DMAS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DMAS and/or CMS.

2.13. Enrollee Grievance

2.13.1. Grievance Filing

2.13.1.1. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page per 42 C.F.R. § 422.504(b)(15)(ii).The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or state law.

2.13.2. Grievance Administration

2.13.2.1. Internal (plan level) Grievance

2.13.2.1.1. An Enrollee may file an Internal Enrollee Grievance with the Contractor or its network providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA. The Contractor must maintain written records of all Grievance activities, and notify CMS and DMAS of all internal Grievances. The system must meet the following standards:

2.13.2.1.1.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.13.2.1.1.2. Timely review of each Enrollee Grievance;

2.13.2.1.1.3. Standard response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance; and

2.13.2.1.1.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeal timeframe or Contractor refuses to grant a request for an expedited Appeal;

2.13.2.1.1.5. Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.13.2.2, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

2.13.2.2. External Grievance (Medicare Only)

2.13.2.2.1. The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare.

2.13.2.2.1.1. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page.

2.13.2.2.1.2. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.14. Enrollee Appeals

2.14.1. General

2.14.1.1. All Contractors shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in Appendix E. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the Contractor misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The Contractor must maintain written records of all Appeal activities, and notify CMS and DMAS of all internal Appeals.

2.14.1.2. The Contractor agrees to be fully compliant with all state and federal laws, regulations, and policies governing the Appeal and State Fair Hearing process, as applicable, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The Contractor shall be financially liable for all judgments, penalties, costs and fees related to an appeal in which the Contractor has failed to comply fully with said requirements. The Contractor must maintain written records of all Appeal activities, and notify CMS and DMAS of all internal Appeals in the manner and format determined by CMS and DMAS.

2.14.1.3. Integrated/Unified Non-Part D Appeals Process Overview

2.14.1.3.1. Notice of Adverse Action – In accordance with 42 C.F.R. §§ 438.404 and 422.568, the Contractor must give the Enrollee written notice of any Adverse Action. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) days in advance of the date of its action. For denial of payment, such notice shall be provided at the time of action.

2.14.1.3.2. An Enrollee or a provider acting on behalf of an Enrollee and with the Enrollee's written consent may appeal the Contractor's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee or provider action on behalf of an Enrollee and with the Enrollee's consent may also appeal the Contractor's delay in providing or arranging for a Covered Service.

2.14.1.4. Integrated Notice

Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and DMAS.

2.14.1.4.1. The notice must explain:

2.14.1.4.1.1. The action the Contractor has taken or intends to take;

2.14.1.4.1.2. The reasons for the action;

2.14.1.4.1.3. The citation to the law or policy supporting such action

2.14.1.4.1.4. The Enrollee's or the provider's right to file an internal Appeal with the Contractor and that exhaustion of the Contractor's internal appeal processes is a prerequisite to filing an external appeal to Medicare or to Medicaid;

2.14.1.4.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.14.1.4.1.6. The Enrollee's right to request a State fair hearing in accordance with 12 VAC 30-110-10 through 12 VAC 30-110-380 and as described in Section 2.14.3.2, including representation rules at a hearing;

2.14.1.4.1.7. Circumstances under which expedited resolution is available and how to request it; and

2.14.1.4.1.8. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.

2.14.1.4.2. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternate Formats and how to access those formats.

2.14.1.4.2.1. Written notice must be translated for the individuals who speak Prevalent Languages.

2.14.1.4.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.14.1.5. Appeal levels

2.14.1.5.1. Initial Appeals (first level internal Appeal) will be filed with the Contractor.

2.14.1.5.2. Subsequent Appeals for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare IRE by the Contractor.

2.14.1.5.3. Subsequent Appeals for services covered by DMAS only (including but not limited to, LTSS, Virginia Medicaid-covered drugs excluded from Medicare Part D, and behavioral health) may be appealed to the DMAS Appeals Division after the initial plan-level Appeal has been completed, within the required timeframe.

2.14.1.5.4. Subsequent Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the Contractor, and an Enrollee may also file a request for a hearing with the DMAS Appeals Division. If an Appeal is filed with both the IRE and the DMAS Appeals Division, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

2.14.1.6. Prescription Drugs

2.14.1.6.1. Part D Appeals may not be filed with the DMAS Appeals Division.

2.14.1.6.2. Appeals related to drugs excluded from Part D that are covered by Medicaid must be filed with the DMAS Appeals Division.

2.14.1.7. Appeal resolution time frames

2.14.1.7.1. All initial Appeals must be resolved by the Contractor within thirty (30) calendar days of receipt for standard Appeals and within seventy-two (72) hours or as expeditiously as the Enrollee's condition requires for Appeals qualifying as expedited Appeals. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the Contractor shall provide written notice to the Enrollee of the reason for the delay.

2.14.1.7.2. For Medicare services Appeals automatically forwarded to the IRE, the IRE must notify the Enrollee of an expedited decision within seventy-two (72) hours, a standard pre-service decision within thirty (30) calendar days and a payment decision within sixty (60) calendar days

2.14.1.7.3. External Appeals to the Medicaid State Fair Hearing process that do not qualify as expedited shall be resolved or a decision issued within ninety (90) days of the date of filing the Appeal for the first year of the Demonstration (CY 2014 and CY 2015), and within seventy-five (75) days of the date of filing the Appeal for the second year of the Demonstration, and within thirty (30) days of the date of filing the Appeal for subsequent years thereafter. The timeline for resolution or issuance of a decision in Medicaid external Appeals may be extended for delays not caused by DMAS, in accordance with existing Federal court order in *Shifflett v. Kozlowski* (W.D.Va 1994), relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays (e.g., the hearing officer leaves the hearing record open after the hearing in order to receive additional evidence or argument from the appellant; the appellant or representative requests to reschedule/continue the hearing; the hearing officer receives additional evidence from a person other than the appellant or his representative and the appellant requests to comment on such evidence in writing or to have the hearing reconvened to respond to such evidence).

2.14.1.7.4. External Appeals to the Medicaid State Fair Hearing process that qualify as expedited Appeals shall be resolved within three (3) business days or as expeditiously as the Enrollee's condition requires. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the Enrollee's interest (upon state request). For any extension not requested by the Enrollee, the Contractor shall provide written notice to the Enrollee of the reason for the delay.

2.14.1.8. Notice of Resolution. The Contractor must provide all decisions to Appeal in writing and shall include, but not be limited to, the following information:

2.14.1.8.1. The decision reached by the Contractor;

2.14.1.8.2. The date of decision;

2.14.1.8.3. For Appeals not resolved wholly in favor of the Enrollee:

2.14.1.8.3.1. The right to request a State Fair Hearing and how to do so;

2.14.1.8.3.2. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the Enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor .

2.14.1.8.4. For expedited Appeals, the Contractor shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar days with a written notice of action.

2.14.1.9. Continuation of Benefits Pending an Appeal and State Fair Hearing

2.14.1.9.1. The Contractor must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes and conditions in 42 C.F.R. § 438.420. This means that such benefits will continue to be provided by providers to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.14.1.9.2. For all Appeals filed with the DMAS Appeals Division, an Enrollee may request continuation of services. DMAS will make a determination on continuation of services in accordance with the Commonwealth's existing Appeals policy at 12VAC30-110-100, in accordance with 42 C.F.R. § 438.420.

2.14.1.9.3. If the final resolution of the Appeal upholds the Contractor's action and services to the Enrollee were continued while the Appeal or State Fair Hearing was pending, the Contractor may recover the cost of the continuation of services from the enrollee.

2.14.2. Internal (Plan-level) Appeals

2.14.2.1. Initial Appeals must be filed with the Contractor. The filing of an internal Appeal and exhaustion of the Contractor's internal Appeal process is a prerequisite to filing an external Appeal to Medicare or Medicaid.

2.14.2.2. Standard Appeals

2.14.2.2.1. The Contractor's Appeals process must include the following requirements:

2.14.2.2.1.1. Acknowledge receipt of each Appeal.

2.14.2.2.1.2. Ensure that the individuals who make decisions on Appeals were not involved in any previous level of review or decision making.

2.14.2.2.1.3. An Appeal may be submitted orally or in writing. If the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. §438.410, the Contractor may require the Enrollee to follow an oral Appeal with a written, signed Appeal..

2.14.2.2.1.4. Provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The Contractor must inform the Enrollee of the limited time available for this, especially in the case of expedited resolution.

2.14.2.2.1.5. Provide the Enrollee and his or her representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including any medical records and any other documents and records considered during the Appeals process.

2.14.2.2.1.6. Consider the Enrollee, representative or estate representative of a deceased Enrollee as parties to the Appeal.

2.14.2.2.2. The Contractor shall respond in writing to standard Appeals as expeditiously as the Enrollee's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the Appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the Contractor provides evidence satisfactory to DMAS that a delay in rendering the decision is in the Enrollee's interest. For any Appeals decisions not rendered within thirty (30) calendar days where the Enrollee has not requested an extension, the Contractor shall provide written notice to the Enrollee of the reason for the delay.

2.14.2.3. Expedited Appeals

2.14.2.3.1. The Contractor shall establish and maintain an expedited review process for Appeals where either the Contractor or the Enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports an Enrollee's Appeal. In instances where the Enrollee's request for an expedited appeal is denied, the Appeal must be transferred to the timeframe for standard resolution of Appeals and the Enrollee must be given prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.

2.14.2.3.2. The Contractor shall issue decisions for expedited Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the Appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the Contractor provides evidence satisfactory to the Department that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the Contractor shall provide written notice to the Enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar days with a written notice of action.

2.14.2.3.3. All decisions to Appeal must be in writing and shall include, but not be limited to, the following information:

2.14.2.3.3.1. The decision reached by the Contractor;

2.14.2.3.3.2. The date of decision;

2.14.2.3.3.3. For Appeals not resolved wholly in favor of the Enrollee:

2.14.2.3.3.3.1. The right to request a State Fair Hearing and how to do so;

2.14.2.3.3.3.2. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the Enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor.

2.14.3. External Appeals

2.14.3.1. The CMS Independent Review Entity (IRE)

2.14.3.1.1. If, on internal Appeal, the Contractor does not decide fully in the Enrollee's favor within the relevant time frame, the Contractor shall automatically forward the case file regarding Medicare services to the CMS IRE for a new and impartial review. The CMS IRE is contracted by CMS.

2.14.3.1.2. For standard external Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within thirty (30) calendar days after it receives the case from the Contractor, or at the end of up to a fourteen (14) calendar day extension.

2.14.3.1.3. If the CMS IRE decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

2.14.3.1.4. For expedited external Appeals, the CMS IRE will send the Enrollee and the Contractor a letter with its decision within seventy-two (72) hours after it receives the case from the Contractor, or at the end of up to a fourteen (14) calendar day extension.

2.14.3.1.5. If the Contractor or the Enrollee disagrees with the CMS IRE's decision, further levels of Appeal may be available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor must comply with any requests for information or participation from such further Appeal entities.

2.14.3.2. The Medicaid State Fair Hearing Process

2.14.3.2.1. If the Contractor's internal Appeal decision is not fully in the Enrollee's favor, the Enrollee may Appeal to the DMAS Appeals Division for Medicaid-based adverse decisions. Such Appeals must be made in writing and may be made via U.S. Mail, fax transmission, hand-delivery or electronic transmission. Appeals to the external Medicaid State Fair Hearing process will not be automatically forwarded to DMAS by the Contractor. Enrollees have the option of filing an expedited Appeal by telephone.

2.14.3.2.2. Parties to the State Fair Hearing include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.14.3.2.3. Appeals to the external Medicaid State Fair Hearing process must be filed within sixty (60) days of the date of the Contractor 's internal Appeal decision, unless the time period is extended by DMAS upon a finding of "good cause" in accordance with current State Fair Hearing regulations. See Section 2.14.1.7.3 and 2.14.1.7.4 for timeframes for issuing standard and expedited external Medicaid Appeal decisions.

2.14.3.2.4. If the DMAS Appeals Division decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision.

2.14.3.2.5. If the Enrollee disagrees with the DMAS Appeals Division's decision, further levels of Appeal are available, including an Appeal to the Circuit Court. There is then an automatic right to Appeal to the Virginia Court of Appeals. The next level of court review is to the Virginia Supreme Court.

2.14.4. Hospital Discharge Appeals

2.14.4.1. When an Enrollee is being discharged from the hospital, the Contractor must assure that the Enrollee receives a written notice of explanation called an *Important Message from Medicare About your Rights* regarding the right to appeal the discharge decision from an inpatient hospital admission.

2.14.4.2. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. The Enrollee must contact the QIO before he/she leaves the hospital but no later than the planned discharge date.

2.14.4.3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The Contractor must ensure that the Enrollee receives the Detailed Notice of Discharge (CMS-10066). Note: an Enrollee may file an oral or written request for an expedited seventy-two (72)-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.

2.14.4.4. The QIO will make its decision within one (1) full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.

2.14.4.5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

2.14.4.6. If the QIO overturns the Contractor's decision, the Contractor must pay for the remainder of the hospital stay.

2.15. Provider Appeals

2.15.1. Contractor's Internal Reconsideration Process for Service Providers.

2.15.1.1. The Contractor shall have an internal Reconsideration process in place available to providers who wish to challenge decisions made by DMAS, its contractors or agents, regarding payment or authorization for Medicaid-based services that have been rendered to an Enrollee. This process must assure that appropriate decisions are made as promptly as possible. At the conclusion of the Contractor's internal reconsideration process, the

Contractor shall issue a final decision letter to the provider. The final decision letter issued to the provider must be mailed on the date appearing on the final decision letter. The final decision letter must include a statement that the provider has exhausted its reconsideration rights with the Contractor and include an explanation of Appeal rights to DMAS, as specified by DMAS.

2.15.2. Compliance with DMAS's Provider Appeal Process.

2.15.2.1. Upon exhaustion of the Contractor's internal reconsideration process for service providers, an Appeal may be filed by service providers, for denial by the DMAS or its agents or contractors, in whole or part, of payment or authorization for Medicaid-based services already rendered to an Enrollee. The provider's exhaustion of the Contractor's internal reconsideration process for providers is a prerequisite to filing for an Appeal to DMAS. Requests for Appeals are considered filed when they are date-stamped into the Appeals Division.

2.15.2.2. The normal business hours of DMAS are from 8:00am to 5:00pm on days that DMAS is open for business. Documents filed after normal business hours on the due date shall be untimely. Full adherence and compliance with all of the timelines and requirements of the DMAS Appeals process contained in the Virginia Administrative Code at 12 VAC 30-20-500 et. seq. shall be required by service providers seeking to avail themselves of the DMAS provider Appeal process. The Appeal process is available to:

2.15.2.2.1. Enrolled providers that have rendered services and have been denied payment in whole or part for Medicaid-based services,

2.15.2.2.2. Providers who have received a notice of program reimbursement or overpayment demand related to Medicaid-based services from DMAS or its contractors,

2.15.2.2.3. Providers who have been denied authorization, in whole or part, for Medicaid-based services already rendered, and

2.15.2.2.4. Providers may not Appeal to DMAS issues of enrollment denial, disenrollment or termination.

2.15.2.3. Upon notification that a service provider has filed an Appeal with DMAS, the Contractor shall file a written case summary with the DMAS Appeals Division, in accordance with the requirements and timelines set forth in DMAS' provider Appeal regulations (12 VAC 30-20-500 et. seq.) within thirty (30) days of the filing of the provider's notice of Appeal. The Contractor shall mail a complete copy of the case summary to the DMAS designated staff and to the provider on the same day that the case summary is filed with the DMAS Appeals Division. The case summary shall address each adjustment, patient, service date, or other disputed matter and shall

state the Contractor's position and authority for each adjustment, patient, service date, or other disputed matter. The case summary shall contain the factual basis for each adjustment, patient, service date, or other disputed matter and any other information, authority, or documentation the Contractor relied upon in taking its action or making its decision. The Contractor shall be responsible for paying the service provider and for all costs associated with the Appeal, including awarded attorneys' fees if the service provider prevails due to the Contractor's failure to provide a sufficient case summary in a timely manner.

2.15.2.4. The Contractor shall facilitate and participate in the DMAS Appeal process that DMAS issued in relation to the program, as well as in full compliance with the requirements and timelines set forth in DMAS Appeal regulations (12 VAC 30-20-500 et. seq.) and the Virginia Administrative Process Act (Code of Virginia 2.2-4000 et. seq.). The Contractor is required to attend all hearings and conferences related to the Appeal process to defend the Contractor's decision. If the Contractor's decision was based, in whole or part, upon a medical determination, including but not limited to Medical Necessity or appropriateness or LOC the Contractor shall provide sufficiently qualified medical personnel to attend the appeal related conference(s) and hearing(s). The Contractor bears responsibility for its own travel and expenses to fulfill its obligations for its witness' attendance at the conference(s) and hearing(s).

2.15.2.5. The Contractor must comply with all federal and state laws, regulations, and policies regarding the Appeal process. The Contractor is required to promptly respond to any requests made by DMAS pertaining to Appeals. In cases where the service provider prevails upon Appeal, in whole or in part, the Contractor shall be responsible for paying the service provider and for all costs associated with the Appeal, including awarded attorneys' fees. The Contractor shall be responsible for reimbursement to DMAS for any financial loss incurred by DMAS due to the Contractor's failure to be in compliance with all federal and state laws, regulations, and policies regarding the Appeal process.

2.15.2.6. The Contractor does not have the right to Appeal in any administrative action.

2.16. Document Production

2.16.1. The Contractor is responsible for the preservation and production of documents associated with any Appeal.

2.16.2 The Contractor shall be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, FOIA request, or any litigation involving the Contractor or the Department, including but not limited to, external Appeals.

2.17. Quality Improvement Program

2.17.1. The Contractor shall:

2.17.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.17.1.1.1. Quality of physical health care, including primary and specialty care;

2.17.1.1.2. Quality of behavioral health care focused on recovery, resiliency and rehabilitation;

2.17.1.1.3. Quality of LTSS;

2.17.1.1.4. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS providers and services;

2.17.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.17.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.17.1.2. Apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.17.1.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.17.1.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.17.1.2.3. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities; and

2.17.1.2.4. Issues identified by the Contractor, DMAS and/or CMS; and

2.17.1.3. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health, and LTSS.

2.17.2. QI Program Structure

2.17.2.1. The Contractor shall structure its QI program for the Demonstration separately from any of its existing Medicaid, or Medicare, or Commercial lines of business. For example, required measures for this Demonstration must be reported for the Demonstration population only. Integrating the Demonstration population into an existing line of business shall not be acceptable.

2.17.2.2. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 CFR § 438, including Subpart D, Quality Assessment and Performance Improvement, 42 CFR § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2.17.2.3. The Contractor shall:

2.17.2.3.1. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.17.2.3.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.17.2.3.3. Seek the input of providers and medical professionals representing the composition of the Contractor's Provider Network in developing functions and activities;

2.17.2.3.4. Establish internal processes to ensure that the QM activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in this Section 2.17 of this Contract and, in addition, the following elements:

2.17.2.3.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.17.2.3.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DMAS;

2.17.2.3.4.3. A process to measure network providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's MMP. The Contractor shall submit a survey plan to DMAS for approval and shall submit the results of the survey to DMAS and CMS;

2.17.2.3.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures;

2.17.2.3.4.5. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in consumer advisory boards; and

2.17.2.3.4.6. In collaboration with and as further directed by DMAS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.17.2.3.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall:

2.17.2.3.5.1. Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

2.17.2.3.5.2. Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS providers with respect to QI program;

2.17.2.3.5.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.17.2.3.5.4. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management.

2.17.2.3.6. Submit to DMAS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DMAS and CMS:

2.17.2.3.6.1. Planned clinical and non-clinical initiatives;

2.17.2.3.6.2. The objectives for planned clinical and non-clinical initiatives;

2.17.2.3.6.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.17.2.3.6.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.17.2.3.6.5. Any issues identified by the Contractor, DMAS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.17.2.3.6.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.17.2.3.6.7. Process for correcting deficiencies.

2.17.2.3.7. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the DMAS Quality monitor and CMT. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.17.2.3.8. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:

2.17.2.3.8.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment and delivery of long term services and supports with substantial involvement in the QI program;

2.17.2.3.8.2. A qualified individual to serve as the Demonstration QI director who will be directly accountable to the Contractor's Virginia executive director and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the MMP's executive leadership team. This individual shall be responsible for:

2.17.2.3.8.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.17.2.3.8.2.2. Maintaining an active role in the Contractor's overall QI structure; and

2.17.2.3.8.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.17.2.3.8.2.3.1. Physical and behavioral health care;

2.17.2.3.8.2.3.2. Pharmacy management;

2.17.2.3.8.2.3.3. Care management;

2.17.2.3.8.2.3.4. LTSS;

2.17.2.3.8.2.3.5. Financial;

2.17.2.3.8.2.3.6. Statistical/analytical;

2.17.2.3.8.2.3.7. Information systems;

2.17.2.3.8.2.3.8. Marketing, publications;

2.17.2.3.8.2.3.9. Enrollment; and

2.17.2.3.8.2.3.10. Operations management;

2.17.2.3.9. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by DMAS, or its designee, that may be attended by representatives of DMAS, a DMAS Contractor, Contractor, and other entities, as appropriate; and

2.17.2.3.10. Serve as liaison to, and maintaining regular communication with, Virginia QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.17.3. QI Activities

2.17.3.1. The Contractor shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.17.3.2. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a), 422.516(a) and 423.514.

2.17.3.3. Performance Measurement

2.17.3.3.1. Contractor shall perform and report the quality and utilization measures identified by CMS and DMAS and in accordance with requirements in the MOU between CMS and the Commonwealth of Virginia of May 21, 2013 , Figure 7-2 Core Quality Measures, and as articulated in this Contract and shall include, but are not limited to:

2.17.3.3.1.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 Core Quality Measures of the MOU referenced above (Figure 7-2). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.17.3.3.2. Contractor shall not modify the reporting specifications methodology prescribed by CMS and DMAS without first obtaining CMS and the state's written approval. Contractor must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and DMAS. CMS and DMAS (or its designee) will perform an independent validation of at least a sample of Contractor's findings.

2.17.3.3.3. Contractor shall monitor other performance measures not specifically stated in contract that are required by CMS. DMAS will use its best efforts to notify Contractor of new CMS requirements.

2.17.3.3.4. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DMAS and CMS, as follows:

2.17.3.3.4.1. Collect and submit to DMAS, CMS and/or CMS' contractors, in a timely manner, data for the measures specified in Figure 7-2;

2.17.3.3.4.2. Contribute to all applicable DMAS and CMS data quality assurance processes, which shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DMAS and rectifying those inadequacies, as directed by DMAS;

2.17.3.3.4.3. Contribute to DMAS and CMS data regarding the individual and aggregate performance of DMAS MMPs with respect to the noted measures; and

2.17.3.3.4.4. Contribute to DMAS processes culminating in the publication of any additional technical or other reports by DMAS related to the noted measures.

2.17.3.3.5. The Contractor shall demonstrate how to utilize results of the measures specified in Figure 7-2 in designing QI initiatives.

2.17.3.4. Enrollee Experience Surveys:

2.17.3.4.1. The Contractor shall conduct Enrollee experience survey activities, as directed by DMAS and/or CMS, as follows:

2.17.3.4.1.1. Conduct, as directed by DMAS and CMS, an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;

2.17.3.4.1.2. Conduct, as directed by DMAS, the HCBS Experience survey for individuals utilizing LTSS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;

2.17.3.4.1.3. Conduct, as directed by DMAS, a quality of life survey, such as the Young and Bullock 2003 survey, adapted for general populations. This survey may be self-administered, or administered by a trained interviewer;

2.17.3.4.1.4. Contribute, as directed by DMAS and CMS, to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by DMAS and CMS and rectifying those inadequacies, as directed by DMAS and CMS;

2.17.3.4.1.5. Contribute, as directed by DMAS, to processes culminating in the development of an annual report by DMAS regarding the individual and aggregate Enrollee experience survey performance of DMAS-contracted MMPs; and

2.17.3.4.1.6. The Contractor shall demonstrate best efforts to utilize Enrollee experience survey results in designing QI initiatives.

2.17.4. QI Project Requirements

2.17.4.1.1. The Contractor shall implement and adhere to all processes relating to the QI project requirements, as directed by DMAS and CMS, as follows:

2.17.4.1.1.1. During the enrollment year and annually thereafter, Contractor will identify applicable representatives to serve on a quality collaborative with DMAS. This collaborative will determine QI initiatives to begin in year 1 of the Demonstration and annually thereafter;

2.17.4.1.1.2. In accordance with 42 C.F.R. §438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QI Project Requirement specifications for its Enrollees; using the format and submission guidelines specified by DMAS and CMS in annual guidance provided for the upcoming contract year;

2.17.4.1.1.3. Implement the QI project requirements, in a culturally competent manner, to achieve objectives as specified by DMAS and CMS;

2.17.4.1.1.4. Evaluate the effectiveness of QI interventions;

2.17.4.1.1.5. Plan and initiate processes to sustain achievements and continue improvements;

2.17.4.1.1.6. Submit to DMAS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by DMAS and CMS. Such reports shall include information regarding progress on QI Project Requirements, barriers encountered and new knowledge gained. As directed by DMAS and CMS, the Contractor shall present this information to DMAS and CMS at the end of the QI requirement project cycle as determined by DMAS and CMS; and

2.17.4.1.1.7. In accordance with 42 C.F.R. §422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DMAS and CMS may require them to address specific topic areas.

2.17.4.2. CMS-Specified Performance Measurement and Performance Improvement Projects

2.17.4.2.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.17.5. External Quality Review (EQR) Activities

2.17.5.1. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by DMAS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include, but are not limited to:

2.17.5.1.1. Annual validation of performance measures reported to DMAS, as directed by DMAS, or calculated by DMAS;

2.17.5.1.2. Annual validation of quality improvement projects required by DMAS and CMS; and

2.17.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of DMAS, regarding access, structure and operations, and quality of care and services furnished to Enrollees. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.17.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:

2.17.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.17.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO, QIO, DMAS and/or CMS staff in a timely manner;

2.17.5.1.3.1.3. Serve as the liaison to the EQRO, QIO DMAS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DMAS in a timely manner; and

2.17.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DMAS.

2.17.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The Contractor shall maintain such documentation for a minimum of ten (10) years;

2.17.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or DMAS;

2.17.5.1.4. Participating in MMP-specific and cross-MMP meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DMAS;

2.17.5.1.5. Implementing actions, as directed by DMAS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, DMAS, and CMS in subsequent years; and

2.17.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DMAS and CMS.

2.17.6. QI for Utilization Management Activities

2.17.6.1. The Contractor shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.

2.17.6.2. The QI activities for the UM program shall include:

2.17.6.2.1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;

2.17.6.2.2. At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of long term services and supports representative of the Contractor or subcontractor, with substantial involvement in the UM program; and

2.17.6.2.3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

2.17.7. Clinical Practice Guidelines

2.17.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

2.17.7.1.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long term services and supports in the relevant field, community-based support services or the Contractor's approved behavioral health performance specifications and clinical criteria;

2.17.7.1.1.2. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of LTSS;

2.17.7.1.1.3. Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, or other State agencies;

2.17.7.1.1.4. Prior to adoption, have been reviewed by the Contractor's medical director, as well as other Contractor practitioners and network providers, as appropriate; and

2.17.7.1.1.5. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.17.7.2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;

2.17.7.3. For guidelines that have been in effect two (2) years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;

2.17.7.4. Disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's web site. The Contractor shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made;

2.17.7.5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services; and

2.17.7.6. Submit to DMAS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

2.17.8. QI Workgroups

2.17.8.1. As directed by DMAS, the Contractor shall actively participate in QI workgroups that are led by DMAS, including any quality management workgroups or activities, attended by representatives of DMAS, DMAS-contractors, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2.17.8.2. DMAS Directed Performance Incentive Program

2.17.8.2.1. DMAS and CMS will require that the Contractor meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in Section 4.2.5.

2.17.8.2.2. In order to receive any withhold payments, the Contractor shall comply with all DMAS and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.17.8.3. Enrollee Incentives

2.17.8.3.1. The Contractor may implement Enrollee Incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The Contractor shall:

2.17.8.3.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

2.17.8.3.1.2. Ensure that the nominal value of Enrollee incentives do not exceed $15, based on the fair market value of the item or less, with a maximum aggregate of $50 per person, per year;

2.17.8.3.1.3. Submit to DMAS, at the direction of DMAS, ad hoc report information relating to planned and implemented Enrollee incentives and assure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as state and federal laws.

2.17.8.4. Behavioral Health Services Outcomes

2.17.8.4.1. The Contractor shall require behavioral health providers to measure and collect clinical outcomes data, to incorporate that data in treatment data available to the Contractor, upon request;

2.17.8.4.2. The Contractor's behavioral health provider contracts shall require the provider to make available behavioral health clinical assessment and outcomes data for quality management and network management purposes;

2.17.8.4.3. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by DMAS, the Contractor shall collaborate with DBHDS, behavioral health providers and CSBs/BHAs to develop outcome measures that are specific to each behavioral health service type. Such outcome measures may include:

2.17.8.4.3.1. Recidivism;

2.17.8.4.3.2. Adverse occurrences;

2.17.8.4.3.3. Treatment drop-out;

2.17.8.4.3.4. Length of time between admissions; and

2.17.8.4.3.5. Treatment goals achieved.

2.17.8.5. External Audit/Accreditation Results

2.17.8.5.1. The Contractor shall inform DMAS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to DMAS, at DMAS' direction, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

2.17.8.6. Health Information System

2.17.8.6.1. The Contractor shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

2.17.9. Evaluation Activities

2.17.9.1. DMAS, CMS and its designated agent(s) will conduct periodic evaluations of the Demonstration over time from multiple perspectives using both quantitative and qualitative methods.

2.17.9.2. The evaluations will be used for program improvement purposes and to assess the Demonstration's overall impact on various outcomes including (but not limited to) enrollment/disenrollment patterns, beneficiary access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and

home and community based waiver), and program staff and provider experiences.

2.17.9.3. As such, the evaluations will include surveys, site visits, analysis of claims and encounter data, focus groups, key informant interviews, and document reviews. The Contractor shall participate in evaluation activities as directed by CMS and/or DMAS and provide information or data upon request.

2.18. Internal Monitoring and Audit

2.18.1. The Contractor shall establish and implement provisions for internal monitoring and auditing.

2.18.2. Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable state and federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

2.18.3. Internal Monitoring and Audit - Annual Plan

2.18.3.1. The Contractor shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as audit schedule and methodology, and types of auditing.

2.18.3.2. The Contractor shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. The Contractor shall consider a combination of desk and on-site audits, including unannounced internal audits or "spot checks" when developing the schedule. The internal monitoring and audit plan shall consist of two (2) components: a detailed schedule of anticipated audits for the year, as well as a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

2.18.3.2.1. Audits Planned for the Upcoming Year

2.18.3.2.1.1. Title/Type

2.18.3.2.1.2. Description

2.18.3.2.1.3. Priority/Risk Level

2.18.3.2.1.4. Frequency

2.18.3.2.2. Completed Audits

2.18.3.2.2.1. Additionally, DMAS requires a retrospective analysis of the internal monitoring and audit plan, which would include, at a minimum, the following:

2.18.3.2.2.1.1. All requirements from 2.18.3.2.1. above;

2.18.3.2.2.1.2. Number of audits planned for each type identified in 2.18.3.2.1.1 above;

2.18.3.2.2.1.3. Number of audits completed for each type identified in 2.18.3.2.1.1 above;

2.18.3.2.2.1.4. Emerging trends;

2.18.3.2.2.1.5. Investigator assigned (if applicable);

2.18.3.2.2.1.6. Findings;

2.18.3.2.2.1.7. Recommendations; and

2.18.3.2.2.1.8. Action taken.

2.18.3.2.3. For the first year of operations in the Commonwealth, the components of Section 2.18 will be modified or waived by DMAS on a case by case basis, as appropriate.

2.18.4. Audit Development: In developing the types of audits to include in the plan Contractor shall:

2.18.4.1. Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.

2.18.4.2. Utilize statistical methods in:

2.18.4.2.1. Randomly selecting facilities, pharmacies, providers, claims, and other areas for review; Determining appropriate sample size; and

2.18.4.2.2. Extrapolating audit findings to the full universe.

2.18.4.3. Assess compliance with internal processes and procedures.

2.18.4.4. Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

2.18.4.5. The Contractor shall also include in their plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and/or Program Integrity Lead and include actions such as the repayment of identified overpayments and making reports.

2.18.4.6. The Compliance Officer should maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis.

2.18.4.7. The Contractor is required to use the most current version of the internal monitoring and audit plan tool, as found in the DMAS Managed Care Technical Manual or provided by DMAS upon request.

2.18.4.8. The Contractor shall develop as part of their work plan a strategy to monitor and audit First Tier, Downstream and Related Entities involved in the delivery of the benefits. Specific data should be analyzed from First Tier, Downstream and Related Entities, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.

2.18.4.9. The Contractor shall include routine and random auditing as part of their contractual agreement with First Tier, Downstream and Related Entities. Contractors shall include in their work plan the number of First Tier, Downstream and Related Entities that will be audited each year, how the First Tier, Downstream and Related Entities will be identified for auditing, and should make it a priority to conduct a certain number of on-site audits.

2.18.4.10. The Contractor is encouraged to invest in data analysis software applications that give them the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

2.18.4.11. The Contractor shall cooperate with DMAS auditors on any recovery audit activity/findings.

2.18.5. Audit Report

2.18.5.1. The Contractor shall produce, and make available to DMAS upon request, a standard audit report for each completed audit, that includes, at a minimum, the following:

2.18.5.1.1. Purpose;

2.18.5.1.2. Methodology;

2.18.5.1.3. Findings;

2.18.5.1.4. Determination of Action and Final Resolution;

2.18.5.1.5. Claims Detail List/Spreadsheet; and

2.18.6. Development of Corrective Action Initiatives

2.18.6.1. The Contractor's PI Plan shall include provisions for corrective action initiatives. The Contractor shall conduct appropriate corrective actions (for example, repayment of overpayments and disciplinary actions against responsible individuals) in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct.

2.18.7. Prompt Response for Reporting Fraud, and Abuse to DMAS

2.18.7.1. The Contractor shall report incidents of potential or actual fraud and abuse to DMAS within forty-eight (48) hours of initiation of any investigative action by the Contractor or within forty-eight (48) hours of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or its Enrollees.

2.18.7.2. The Contractor shall provide information and a procedure for Enrollees, network providers and First Tier, Downstream and Related Entities to report incidents of potential or actual fraud, waste and abuse to the Contractor and to DMAS.

2.18.7.3. The Contractor shall report all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

2.18.7.4. All reports shall be sent to DMAS and CMS in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. The Contractor shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

2.18.7.5. Any Medicaid referrals that need to be sent to the Medicaid Fraud Control Unit (MFCU) must be forwarded to DMAS. The DMAS agrees to keep the MFCU informed on reported potential fraud and abuse activities involving the administration of the managed care contracts.

2.18.8. Cooperation with State and Federal Investigations

2.18.8.1. The Contractor shall cooperate with all fraud, waste and abuse investigation efforts by DMAS, CMS and other state and federal offices.

2.18.9. Program Integrity Compliance Audit (PICA)

2.18.9.1. The PICA is a compliance and valuation measure completed by the Contractor to evaluate organization-level compliance and adherence to the terms of the Contract and best practice models.

2.18.9.2. Completion of the PICA requires electronic submission of any and all referenced materials (MMP Policies and Procedures manuals, etc.) and documents annually to DMAS via email no later than January 1st of each contract year, commencing in 2015.

2.18.9.3. DMAS may customize the PICA to reflect areas of particular importance or focus based on trends, previous PICA findings, or other DMAS concerns. The Contractor is required to use the most current version of the PICA tool, as found in the DMAS Managed Care Technical Manual, in submission of the PICA.

2.18.9.4. For 2015-2016 the focus area will be a retrospective analysis of the internal monitoring and audit plan as required in Section 2.18.

2.18.9.5. Once every three (3) years, the Contractor shall cooperate with and allow the EQRO to perform an onsite review of the Contractor's Program Integrity policies and procedures to ensure they are fully integrated and operationalized.

2.18.9.6. During the years when the comprehensive on-site review (OSR) is not conducted, DMAS will convene an interdepartmental team of internal subject matter experts to perform the PICA desktop review.

2.18.9.7. For all modified and comprehensive PICAs, the Contractor shall adhere to the timeliness and tasks set forth by the EQRO or DMAS.

2.18.10. Provider Audits, Overpayments, and Recoveries

2.18.10.1. When the Contractor identifies potential or actual fraud (as defined in 42 C.F.R. §455.2) by one of its providers or First Tier, Downstream and Related Entities, the allegation must be referred immediately to DMAS .

2.18.10.2. The Contractor shall notify DMAS upon formal initiation of a recovery from a solely conducted audit by the Contractor on its own network. Likewise, DMAS shall notify the Contractor of formal initiation of a recovery.

2.18.10.3. The Contractor shall notify DMAS upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by DMAS.

2.18.10.4. DMAS, pursuant to 42 C.F.R. Part § 455, et. seq. and Section 5.4 of this Contract, may conduct audits of the Contractor's Provider Network, and as a result of those audits, may recover funds as appropriate.

2.18.10.5. The Contractor shall suspend payments to the Contractor's providers or First Tier, Downstream and Related Entities, pursuant to 42 C.F.R.§ 455.23 and as directed by DMAS or MFCU based on a good cause determination.

2.18.10.6. The Contractor shall perform recoveries, initiated by DMAS, resulting from audits of the Contractor's network.

2.18.10.7. The Contractor shall participate in joint audits, where DMAS and the Contractor simultaneously or concurrently institute investigations of the Contractor's network.

2.18.10.8. The Contractor shall perform recoveries based upon joint audits by DMAS and the Contractor.

2.19. Marketing, Outreach, and Enrollee Communications Standards

2.19.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.19.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (Chapter 3 of the Medicare Managed Care Manual and Chapter 2 of the Prescription Drug Benefit Manual), with the following exceptions or modifications:

2.19.1.1.1. The Contractor must refer Enrollees and Eligible Beneficiaries who inquire about CCC eligibility or enrollment to DMAS' authorized agent, although the Contractor may provide Enrollees and Eligible Beneficiaries with factual information about the Contractor's MMP and its benefits prior to referring a request regarding eligibility or enrollment to the DMAS authorized agent;

2.19.1.1.2. The Contractor must make available to CMS and DMAS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible Beneficiaries;

2.19.1.1.3. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or Eligible Beneficiaries, including persons with disabilities and persons using public transportation;

2.19.1.1.4. The Contractor may not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible Beneficiaries to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor;

2.19.1.1.5. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.19.1.1.6. The Contractor's sales agents are not permitted to conduct unsolicited personal/individual appointments. To the extent a Contractor offers individual appointments, they must be staffed by trained ESRs;

2.19.1.1.7. An individual appointment must only be set up at the request of the Enrollee or Eligible Beneficiary or his/her authorized representative. A Contractor can offer an individual appointment to an Enrollee or Eligible Beneficiary that has contacted the Contractor to request assistance or information. However, the Contractor is prohibited from making unsolicited offers of individual appointments; and

2.19.1.1.8. The Contractor must make reasonable efforts to conduct an appointment in the Enrollee or Eligible Beneficiary's preferred location. The Contractor cannot require that an individual appointment occur in an Enrollee or Eligible Beneficiary's home.

2.19.1.1.9. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.19.1.1.9.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits; and

2.19.1.1.9.2. The Contractor is endorsed by CMS, Medicare, Medicaid, the Federal government, DMAS or similar entity.

2.19.1.1.10. Annually, the Contractor shall present its marketing plan to DMAS for review and approval.

2.19.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

2.19.2.1. Made available in Alternate Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.19.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;

2.19.2.3. Translated into any non-English language that meets the more stringent of either: (1) Medicare's five (5) percent threshold for language translation; or (2) DMAS' Prevalent Language requirements.

2.19.2.4. Mailed with a multi-language insert that indicates that the Enrollee can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare

Marketing Guidelines provisions on the multi-language insert and any additional languages that meet the more stringent of either: (1) Medicare's five (5) percent threshold for language translation; or (2) DMAS' Prevalent Language requirements.

2.19.2.5. Distributed to the Contractor's entire Service Area as specified in Appendix J of this Contract.

2.19.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

2.19.3.1. The Contractor must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and DMAS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DMAS. CMS and DMAS may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.19.3.2. CMS and DMAS may conduct additional types of review of Contractor marketing, outreach, and Enrollee Communications activities, including, but not limited to:

2.19.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.19.3.2.2. Random review of actual marketing, outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.19.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DMAS determine it is appropriate to investigate.

2.19.3.2.4. "Secret shopper" activities where CMS or DMAS request Contractor materials, such as Enrollment packets.

2.19.3.3. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.19.3.3.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or new Enrollees more than 90 days prior to the effective date of Enrollment for the Contract year. In addition, for the first year of the Demonstration, the Contractor may not begin marketing activity until the Contractor has entered into this contact, passed the CMS/Virginia readiness review, and is connected to CMS Enrollment and payment systems such that the Contractor is able to receive payment and Enrollments.

2.19.4. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.19.4.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the Contractor must provide Enrollees with the following materials which, with the exception of the materials specified in 2.19.4.1.3 and 2.19.4.1.4 below, must also be provided annually thereafter:

2.19.4.1.1. An Evidence of Coverage (EOC)/Enrollee Handbook document that is consistent with the requirements at 42 C.F.R. §§438.10, 422.111, and 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and DMAS.

2.19.4.1.1.1. Enrollee rights (see Appendix C);

2.19.4.1.1.2. An explanation of the Enrollee Medical Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.19.4.1.1.3. How to obtain a copy of the Enrollee's Enrollee Medical Record;

2.19.4.1.1.4. How to obtain access to specialty, behavioral health, pharmacy and LTSS providers;

2.19.4.1.1.5. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.19.4.1.1.5.1. What constitutes emergency medical condition, Emergency Services, and Post-stabilization Care Services, with reference to the definitions is 42 C.F.R. § 438.114(a);

2.19.4.1.1.5.2. The fact that PA is not required for Emergency Services;

2.19.4.1.1.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.19.4.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.19.4.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.19.4.1.1.5.6. The Post-Stabilization Care Services rules at 42 C.F.R. § 422.113(c).

2.19.4.1.1.6. Information about advance directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including:

2.19.4.1.1.6.1. Enrollee rights under the law of the Commonwealth of Virginia;

2.19.4.1.1.6.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

2.19.4.1.1.6.3. That complaints concerning noncompliance with the advance directive requirements may be filed with DMAS; and

2.19.4.1.1.6.4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee.

2.19.4.1.1.6.5. The Contractor must update materials to reflect any changes in state law as soon as possible, but no later than 90 days after the effective date of change.

2.19.4.1.1.7. How to obtain assistance from ESRs;

2.19.4.1.1.8. How to file Grievances and internal and external Appeals, including:

2.19.4.1.1.8.1. Grievance, Appeal and State fair hearing procedures and timeframes;

2.19.4.1.1.8.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone for expedited external appeals only (only expedited appeals may be received telephonically for external appeals through the State Fair Hearing process);

2.19.4.1.1.8.3. A statement that when requested by the Enrollee, benefits will continue at the plan level for all benefits, and if the Enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay to DMAS the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee; and

2.19.4.1.1.8.4. How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.19.4.1.1.8.5. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DMAS or CMS may identify, including an Ombudsman;

2.19.4.1.1.8.6. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.19.4.1.1.8.7. How and where to access any benefits that are available under the Virginia Medicaid State plan or applicable waivers but are not covered under the Contract;

2.19.4.1.1.8.8. How to change providers; and

2.19.4.1.1.8.9. How to disenroll voluntarily.

2.19.4.1.2. A summary of benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DMAS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

2.19.4.1.3. A combined provider and pharmacy directory that is consistent with the requirements in CMS marketing guidance.

2.19.4.1.4. A single identification (ID) card for accessing all covered services under the plan that uses the model document developed by CMS and DMAS;

2.19.4.1.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DMAS' outpatient prescription drug benefit and that uses the model document developed by CMS and DMAS.

2.19.4.1.6. The procedures for an Enrollee to change MMPs or to Opt Out of the Demonstration.

2.19.4.1.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.19.4.1.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the DMAS.

2.19.4.1.7.2. A combined provider and pharmacy directory as frequently as specified in Section 2.19.5; and

2.19.4.1.7.3. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the plan;

2.19.4.1.8. The Contractor must provide all Medicare Part D required notices, with the exception of the late Enrollment penalty notices and the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.19.4.1.9. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least sixty (60) days advance notice regarding changes to the comprehensive, integrated formulary.

2.19.4.1.10. The Contractor must ensure that all information provided to Enrollees and Eligible Beneficiaries (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.19.4.1.10.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;

2.19.4.1.10.2. For vital materials, available in any languages that meet the more stringent of either: (1) Medicare's five (5) percent threshold for language translation; or (2) DMAS' Prevalent Language requirements, as provided for in the Medicare-Medicaid marketing guidance.

2.19.4.1.10.3. Written with cultural sensitivity and at or below a 6th grade reading level; and

2.19.4.1.10.4. Available in Alternate Formats, according to the needs of Enrollees and Eligible Beneficiaries, including Braille, oral interpretation services in non-English languages, as specified in Section 2.19.2 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.19.5. Provider and Pharmacy Network Directory

2.19.5.1. Maintenance and Distribution: The Contractor must:

2.19.5.1.1. Maintain a combined provider and pharmacy network directory that uses the model document developed by CMS and DMAS;

2.19.5.1.2. Provide either a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to all new at the time of enrollment and, upon request, to both new and continuing Enrollees;

2.19.5.1.3. Provide a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to continuing Enrollees at least every three (3) years after the time of Enrollment, unless there is a significant change to the network, in which case the Contractor must send a special mailing of an updated directory or information about the network change and how to access a copy, as specified in the Medicare-Medicaid marketing guidance immediately;

2.19.5.1.4. Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.19.5.1.5. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and

2.19.5.1.6. Include written and oral offers of such provider and pharmacy directory in its outreach and orientation sessions for new Enrollees.

2.19.5.2. Content of Provider and Pharmacy Directory

2.19.5.2.1. The provider and pharmacy directory must include, at a minimum, the following information for all providers/pharmacies in the Contractor's provider/pharmacy network:

2.19.5.2.1.1. The names, addresses, and telephone numbers of all current network providers and pharmacies.

2.19.5.2.1.2. Network providers with areas of special experience, skills and training, including providers with expertise in treating:

2.19.5.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.19.5.2.1.2.2. Individuals who are homeless;

2.19.5.2.1.2.3. Individuals who are Deaf or hard-of-hearing and blind or visually impaired;

2.19.5.2.1.2.4. Persons with co-occurring disorders; and

2.19.5.2.1.2.5. Other specialties.

2.19.5.2.1.3. Office hours for each network provider, including the names of any network provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

2.19.5.2.1.4. The cultural and linguistic capabilities of network providers, including languages spoken by the network provider or by skilled medical interpreter at the network provider's site;

2.19.5.2.1.5. Network provider licensing information;

2.19.5.2.1.6. Whether the network provider is accessible for people with physical disabilities, including its office, exam room(s) and equipment;

2.19.5.2.1.7. Whether the provider is accepting new patients;

2.19.5.2.1.8. Network provider access by public transportation;

2.19.5.2.1.9. Languages other than English spoken by providers or by skilled medical interpreters at the provider's site, including ASL, and whether translation services are available;

2.19.5.2.1.10. For behavioral health providers, qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use);

2.19.5.2.1.11. For pharmacies, instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line (as described in Section 2.12.2) for assistance in finding a convenient pharmacy;

2.19.5.2.1.12. A description of the roles of the ICT and the process by which Enrollees select and change PCPs; and

2.19.5.2.1.13. Whether there are any restrictions on the Enrollee's freedom of choice among network providers.

2.20. Financial Requirements

2.20.1. Financial Viability

2.20.1.1. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402[1], and 42 CFR § 438.116,

2.20.1.2. The Contractor shall meet all state and federal financial soundness requirements. These may include:

2.20.1.2.1. The Contractor must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the entity's debts, if the entity becomes insolvent.

[1] 42 CFR § 422.402, The standards established under this part supersede any state law or regulation (other than state licensing laws or state laws relating to plan solvency) with respect to the Medicare Advantage (MA) plans that are offered by VA organizations.

2.20.1.2.2. The Contractor must produce adequate documentation satisfying the state that it has met its solvency requirements.

2.20.1.2.3. The Contractor must also maintain reserves to remain solvent for a 45-day period, and provide satisfactory evidence to the state of such reserves.

2.20.2. Financial Stability

2.20.2.1. The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed plans in Virginia. The Contractor shall comply with all Bureau of Insurance standards. Bureau of Insurance standards may be found at http://www.scc.virginia.gov/PublicForms/561/hmo.pdf (see Item 22 on page 4).

2.20.3. Other Financial Requirements

2.20.3.1. The Contractor must cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.21. Data Submissions, Reporting Requirements, and Survey

2.21.1. General Requirements for Data

2.21.1.1. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.21.1.1.1. All information CMS and DMAS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.21.1.1.2. Any information CMS and DMAS require to comply with all applicable federal or state laws and regulations; and

2.21.1.1.3. Any information CMS or DMAS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and enrollment/disenrollment rates.

2.21.2. General Reporting Requirements

2.21.2.1. The Contractor must:

2.21.2.1.1. Submit to DMAS the applicable the DMAS reporting requirements in compliance with this Contract;

2.21.2.1.2. Submit to CMS applicable Medicare reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514 and 438 et. seq.

2.21.2.1.3. Submit to CMS all applicable MMP reporting requirements;

2.21.2.1.4. Submit to CMS and DMAS all required reports and data in accordance with the specifications, templates and time frames described in this Contract;

2.21.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to long-term services and supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by DMAS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DMAS;

2.21.2.1.6. Upon request, submit to CMS and DMAS any internal reports that the Contractor uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;

2.21.2.1.7. Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DMAS; and

2.21.2.1.8. Provide to CMS and DMAS, in a form and format approved by CMS and DMAS and in accordance with the timeframes established by CMS and DMAS, all reports, data or other information CMS and DMAS determine are necessary for compliance with provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.

2.21.3. Information Management and Information Systems

2.21.3.1. General: the Contractor shall:

2.21.3.1.1. Maintain Information Systems (Systems) that will enable the Contractor to meet all of DMAS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DMAS requirements, and any future IT architecture or program changes. Solutions must be compliant with COV Information Technology Resource Management (ITRM) policies, standards, and guidelines. A complete list can be located: http://www.vita.virginia.gov/library/default.aspx?id=537.

2.21.3.1.2. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DMAS and any other entity deemed appropriate by DMAS. Such files shall be transmitted to DMAS through secure FTP, HTS, or a similar secure data exchange as determined by DMAS;

2.21.3.1.3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by DMAS, establish appropriate links on the Contractor's website that direct users back to the DMAS website portal;

2.21.3.1.4. The Contractor shall cooperate with DMAS in its efforts to verify the accuracy of all Contractor data submissions to DMAS; and

2.21.3.1.5. Actively participate in any DMAS Systems Workgroup, as directed by DMAS. The workgroup shall meet in the location and on a schedule determined by DMAS

2.21.3.2. Design Requirements

2.21.3.2.1. The Contractor shall comply with DMAS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.

2.21.3.2.2. The Contractor's Systems shall interface with DMAS Legacy MMIS system, DMAS' MMIS system, the DMAS Virtual Gateway, and other DMAS IT architecture.

2.21.3.2.3. The Contractor shall have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Interface files, which include, but are not limited to:

2.21.3.2.3.1. Inbound Interfaces

2.21.3.2.3.2. Monthly MMP Provider Network Directory.

2.21.3.2.3.3. Outbound Interfaces

2.21.3.2.3.4. HIPPAA 834 Outbound Mid-month and End of month File

2.21.3.2.3.5. HIPAA 820; and

2.21.3.2.3.6. Proprietary Reports:

2.21.3.2.3.6.1. Commonwealth Coordinated Care Encounter Detail and Summary reports

2.21.3.2.3.6.2. Commonwealth Coordinated Care Long Term Care Patient Pay report

2.21.3.2.3.6.3. Commonwealth Coordinated Care Capitation Patient Pay Discrepancy report.

2.21.3.2.4. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.21.3.2.5. The Contractor shall demonstrate controls to maintain information integrity.

2.21.3.2.6. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DMAS.

2.21.3.2.7. System Access Management and Information Accessibility Requirements

2.21.3.2.7.1. The Contractor shall make all Systems and system information available to authorized CMS, DMAS and other agency staff as determined by CMS or DMAS to evaluate the quality and effectiveness of the Contractor's data and Systems.

2.21.3.2.7.2. The Contractor is prohibited from sharing or publishing CMS or DMAS data and information without prior written consent from CMS or DMAS.

2.21.3.2.8. System Availability and Performance Requirements

2.21.3.2.8.1. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and providers twenty-four (24) hours a day, seven (7) days a week.

2.21.3.2.8.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DMAS upon request. In the event of System failure or unavailability, the Contractor shall notify DMAS upon discovery and implement the COOP immediately.

2.21.3.2.8.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.22. Encounter Reporting

2.22.1. General

2.22.1.1. The Contractor must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations, as may be updated from time to time.

2.22.1.2. Furthermore, the Contractor's Systems shall generate and transmit encounter data files according to additional specifications as may be provided by CMS or DMAS and updated from time to time.

2.22.1.3. CMS and DMAS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.22.2. Requirements

2.22.2.1. The Contractor shall:

2.22.2.1.1. Collect and maintain 100% encounter data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to DMAS eligibility data;

2.22.2.1.2. Participate in site visits and other reviews and assessments by CMS and DMAS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of encounter data;

2.22.2.1.3. Upon request by CMS, DMAS, or their designee, provide medical records of Enrollees and a report from administrative databases of the encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;

2.22.2.1.4. Produce encounter data according to the specifications, format, and mode of transfer reasonably established by CMS, DMAS, or their designee, in consultation with the Contractor. Such encounter data shall include elements and level of detail determined necessary by CMS and DMAS. As directed by CMS and DMAS, such encounter data shall also include the National Provider Identifier of the ordering and referring physicians and professionals and any National Drug Code;

2.22.2.1.5. Submit complete, timely, reasonable and accurate encounter data to CMS no less than monthly and in the form and manner specified by DMAS and CMS. CMS will forward encounter data directly to DMAS.

2.22.2.1.6. Submit encounter data that is at a minimum standard for completeness and accuracy as defined by CMS and DMAS. The Contractor must also correct and resubmit denied encounters as necessary;

2.22.2.1.7. Report as a voided claim in the monthly encounter data submission any claims that the Contractor pays, and then later determines should not have paid.

2.22.2.2. If CMS, DMAS, or the Contractor, determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

2.22.2.2.1.1. Notify CMS and DMAS, prior to encounter data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

2.22.2.2.1.2. Submit for CMS and DMAS approval, within a time frame established by CMS and DMAS, which shall in no event exceed thirty (30) days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

2.22.2.2.1.3. Implement the CMS and DMAS-approved corrective action plan within a time frame approved by CMS and DMAS, which shall in no event exceed thirty (30) days from the date that the Contractor submits the corrective action plan to CMS and DMAS for approval; and

2.22.2.2.1.4. Participate in a validation study to be performed by CMS, DMAS, and/or their designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. The Contractor may be financially liable for such validation study.

Section 3. CMS and DMAS Responsibilities

3.1. Contract Management

3.1.1. Administration: CMS and DMAS will:

3.1.1.1. Designate a CMT that will include at least one representative from CMS and at least one contract manager from DMAS authorized and empowered to represent CMS and DMAS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and DMAS representatives will act as liaisons between the Contractor and CMS and DMAS for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the Contractor;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the Contractor;

3.1.1.1.5. Coordinate requests for assistance from the Contractor and assign CMS and DMAS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.1.6. Coordinate requests for assistance from the Contractor and assign CMS and DMAS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.1.7. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DMAS; and

3.1.1.1.8. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DMAS; and

3.1.1.1.9. Inform the Contractor of any discretionary action by CMS or DMAS under the provisions of the Contract;

3.1.1.1.10. Coordinate review of marketing materials and procedures; and

3.1.1.1.11. Coordinate review of Grievance and Appeals data, procedures,

3.1.1.2. Review, approve, and monitor the Contractor's Outreach and orientation materials and procedures;

3.1.1.3. Review, approve, and monitor the Contractor's Complaint and Appeals procedures;

3.1.1.4. Apply one or more of the sanctions provided in Section 5.3.14, including termination of the Contract in accordance with Section 5.5, if CMS and the DMAS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.1.5. Conduct site visits as determined necessary by CMS and DMAS to verify the accuracy of reported data;

3.1.1.6. Coordinate the Contractor's external quality reviews conducted by the external quality review organization; and,

3.1.1.7. Send transition reports to the Contractor in an electronic format

3.1.2. Performance Evaluation

3.1.2.1. CMS and DMAS will, at their discretion:

3.1.2.1.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Section 2.21.2, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DMAS will provide the Contractor with the written results of these evaluations;

3.1.2.1.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.1.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys; and

3.1.2.1.4. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and DMAS will maintain systems to provide:

3.2.1.1. Enrollment and disenrollment, information to the Contractor; and

3.2.1.2. Continuous verification of eligibility status.

3.2.2. DMAS Enrollment Vendor

3.2.2.1. DMAS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1.1. Develop generic materials to assist Eligible Beneficiaries in choosing whether to enroll in the Demonstration. Said materials shall present the Contractor's MMP in an unbiased manner to Enrollees eligible to enroll in the Contractor's MMP. DMAS may collaborate with the Contractor in developing MMP-specific materials;

3.2.2.1.2. Present the Contractor's MMP in an unbiased manner to Eligible Beneficiaries or those seeking to transfer from one MMP to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.1.2.1. The rights and responsibilities of participation in the Demonstration;

3.2.2.1.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the Comprehensive Assessment, and the ICT;

3.2.2.1.2.3. Orientation and other Enrollee services made available by the Contractor;

3.2.2.1.3. Enroll, disenroll, and process transfer requests of Enrollees in the Contractor's MMP, including completion of DMAS' enrollment and disenrollment forms;

3.2.2.1.4. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.1.5. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.2.2.1.6. At its discretion, develop and implement processes and standards to measure and improve the performance of the DMAS enrollment vendor staff. DMAS shall monitor the performance of the DMAS enrollment vendor.

3.3. Ombudsman Program

3.3.1. DMAS will capitalize on the strengths of its existing long-term care ombudsman program (LTCOP) to expand the current local Ombudsman Program and build a new and distinct component of Ombudsman services – called "Coordinated Care Advocates"-- to address the large number of CCC beneficiaries who live in the community and would not otherwise fall within the purview of the existing LTCOP. Together the Ombudsmen and Coordinated Care Advocates will create a cadre of independent advocates with varied areas of advocacy experience and expertise in health and human services delivery (e.g., behavioral health, disability services, language and cultural diversity skills), promoting access to broad range of services and supports for the beneficiary population, and a robust resource base of knowledge and expertise in problem-solving strategies.

3.3.2. DMAS will provide any Ombudsman reports to the CMT and the Contractor on a regular basis.

Section 4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments

4.1.1.1. CMS and DMAS will each contribute to the total Capitation Payment paid to the Contractor. CMS and DMAS will each make monthly payments for each Enrollee to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DMAS reflecting coverage of Medicaid services (Medicaid Component).

4.1.1.2. The Medicare Parts A/B payment will be risk adjusted using the Medicare Advantage CMS-HCC Model and CMS HCC-ESRD Model, except as specified in Section 4.1.5.1. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the rate cell methodology described in Section 4.1.3.

4.1.1.3. CMS and DMAS will provide the Contractor with a rate report on an annual basis for the upcoming calendar year.

4.1.2. Demonstration Year Dates

4.1.2.1. Capitation Rate updates will take place on January 1st of each calendar year or more frequently, as described in this section; however, savings

percentages and quality withhold percentages (see Sections 4.1.4 and 4.2.5) will be applied based on Demonstration Years, as follows:

4.1.2.1.1. Demonstration Year 1: April 1, 2014-December 31, 2015

4.1.2.1.2. Demonstration Year 2: January 1, 2016-December 31, 2016

4.1.2.1.3. Demonstration Year 3: January 1, 2017-December 31, 2017

4.1.3. Capitated Rate Structure

4.1.3.1. Underlying Rate Structure for Medicaid Component of the Capitation Payment

4.1.3.1.1. DMAS shall pay the Contractor a monthly per member per month (PMPM) amount (the Medicaid Component) for each Demonstration region by rate cell as described below.

4.1.3.1.2. The baseline spending data for Medicaid services used for calculating the Capitation Rates is the most recent two-year historical fee-for-service data (calendar years 2011 and 2012 for Demonstration Year 1) from the total population that would have been eligible for Enrollment in the Demonstration during the historical baseline period. Completion factors are calculated and applied to the baseline data, in order to include expenditures for services that were incurred but not reported in the available data. The data are then adjusted for known policy and program changes that will be in effect during the contract period. The completed and adjusted data are trended forward to the midpoint of the Contract period and used to develop Capitation Rates. All steps in this process are subject to CMS review.

4.1.3.1.3. The Capitation Payments are based on the rate cell structure and FIPS codes and are automatically generated by the DMAS information system at the rates established in this Contract. Any and all costs incurred by the Contractor in excess of the Capitation Payment will be borne in full by the Contractor.

Table 1: Medicaid Rate Cell Categories

Rating Category Rate Cell	Description
Community Well	Enrollees who do not meet a Nursing Facility Level of Care (NFLOC) standard or meet NFLOC standard and are currently in a nursing home for fewer than 20 days.

	Rates will vary by the following age groups: 21–64 and 65+. Rates will vary for the five (5) Demonstration regions.
Nursing Facility Level of Care	Single rate cell for all individuals meeting a NFLOC including: a) Enrollees in the EDCD Waiver; b) Enrollees in a NF for twenty (20) or more consecutive days. An individual's initial screening to determine NFLOC will be conducted by a state-reimbursed, external preadmission screening team. Annual reassessment screenings for NFLOC will be conducted by the Contractor, but monitored by DMAS for quality assurance. Rates will vary by the following age groups: 21–64 and 65+. There will be a member Enrollment mix adjustment (MEMA) that will provide more revenue to MMPs that have a greater proportion of high risk/cost Enrollees (e.g. NF residents) compared to MMPs with a lower proportion of high risk/cost Enrollees (EDCD waiver). Once a NFLOC recipient is determined to no longer meet NFLOC criteria, the Contractor continues to receive the higher NFLOC Capitation Rate for two (2) full months following the determination. Beginning with the third month, the Contractor will receive the Community Well Capitation Rate. Rates will vary for the five (5) Demonstration regions.

4.1.3.1.4. Payment rates for Enrollees who meet NFLOC will be blended, in order to further the goal of providing services at the lowest appropriate setting and intensity level for each Enrollee. In order to provide adequate payment to the Contractor for their actual Enrollment mix, the blended rate cells will be risk adjusted using the MEMA as described further in Section 4.2.4. In general, the MEMA adjusts the blended rates, based on the proportion of the cohort receiving LTSS in a NF versus in the community. The MEMA will be calculated at the beginning of the rate period and recalculated at key times over the Demonstration Contract periods.

4.1.3.2. Underlying Rate Structure for Medicare Component of the Capitation Rate

4.1.3.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.1.3.2.2. Medicare A/B Component

4.1.3.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population projected to otherwise be in each program absent the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.1.3.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3-star county rate (benchmark) for the applicable county.

4.1.3.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.1.3.2.2.4. The Medicare A/B Component will be updated annually consistent with annual Fee-for-Service (FFS) estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.1.3.2.3. Medicare Part D

4.1.3.2.3.1. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors. The CY 2014 Part D NAMBA is $75.88.

4.1.3.2.3.2. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.1.4. Aggregate Savings Percentages

4.1.4.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.1.4.2.

4.1.4.1.1. Demonstration Year 1: 1%

4.1.4.1.2. Demonstration Year 2: 2%

4.1.4.1.3. Demonstration Year 3: 4%

4.1.4.2. Rate updates will take place on January 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.

4.1.4.3. Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

4.1.5. Risk Adjustment Methodology

4.1.5.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.

4.1.5.1.1. In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2014 with Medicare Advantage experience in 2013, prior to the Demonstration.

4.1.5.1.2. In calendar year 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's enrollment phase-in as of September 30, 2014.

4.1.5.1.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees.

4.1.5.1.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.

4.1.5.2. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

4.1.5.3. Medicaid: The Medicaid component will employ rating categories described in Section 4.1.3.1. In addition, a MEMA will be used.

4.1.5.4. The MEMA addresses the relative risk/cost differences of the sub-populations that make up the combined rate for individuals who meet NFLOC These two sub-populations are the NFLOC – Institutional (NFLOC-I) and NFLOC – Waiver (NFLOC-W) populations. The MEMA will provide more revenue to MMPs that have a greater proportion of high risk/cost Enrollees residing in an institution (NFLOC-I) compared to MMPs with a lower proportion of these Enrollees (NFLOC-W) and is calculated and applied in the method that follows:

4.1.5.4.1. Separate NFLOC Capitation Rates are developed for the two sub-populations of NFLOC individuals and then the two rates are combined to develop a weighted average rate using the Enrollment distribution of the most recent available month for the weight value.

4.1.5.4.2. A snapshot of the NFLOC Enrollment mix on January 1, 2014 of all Enrollees who are NFLOC and eligible for Enrollment into the Demonstration will be taken and used to establish the initial NFLOC Capitation Rates. Each Enrollee will receive a risk score based on their placement on January 1, 2014. This risk score will be held constant through the first year of the Demonstration and may be updated in years two and three for continuous Enrollees.

4.1.5.4.3. This weighted average NFLOC capitation rates will be paid to health plans for opt-in Enrollment beginning in April 1, 2014 for Phase I and June 1, 2014 for Phase II. Contractor will continue to be paid this rate for 90 days past each phase's Passive Enrollment date.

4.1.5.4.4. An MMP-specific weighted risk score for each Enrollment phase will be calculated 90 days after the start of the Passive Enrollment effective date. For Phase I, that date is October 1, 2014; for Phase II, that date is January 1, 2015.

4.1.5.4.5. At the completion of 90 days past the start of the Passive Enrollment period for each phase, the weighted average Capitation Rate will be recalculated based on the risk scores for each Enrollee established before the start of the Demonstration, and the actual Enrollment of those individuals in each MMP at the 90-day mark.

4.1.5.4.6. DMAS will apply the updated weighted Capitation Rates on a prospective basis.

4.1.5.4.7. Those enrolled in the Demonstration through opt-in and Phase I and Phase II Passive Enrollment are considered the first cohort and their risk score will be updated and tracked separately from subsequent new Enrollees. Future calculations will adjust for first cohort members who leave the program, either voluntarily or as a result of death.

4.1.5.4.8. Risk scores will be established for new cohorts using the same methods as those described above, with the cohorts defined as those who entered the Demonstration during each 6-month period. This creates a series of cohorts that will be measured as of their date of entry to the program. Over the course of the Demonstration there would be several cohorts, all of which would be measured separately, then aggregated to establish the appropriate payment rate for each plan.

4.1.5.4.9. The MEMA adjustment will be budget neutral.

4.1.6. Medical Loss Ratio (MLR)

4.1.6.1. Medical loss ratio Guarantee: The Contractor has a target MLR of eighty-five percent (85%).

4.1.6.1.1. If the Contractor has an MLR between eighty-five (85) percent and ninety (90) percent of the joint Medicare and Medicaid payment, the Commonwealth and CMS may require a corrective action plan or remit an amount not to exceed twenty-five (25) percent of the difference between the actual MLR and 90% as defined below on the Contractor. Any collected remittance would be distributed proportionally back to the Medicaid and Medicare programs on a percent of premium basis.

4.1.6.1.2. If the MLR calculated as set forth below is less than the target MLR, the Contractor shall refund to DMAS and CMS an amount equal to the difference between the calculated MLR and the target MLR (expressed as a percentage) multiplied by the coverage year revenue. DMAS and CMS shall calculate a MLR for Enrollees under this Contract for each coverage year, and shall provide to the Contractor the amount to be refunded, if any, to DMAS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and DMAS, separately, any amount to be refunded may be recovered either by requiring the Contractor to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, DMAS and CMS may adopt NAIC reporting standards and protocols after giving written notice to the Contractor.

4.1.6.2. MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:

4.1.6.2.1. All Covered Services required in the Demonstration under Section 2.4 and Appendix A;

4.1.6.2.2. Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the CCC; and

4.1.6.2.3. Care Coordination Expense. That portion of the personnel costs for care coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for Contractor's medical director that is attributable to this Contract shall be included as a benefit expense.

4.1.6.3. The revenue used in the MLR calculation will consist of the Capitation Payments due from DMAS and CMS for services provided during the coverage year. Revenue will include amounts withheld pursuant to Section 4.2.5, regardless of whether the Contractor actually receives the amount in Section 4.2.5.

4.1.6.4. Data Submission. The Contractor shall submit to DMAS and CMS, in the form and manner prescribed by the Department and CMS, the necessary data to calculate and verify the MLR after the end of the coverage year.

4.1.6.5. Medical Loss Ratio Calculation. Within ninety (90) days following the six (6) month claims run-out period following the coverage year, DMAS and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The Contractor shall have sixty (60) days to review the MLR calculation. Each Party shall have the right to review all data and methodologies used to calculate the MLR.

4.1.6.6. Coverage Year. The coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available from the coverage year, including IBNP and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

4.2. Payment Terms

4.2.1. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate or the Medicare Advantage 3-star country rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. Enrollee contribution to care amounts will be deducted from the Medicaid Component of the monthly Capitation Payment amount, in accordance with Section 4.4.3.

4.2.2. Timing of Capitation Payments

4.2.2.1. CMS and DMAS will each make monthly Capitation Payments to the Contractor. If an individual is enrolled with the Contractor on the first day of a month, the Contractor has the responsibility of providing covered services to that Enrollee for that month, even if the Enrollee moves to another locality. If the Enrollee moves to a locality outside of the Contractor's Service Area, the Enrollee will be disenrolled from the Contractor at the end of the month that the move is confirmed. Any and all costs incurred by the Contractor in excess of the Capitation Payment will

be borne in full by the Contractor. The Contractor shall accept the Department's electronic transfer of funds to receive Capitation Payments.

4.2.2.2. Enrollments

4.2.2.2.1. CMS will make monthly PMPM Capitation Payment to the Contractor. The PMPM Capitation Payment for a particular month will reflect payment for the beneficiaries with effective Enrollment into the Contractor's MMP as of the first day of that month, as described in Section 2.3.

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

4.2.2.3. Disenrollments

4.2.2.3.1. The final PMPM Capitation Payment made by CMS and DMAS to the Contractor for each Enrollee will be for the month: a) in which the disenrollment was submitted, b) the Enrollee loses eligibility, or c) the Enrollee dies (see Section 2.3).

4.2.3. Enrollee Contribution to Care Amounts- Patient Pay for Medicaid Long Term Supports and Services

4.2.3.1. When an Enrollee's income exceeds an allowable amount, he or she must contribute toward the cost of their LTSS. This contribution, known as the Patient Pay amount, is required for individuals residing in a NF and for those receiving EDCD services. Patient Pay is required to be calculated for every individual receiving NF or waiver services, although not every eligible individual will end up having to pay each month.

4.2.3.2. DMAS will provide information to the Contractor that identifies Enrollees who are required to pay a Patient Pay amount and the amount of the obligation as part of the monthly transition report. DMAS Capitation Payments to Contractors for individuals who are required to pay a Patient Pay Amount will be net of the monthly Patient Pay amount. The Contractor shall develop policies and procedures regarding the collection of the Patient Pay obligation. The MMP may collect it directly from the Enrollee or assign this responsibility to LTSS providers. If it is the responsibility of the LTSS provider(s) to collect the Patient Pay amounts from Enrollees, the Contractor shall reduce reimbursements to LTSS providers equal to the Patient Pay amounts each month. The Contractor

must use DMAS' method for assigning Patient Pay collection to LTSS providers unless an alternate methodology is approved by DMAS.

4.2.3.2.1. For EDCD Waiver services, the provider with the most authorized hours is considered the primary service provider and is responsible for the collection of the Patient Pay amount. If the most authorized hours are for consumer directed (CD) services, the patient pay amount must be deducted from the CD personal care attendant's payroll by the F/EA. The Contractor will need to establish communication and reporting mechanisms with the F/EA. Respite care providers are responsible for collecting the Patient Pay only when respite care is the sole authorized LTSS. When an individual enrolled with the Contractor is determined to be newly eligible for LTSS, the Contractor shall submit a DMAS-225 form to the local DSS eligibility worker, in order for the eligibility worker to determine the Patient Pay amount. The Contractor shall establish a process to ensure collection of the Patient Pay amounts and coordinate with LTSS service providers.

4.2.3.2.2. DMAS-225 Form

4.2.3.2.2.1. The Medicaid LTC Communication Form (DMAS-225) is used by the DSS to inform providers of Medicaid eligibility and to exchange information. The Contractor or its designee must ensure that a completed DMAS-225 is in the record of each individual receiving nursing facility or EDCD Waiver services.

4.2.4. Modifications to Capitation Rates

4.2.4.1.1. DMAS and CMS may propose modifications, additions, or deletions to the rate cell structure over the course of the Demonstration. Any modifications to the rate cell structure will be subject to agreement by the other governmental party. DMAS and CMS will inform the Contractor of such changes to the rate cell structure in writing, and the Contractor shall accept such changes.

4.2.4.1.1.1. Rates will be updated using a similar process for each calendar year. Changes to the Medicare and Medicaid baselines (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement and Medicaid rate process will be made only if and when CMS and DMAS jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. For changes solely affecting the Medicare program baseline, CMS will consult with DMAS prior to making any adjustment, but DMAS concurrence will not be required. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in federal law and/or state policy used in the development of baseline estimates; and changes to coding intensity. CMS and/or DMAS will make changes to baseline estimates within thirty (30) days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.

4.2.4.1.2. Changes to the savings percentages will be made if and when CMS and DMAS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.

4.2.4.1.3. In the event that one-third of MMPs experience losses in Demonstration Year 1 exceeding three (3) percent of revenue over all regions in which those plans participate, based on at least twenty (20) months of data from Demonstration Year 1, the savings percentage for Demonstration Year 3 will be reduced to three (3) percent In the event that one-third of MMPs show MMLRs below ninety (90) percent over all regions in which those plans participate, CMS and DMAS will review the MMP financial reports, encounter data, and other information to assess the ongoing financial stability of the MMP and the appropriateness of Capitation Payments. At any point, DMAS may request that CMS review documentation from specific plans to assess the appropriateness of Capitation Rates and identify any potential prospective adjustments that would ensure the rate-setting process is meeting the objective of Medicare and Medicaid jointly financing the costs and sharing in the savings.

4.2.5. Quality Withhold Policy for Medicaid and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.2.5.1. Under the Demonstration, both CMS and DMAS will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D Component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.2.5.2. CMS and DMAS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.2.5.3. Whether or not the Contractor has met the quality requirements in a given year will be made public.

4.2.5.4. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information regarding the methodology will be made available in future technical guidance.

4.2.5.5. Withhold Measures in Demonstration Year 1

4.2.5.5.1. Table 2 below identifies the withhold measures for Demonstration Year 1. Because Demonstration Year 1 crosses calendar and Contract years, the Contractor will be evaluated to determine whether it has met required quality withhold requirements at the end of both CY 2014 and CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual Enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Table 2: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Encounter data	Encounter data submitted accurately and completely in compliance with Contract requirements.	CMS/DMAS defined process measure	X	
Assessments	Percent of Enrollees with initial assessments completed within 60 & 90 days of Enrollment, per Virginia's Model of Care requirements.	CMS/DMAS defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with Contract requirements.	CMS/DMAS defined process measure	X	

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Enrollees get appointments and care In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	AHRQ/CAHPS	X	
Plans of Care and Documentation of Care Goals	Percent of Enrollees with Plans of Care developed within specified timeframes Percent of Enrollee Plans of Care that contain documented discussions of care goals	CMS/DMAS defined		X
Hospital, Nursing Facility, and Community	Contractor has established work plan and systems in place for ensuring smooth transitions to and from	CMS/DMAS defined		X

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Transitions	hospitals, nursing facilities, and the community.			
Adjudicated Claims	Percent of adjudicated claims submitted to Contractors that were paid within the timely filing requirements.	CMS/DMAS defined process measure		X

4.2.5.6. Withhold Measures in Demonstration Years 2 and 3

4.2.5.6.1. The quality withhold will increase to two (2) percent in Demonstration Year 2 and three (3) percent in Demonstration Year 3.

4.2.5.6.2. Payment will be based on performance on the quality withhold measures listed in Table 3 below.

Table 3: Quality Withhold Measures for Demonstration Years 2 and 3

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Plan all-cause hospital readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Annual flu vaccine	Percent of plan Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients ages 21 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	

Domain	Measure	Source	CMS Core Withhold Measure	DMAS Specified Measure
Reducing the risk of falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Controlling blood pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for oral diabetes medications	Percent of plan Enrollees with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Assessments	Percent of Enrollees with initial assessments completed within required timeframes, per Virginia's Model of Care requirements.	CMS/DMAS defined		X
Plans of Care	Percent of Enrollees with Plans of Care developed within specified timeframes	CMS/DMAS defined		X
Adjudicated Claims	Percent of adjudicated claims submitted to Contractors that were paid within the timely filing requirements.	CMS/DMAS defined process measure		X
Hospital, Nursing Facility, and Community Transitions	Percent of individuals who transitioned to and from hospitals, nursing facilities and the community.	CMS/DMAS defined		X
Severe Mental Illness (SMI)	Percent of individuals with SMI who are receiving primary care services.	CMS/DMAS defined		X

4.2.6. American Recovery and Reinvestment Act of 2009

4.2.6.1. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.2.7. Suspension of Payments

4.2.7.1. DMAS may suspend payments to Contractor in accordance with 42 CFR § 455.23as determined necessary or appropriate by DMAS.

4.3. Transitions between Rating Categories and Risk Score Changes

4.3.1. Rating Category Changes

4.3.1.1. The Medicaid Component of the Capitation Rates will be updated following a change in an Enrollee's status relative to the rate cells in Section 4.1.3. On a monthly basis, as part of Capitation Payment processing, the rating category of each Enrollee will be determined. Individuals who are in a NF for twenty (20) days or more and Enrollees who are in a waiver based on the Enrollment status in the DMAS eligibility file will be in the nursing home eligible rating category. All others will be in the community well category.

4.3.2. Medicare Risk Score Changes

4.3.2.1. Medicare CMS-HCC, HCC-ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.4. Reconciliation

4.4.1. CMS and DMAS will implement a process to reconcile Enrollment and Capitation Payments for the Contractor that will take into consideration the following circumstances:

4.4.1.1. Transitions between RCs;

4.4.1.2. Retroactive changes in eligibility, RCs, or Enrollee contribution amounts;

4.4.1.3. Changes in CMS-HCC and RxHCC risk scores; and,

4.4.1.4. Changes through new Enrollment, disenrollment, or death.

4.4.2. The reconciliation may identify underpayments or overpayments to the Contractor.

4.4.3. Medicaid Capitation Reconciliation

4.4.3.1. Retroactive adjustments to Enrollment and payment shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to Enrollment without regard to timelines of the adjustment. The Contractor shall assure correct payment to providers as a result of Enrollment

updates/corrections. DMAS shall assure correct payment to the Contractor for any retroactive Enrollment adjustments.

4.4.3.2. DMAS will reconcile payments related to the MEMA adjustment on a periodic basis.

4.4.4. Medicare Capitation Reconciliation

4.4.4.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.

4.4.5. Audits/Monitoring

4.4.5.1. CMS and DMAS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DMAS.

4.5. Payment in Full

4.5.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.5.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DMAS and the Contractor), for this Demonstration agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.5.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Federal Government to the Contractor, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.

Section 5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

5.1.1.1. The Contractor must notify CMS and DMAS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DMAS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to

Appendix D. The Contractor must notify CMS and DMAS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment

5.1.2.1. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DMAS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government, DMAS, or its authorized agents.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

5.1.4. Subrogation

5.1.4.1. Subject to CMS and DMAS lien and third-party recovery rights and responsibilities, and consistent with Section 5.1.13.3.1 of this Contract and any additional CMS and DMAS guidance, the Contractor must:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.1.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.1.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.1.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 USC §1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements

5.1.6.1. The Contractor must disclose to CMS and DMAS information on its ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B [42 CFR 455.104, 455.105, 455.106]. The Contractor must obtain federally required disclosures from all network providers and applicants in accordance with 42 C.F.R. § 1002.3, and as specified by DMAS and CMS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to CMS and DMAS in accordance with this Contract and relevant state and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A), 42 C. F. R. § 438.610 and 42 C.F.R. § 455.436, if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act.

5.1.7. Physician Incentive Plans

5.1.7.1. The Contractor may, in its discretion, operate a physician incentive plan only if:

5.1.7.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control;

5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

5.1.7.1.3. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

5.1.7.2. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 422.208, 422.210, and 438.6(h). The Contractor must submit all information required to be disclosed to CMS and the DMAS in the manner and format specified by CMS and the DMAS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.3. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by DMAS that results from the Contractor's or its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and DMAS, that it has made a good faith effort to comply with the cited requirements.

5.1.8. Physician Identifier

5.1.8.1. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DMAS for each of its PCPs in the format and time-frame established by CMS and DMAS in consultation with the Contractor.

5.1.9. Timely Provider Payments

5.1.9.1. The Contractor must make timely payments to its providers. The Contractor must ensure that ninety percent (90%) of claims from physicians who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Covered Service providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.9.1.1. Clean claims include claims with errors originating from the Contractor's claims systems but does not include claims from a provider who is under investigation for fraud or abuse, nor claims under review for Medical Necessity.

5.1.9.1.2. Interest charges shall be paid for Medicaid claims in accordance with 2.10.1.5.

5.1.9.1.3. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 CFR § 423. 505(i)(3)(vi).

5.1.10. Protection of Enrollee-Provider Communications

5.1.10.1. In accordance with 42 USC §1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a Provider or clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the Provider or clinical First Tier, Downstream or Related Entity is acting within the lawful scope of practice.

5.1.11. Protecting Enrollee from Liability for Payment

5.1.11.1. The Contractor must:

5.1.11.1.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.11.1.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.11.1.1.2. Services (other than excluded services) provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DMAS for such services; or

5.1.11.1.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services.

5.1.11.1.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A;

5.1.11.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;

5.1.11.1.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming CCC eligible, incurred a bill that has not been paid; and

5.1.11.1.5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the Contractor's Provider Network that does not comply with such provisions.

5.1.12. Moral or Religious Objections

5.1.12.1. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

5.1.12.1.1. To DMAS;

5.1.12.1.2. With its application for a Contract;

5.1.12.1.3. Whenever it adopts the policy during the term of the Contract; and

5.1.12.1.4. The information provided must be

5.1.12.1.4.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.12.1.4.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.12.1.4.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.1.12.2. Third Party Liability Comprehensive Health Coverage

5.1.12.2.1. Enrollees, determined by DMAS as having comprehensive health coverage other than Medicare or Medicaid, will be assigned to the fee-for-service program, effective the first day of the month following the month in which the coverage was verified. Enrollees will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the Contractor is responsible for coordinating all benefits covered under this Contract.

5.1.12.2.2. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), the state is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the Enrollee was not identified for exclusion prior to enrollment in the MMP, the Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to DMAS and CMS. The Contractor shall notify DMAS and CMS on a monthly basis of any Enrollees identified during that past month that were discovered to have comprehensive health coverage.

5.1.12.2.3. When the other payor is a commercial MMP/HMO organization, the Contractor is responsible for the full copayment amount. The Enrollee may not be billed by provider.

5.1.13. Worker's Compensation

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

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

5.1.13.2. Estate Recoveries

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

5.1.13.3. Other Coverage

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

5.1.13.3.2. Enrollees with these other resources shall remain enrolled in the MMP, as long as they continue to meet eligibility requirements. The Contractor shall notify DMAS and CMS on a monthly basis of any Enrollees identified during that past month who are discovered to have any of the above coverage, including Enrollees identified as having trauma injuries. The Contractor shall provide DMAS and CMS with all encounter/claims data associated with care given to Enrollees who have been identified as having any of the above coverage.

5.2. Confidentiality

5.2.1. Statutory Requirements

5.2.1.1. The Contractor understands and agrees that CMS and DMAS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under the Code of Virginia § 32.1-127.1:03 The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable state and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data

5.2.2.1. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to

design, development, operation, or maintenance of the laws and regulations relating to confidentiality.

5.2.3. Data Security

5.2.3.1. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

5.2.3.1.1. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c).

5.2.3.1.2. The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule.

5.2.4. Return of Personal Data

5.2.4.1. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DMAS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DMAS will destroy such data or material.

5.2.5. Destruction of Personal Data

5.2.5.1. For any PHI received regarding an Eligible Beneficiary referred to Contractor by DMAS who does not enroll in Contractor's plan, the Contractor must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.2.6. Research Data

5.2.6.1. The Contractor must seek and obtain prior written authorization from CMS and DMAS for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. The term "applicable law," as used in this Contract, means, without limitation, all federal and state law, and the regulations, policies, procedures, and instructions of CMS and DMAS all as existing now or during the term of this Contract.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the Commonwealth of Virginia or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

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

5.3.4. Loss of Licensure

5.3.4.1. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or state approvals, the Contractor must report such loss to CMS and DMAS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification

5.3.5.1. The Contractor shall indemnify and hold harmless CMS, the federal government, the Commonwealth of Virginia, and DMAS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DMAS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1.1. The Contractor is notified of any claims within a reasonable time from when CMS and DMAS become aware of the claim; and

5.3.5.1.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or state law, solely on the basis of such license or certification. This section does not prohibit the Contractor from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor. The Contractor will provide each provider or group of providers whom it declines to include in its network written notice of the reason for its decision. Nothing in the section, above, may be construed to require the Contractor to contract with providers beyond the number necessary to meet the needs of its Enrollees; precludes the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

5.3.6.2. If a Complaint or claim against the Contractor is presented to DMAS for handling discrimination complaints, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant

5.3.7.1. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by *The Code of Virginia* § 38.2-505 . Without limiting such other rights as it may have, CMS and DMAS will be entitled to rescind this Contract in the event of noncompliance with this Subsection. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51) percent of the ownership interests of the Contractor.

5.3.8. Information Sharing

5.3.8.1. During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to

all applicable federal and state laws, the Contractor must arrange for the transfer, at no cost to CMS, DMAS, or the Enrollee, of medical information regarding such Enrollee to any subsequent provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or directed by CMS and DMAS the Enrollee, regulatory agencies of Virginia, or the United States Government. With respect to Enrollees who are in the custody of the Commonwealth, the Contractor must provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee's Medical Records in a timely manner.

5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder; provided, however, that the Contractor must provide CMS and DMAS with a complete list of such plans and services, upon request. CMS and DMAS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DMAS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10. Counterparts

5.3.10.1. This Contract may be executed simultaneously in two (2) or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.13. Corrective Action Plan

5.3.13.1. If, at any time, CMS and DMAS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS

and DMAS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DMAS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DMAS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DMAS or other intermediate sanctions as described in Subsection 5.3.14.

5.3.14. Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1. In addition to termination under Subsection 5.5, CMS and DMAS may, impose any or all of the sanctions in Subsection 5.3.14 upon any of the events below; provided, however, that CMS and DMAS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction. Sanctions may be imposed in accordance with this section if the Contractor:

5.3.14.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.14.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.14.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.14.1.4. Misrepresents or falsifies information provided to CMS, DMAS and its authorized representatives,, Enrollees, prospective Enrollees , or its Provider Network;

5.3.14.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.14.1.6. Fails to comply with federal or state statutory or regulatory requirements related to this Contract;

5.3.14.1.7. Violates restrictions or other requirements regarding marketing;

5.3.14.1.8. Fails to comply with quality management requirements consistent with Section 2.17;

5.3.14.1.9. Fails to comply with any corrective action plan required by CMS and DMAS;

5.3.14.1.10. Fails to comply with financial solvency requirements;

5.3.14.1.11. Fails to comply with reporting requirements; or

5.3.14.1.12. Fails to comply with any other requirements of this Contract.

5.3.14.2. Such sanctions may include:

5.3.14.2.1. Financial penalties consistent with 42 C.F.R. § 438.704;

5.3.14.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.14.2.3. Suspension of Enrollment (including assignment of Enrollees);

5.3.14.2.4. Suspension of payment to the Contractor;

5.3.14.2.5. Disenrollment of Enrollees;

5.3.14.2.6. Suspension of marketing; and

5.3.14.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.14.3. If CMS or DMAS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and DMAS may:

5.3.14.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DMAS; or

5.3.14.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.14.4. Before imposing any intermediate sanctions, DMAS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DMAS and CMS elect to provide.

5.3.15. Additional Administrative Procedures

5.3.15.1. CMS and DMAS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract

administration and other management matters. The Contractor must comply with all such program memoranda as may be issued from time to time.

5.3.16. Effect of Invalidity of Clauses

5.3.16.1. If any clause or provision of this Contract is in conflict with any federal or state law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.17. Conflict of Interest

5.3.17.1. Neither the Contractor nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DMAS with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and DMAS require that neither the Contractor nor any First Tier, Downstream, or Related Entity has any financial, legal, and contractual or other business interest in any entity performing MMP enrollment functions for DMAS, the CST Enrollment Vendor and First Tier, Downstream, or Related Entity(ies), if any.

5.3.18. Insurance for Contractor's Employees

5.3.18.1. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and DMAS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or DMAS, provide certification of professional liability insurance coverage.

5.3.19. Key Personnel

5.3.19.1. The Contractor's Project Manager and/or the Executive with oversight of the Program, Chief Medical Officer/Medical Director, Pharmacy Director, Behavioral Health Director, Director of /Long Term Services and Support, ADA Compliance Director, Chief Financial Officer, Chief Operating Officer or Director of Operations, Quality Manager, Senior Manager of Clinical Services, Claims Director, IT Director, Compliance Officer and/or equivalent position(s) are "key personnel." The Contractor shall submit to DMAS the name, resume, and job description for each of the key personnel to DMAS within five (5) days of executing this Contract. If the Contractor substitutes another individual for any individual identified by the Contractor as key personnel, the Contractor must notify DMAS

immediately and provide the name(s) and resumes of qualified replacements.

5.3.19.2. If DMAS is concerned that any of the key personnel are not performing the responsibilities, including but not limited to, those provided for in the person's position under Section 5.3.19 DMAS shall inform the Contractor of this concern. The Contractor shall investigate said concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify DMAS of such actions. If the Contractor's actions fail to ensure full compliance with the terms of this Contract, as determined by DMAS, the corrective action provisions in Section 5.3.13 may be invoked by DMAS.

5.3.20. Waiver

5.3.20.1. The Contractor, CMS, or DMAS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DMAS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DMAS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.21. Section Headings

5.3.21.1. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.3.22. Immigration and Control Act of 1986: By signing this Contract the Contractor certifies that they do not and shall not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

5.3.23. Other State Terms and Conditions

5.3.23.1. Debarment Status: By signing this Contract the Contractor certifies that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from entering into contracts for the type of services covered herein, nor are they an agent of any person or entity that is currently so debarred.

5.3.23.2. Antitrust: By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia and CMS all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the

Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia and CMS under said contract.

5.3.23.3. Drug-Free Workplace: During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractors employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractors workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Business Associate maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Vendor.

5.3.23.3.1. For the purposes of this section, "*drug-free workplace*" means a site for the performance of work done in connection with this Contract, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

5.3.23.3.2. The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

5.3.23.4. Business Associate Agreement (BAA): The Contractor shall be required to enter into a DMAS and CMS-approved Business Associate Agreement (BAA) with DMAS and CMS to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). Such agreement will be compliant with the Data Use Addendum, provided at Appendix G to this Contract. The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all state and federal laws and regulations with regards to handling, processing, or using the Department's PHI and ePHI. This includes but is not limited to 45 C.F.R. Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement. The Contractor shall keep abreast of the

regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to DMAS or CMS.

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

5.3.23.6. Business Transaction Reporting: The Contractor shall also notify the Department within ten (10) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership.

5.3.23.6.1. Business transactions to be disclosed include, but are not limited to:

5.3.23.6.1.1. Any sale, exchange, or lease of any property between the Contractor and a party in interest;

5.3.23.6.1.2. Any lending of money or other extension of credit between the Contractor and a party in interest; and

5.3.23.6.1.3. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a party in interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

5.3.23.6.2. The Contractor shall advise the Department, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid business in Virginia or other states. This includes, but is not limited to, sale of existing business to other entities or a complete exit from the Medicaid market in another state or jurisdiction.

5.3.23.7. Compliance with VITA Standard: The Contractor shall comply with all state laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and

visually impaired individuals. These accessibility standards are state law (*see* § 2.2-3502 and § 2.2-3503 of the *Code of Virginia)*. The Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to the Virginia Code as well as any subsequent revisions to the Virginia Information Technologies Standards. The current Virginia Information Technologies Accessibility Standards are published on the Internet at http://www.vita.virginia.gov/library/default.aspx?id=663.

5.3.23.8. Continuity of Services:

5.3.23.8.1. The Contractor recognizes that the services under this contract are vital to DMAS and must be continued without interruption and that, upon contract termination, a successor, either DMAS or another Contractor, may continue them. The Contractor agrees:

5.3.23.8.1.1. To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;

5.3.23.8.1.2. To make all DMAS owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and

5.3.23.8.1.3. That DMAS shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.

5.3.23.8.2. The Contractor shall, upon written notice from DMAS, furnish phase-in/phase-out services for up to ninety (90) days after this contract expires and shall negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the DMAS' approval.

5.3.23.8.3. The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the DMAS in writing prior to commencement of said work.

5.3.23.9. Severability: Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. DMAS, CMS and Contractor further agree that in the event any provision is deemed an invalid part of this Contract, they shall immediately begin negotiations for a suitable replacement provision.

5.4. Record Retention, Inspection, and Audits

5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years.

5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DMAS and other regulatory agencies, available to CMS and DMAS and its agents, designees or contractors or any other authorized representatives of the Commonwealth of Virginia or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DMAS may require, in a manner that meets CMS and DMAS' record maintenance requirements.

5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and state requirements.

5.5. Termination of Contract

5.5.1. Termination without Prior Notice

5.5.1.1. In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Virginia Medicaid programs, CMS or DMAS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. CMS or DMAS may terminate the contract in accordance with regulations that are current at the time of the termination.

5.5.1.2. Without limiting the above, if CMS and DMAS determine that participation of the Contractor in the Medicare or Virginia Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Virginia Medicaid program, CMS or DMAS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DMAS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Eligible Beneficiaries.

5.5.1.3. United States law will apply to resolve any claim of breach of this Contract.

5.5.2. Termination with Prior Notice

5.5.2.1. CMS or DMAS may terminate this Contract without cause upon no less than 180 days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the Contractor may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a), except in Demonstration Year 1, in which the Contractor may choose to non-renew the Contract as of December 31, 2014 provided the Contractor gives notice before August 1, 2014, and may terminate the contract by mutual consent of CMS and DMASat any time pursuant to 42 C.F.R. 422.508. In considering requests for termination under 42 C.F.R. §422.508m CMS and DMAS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and DMAS prior to their use.

5.5.2.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.1.1 and non-renewal of this Contract as described in Section 5.7 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two (2) years due to termination.

5.5.3. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.4. Termination for Cause

5.5.4.1. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DMAS

determines that a delay in te11rmination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DMAS may expedite the termination.

5.5.4.2. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. §422.510 and §438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DMAS must:

5.5.4.2.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.4.2.2. Notify the Contractor of its appeal rights as provided in 42 C.F.R. §422 Subpart N and §438.710.

5.5.5. Termination due to a Change in Law

5.5.5.1. In addition, CMS or DMAS may terminate this Contract upon thirty (30) days' notice due to a material change in law, or with less or no notice if required by law.

5.5.6. Continued Obligations of the Parties

5.5.6.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Virginia Medicaid programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan. CMS and DMAS will disenroll beneficiaries by the end of the month that termination, expiration, or non-renewal of this contract is effective..

5.5.6.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.6.2.1. If CMS or DMAS, or both, elect to terminate or not renew the Contract, CMS and DMAS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and state requirements;

5.5.6.2.2. The Contractor must promptly return to CMS and DMAS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.5.6.2.3. The Contractor must supply to CMS and DMAS all information necessary for the payment of any outstanding claims determined by CMS and DMAS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Order of Precedence

5.6.1. The following documents are incorporated into and made a part of this Contract, including all appendices:

5.6.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year; and

5.6.1.2. Memorandum of Understanding, a document between CMS and the Commonwealth of Virginia Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (May 21, 2013);

5.6.1.3. Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties;

5.6.1.4. The Contractor's response to the Request for Proposals (RFP) RFP2013-05; and

5.6.1.5. Any State or Federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance; and Reporting Requirements.

5.6.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

5.6.2.1. The Contract terms and conditions, including all appendices;

5.6.2.2. Capitated Financial Alignment Application;

5.6.2.3. The MOU between CMS and Virginia;

5.6.2.4. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties;

5.6.2.5. The Contractor's response to the RFP2013-05; and

5.6.2.6. Any State or Federal Requirements or Instructions released to MMPs. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance; and Reporting Requirements.

5.6.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.7. Contract Term

5.7.1. This Contract shall be in effect through December 31, 2015, and, so long as the Contractor has not provided CMS with a notice of intention not to renew, and CMS/DMAS have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506, shall be renewed in one year terms, through December 31, 2017.

5.8. Amendments

5.8.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or state statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

5.9. Written Notices

5.9.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

Copies to:

To: Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Copies to:

_____

_____

_____

_____

To: Humana Health Plan, Inc.
321 West Main Street, 12th Floor
Louisville, Kentucky 40202

Copies to:

Jennifer Coleman, Director, Medicaid Program

Candice McAuliffe, Project Manager

Daniele Ruskin, Esq., Deputy General Counsel

Section 6. Signatures

In Witness Whereof, CMS, DMAS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Humana Health Plan, Inc.:

Authorized Signatory: (Name and Title)

Timothy A. Wheatley
President-Medicare
Medicaid

12-11-2013

(Signature) (Date)

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Authorized Signatory: Francis T. Mccullough, Associate Regional Administrator for Philadelphia Regional Office

(Signature) (Date)

Authorized Signatory: Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

(Signature) (Date)

Commonwealth of Virginia, Department of Medical Assistance Services

Authorized Signatory: Cynthia B. Jones, Director

(Signature) (Date)

Section 6. Signatures

In Witness Whereof, CMS, DMAS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Humana Health Plan, Inc.:

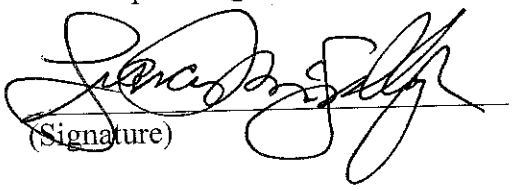
Authorized Signatory: (Name and Title)

_____ _____

(Signature) (Date)

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Authorized Signatory: Francis T. Mccullough, Associate Regional Administrator for Philadelphia Regional Office



(Signature) 12/11/2013 (Date)

Authorized Signatory: Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

(Signature) 12/10/13 (Date)

Commonwealth of Virginia, Department of Medical Assistance Services

Authorized Signatory: Cynthia B. Jones, Director

_____ _____

(Signature) (Date)

Section 6. Signatures

In Witness Whereof, CMS, DMAS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Humana Health Plan, Inc.:

Authorized Signatory: (Name and Title)

_____ _____

(Signature) (Date)

United States Department of Health and Human Services, Centers for Medicare & Medicaid Services:

Authorized Signatory: Francis T. Mccullough, Associate Regional Administrator for Philadelphia Regional Office

_____ _____

(Signature) (Date)

Authorized Signatory: Danielle R. Moon, J.D., M.P.A., Director, Medicare Drug & Health Plan Contract Administration Group

_____ _____

(Signature) (Date)

Commonwealth of Virginia, Department of Medical Assistance Services

Authorized Signatory: Cynthia B. Jones, Director

Cynthia Jones 1/24/14

(Signature) (Date)

APPENDIX A. Covered Services

A.1 Medical Necessity

A.1.1 The Contractor shall provide services to Enrollees as follows:

A.1.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.1.2.1 Prevent, diagnose, or treat health impairments;

A.1.1.2.2 Attain, maintain, or regain functional capacity.

A.1.2 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.4.1 Developed with input from, including but not limited to, practicing physicians in the Contractor's Service Area;

A.1.4.2 Developed in accordance with standards adopted by national accreditation organizations;

A.1.4.3 Developed in accordance with the definition of Medical Necessity in Section 1;

A.1.4.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.4.5 Evidence-based, if practicable; and,

A.1.4.6 Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.5 The Contractor's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at a minimum, be submitted to DMAS annually for approval no later than 30 days prior to the start of a new Contract Year, and no later than 30 days prior to any change.

A.1.6 The Contractor must offer to Enrollees any additional non-medical programs and services available to a majority of the Contractor's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by DMAS and the Contractor, such as health club discounts, diet workshops and health seminars. The Contractor's capitation rate shall not include the costs of such programs and services.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received DMAS and CMS approval.

A.2 Covered Services: The Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1.1 All services provided under Medicare Part A

A.2.1.2 All services provided under Medicare Part B

A.2.1.3 All services provided under Medicare Part D

A.2.1.4 Particular pharmacy products that are covered by DMAS and may not be covered under Medicare Part D, including:

A.2.1.5 Over-the-counter (OTC) drugs as specified at https://Virginiadruglist.ehs.state.ma.us/MHDL/pubdownloadpdfcurrent.do?id=221;

A.2.1.6 Barbiturates for indications not covered by Part D (butalbital, mephobarbital, phenobarbital secobarbital);

A.2.1.7 "Miscellaneous" drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and

A.2.1.8 Prescription vitamins and minerals.

A.2.1.9 Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.2.1.10 All services listed and defined in Appendix B below.

A.3 Limitations on Covered Services

A.3.1 The following services and benefits shall be limited as Covered Services:

A.3.1.1 Termination of pregnancy may be covered only as allowed by applicable state and federal law (42.C.F.R. Part 441, Subpart E).

A.3.1.2 Sterilization services may be covered only as allowed by state and federal law (see 42 C.F.R. Part 441, Subpart F).

A.4 Cost-sharing for Covered Services

A.4.1 Except as described in Section 4.2.3 above, cost-sharing of any kind is not permitted in this Demonstration.

A.4.2 Cost sharing for Part D drugs. Co-pays charged by the Contractor for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.3 The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

APPENDIX B. Covered Services Definitions

In addition to all Medicare services, the Contractor is responsible for providing Medicaid covered benefits described below. All benefit limits for Medicaid covered services should be verified through the State Plan for Medicaid 12 VAC 30-50 and the appropriate DMAS Provider Manual. The Contractor shall provide Medicare benefits as defined by CMS and its contractors.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Case Management Services for Participants of Auxiliary Grants	12 VAC 30-50-470 12VAC30-10-320 Chapter iv of the Assisted Living Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved out (pursuant to 12VAC30-10-320)	**The plan is not required to cover this service.** This service will be covered through a carve out. This is not a widely used program and is included as part of the annual reassessment screening process for assisted living recipients.
Targeted Case Management	12 VAC 30-50-440 Chapter IV of the Mental Retardation/Intellectual Disability Community Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved Out	**The plan is not required to cover this service.** This service is provided by the Community Services Boards.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover all Medically Necessary court ordered dual Demonstration covered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Dental Services (ADULT)	12 VAC 30-50-190 38.2-341.12 of the Code of Virginia The Dental Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Non-covered, except for certain circumstances. See notes.	The plan shall cover CPT codes billed by an MD as a result of an accident. The plan shall cover CPT and other "non-CDT" procedure codes billed for Medically Necessary procedures of the mouth. The plan shall cover Medically Necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care. Optional: The plan, at its option, may cover certain dental services as for Demonstration Enrollees.
Family Planning Services	12 VAC 30-50-130 42C.F.R. § 441.20 42 C.F.R. § 431.51(b)(2)	Carved In	The plan shall cover all family planning services and supplies for Enrollees of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices provided under the supervision of a physician. Covered services do not include services to treat infertility or to promote fertility. The plan may not restrict an Enrollee's choice of provider for family planning services, drugs, devices or supplies, and the plan shall cover all family planning services and supplies provided to its Enrollees by network providers and by out-of-network providers. Federal law (42 C.F.R. § 441.20) requires that the plan also allow the Enrollee, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. There are no cost sharing responsibilities for family planning services. The plan must ensure that preauthorization requirements do not apply to family planning services. The plan shall comply with the requirements set forth in 42 C.F.R. § 441, Subpart F, as amended, and shall comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, § 54.1-2974. The plan may not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. Hysterectomies performed solely for the purpose of rendering an Enrollee incapable of reproducing are not covered by Medicaid. The Department's Family Planning State Plan Program by the CMS is not covered under the CCC program.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
High-Risk Prenatal Services	12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-510 12 VAC 30-50-410 Chapter 4 of the Baby Care Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	Provide or arrange for services for pregnant women. These services shall address the following major goals: To reduce infant mortality and morbidity; To ensure provision of comprehensive services to pregnant and postpartum women, and To assist pregnant and postpartum women and caregivers of infants in meeting other priority needs that affect their well-being and that of their families. These needs may include non-medical needs and non-covered services. Program services shall include, at a minimum, the following: Case management services for high-risk pregnant women that include coordination of services for maternal health to minimize fragmentation of care, reduce barriers, and link Enrollees with appropriate services to ensure comprehensive, continuous health care. These coordination services will include: a. Assessment to determine Enrollees' needs which includes psychosocial, nutrition, and medical factors. b. Person-centered service planning to develop individualized descriptions of what services and resources are needed to meet the service needs of the Enrollee and how to access those resources. c. Coordination and referrals that will assist the Enrollee in arranging for appropriate services and ensure continuity of care. d. The plan shall develop and offer expanded prenatal care services for all pregnant women comparable to those described in 12 VAC 30-50-510 and 12 VAC 30-50-290. They shall provide a comprehensive prenatal care service package which may include services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when Medically Necessary.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01 Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The plan shall ensure that, as a routine component of prenatal care, every pregnant Enrollee shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant Enrollee consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant Enrollee shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the Enrollee's Medical Record.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Home Health Services	12 VAC 30-50-160 Chapter IV of the Home Health Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. Visits by a licensed nurse and home health aide services shall be covered as Medically Necessary. Rehabilitation services (physical therapy, occupational therapy, and speech-language therapy) shall also be covered under the Enrollee's home health benefit. The plan must manage the following service related conditions, where Medically Necessary and regardless of whether the need is long-term or short-term: B-12 shots, insulin injections, central line and porta cath flushes, blood draws for example where the Enrollee is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance, changing of indwelling catheter. This includes those instances where the Enrollee cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The plan shall not refer for skilled nursing under the home and community based waivers for these conditions. **The plan is not required to, but may at their option, cover** the following home health services, except if ordered by a physician as a result of an high-risk pregnancy screen: medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Medical Supplies and Equipment	12 VAC 30-50-160 12 VAC 30-50-165 12VAC30-120-195 Durable Medical Equipment & Supplies Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover all medical supplies and equipment at least to the extent they are covered by DMAS. The plan is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the Enrollee is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the Enrollee is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following: • Customized wheelchairs and required components; • Customized prone standers; and, • Customized positioning devices Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition is administered orally or through nasogastric or gastrotomy tube, and is necessary to treat a medical condition.
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover this service. The plan shall also be responsible for non-nursing facility services and shall work with the NF on discharge planning if appropriate. The plan will establish strong relationships with NFs to ensure that Enrollees in NFs receive high quality care, maintain good health, and to reduce avoidable hospital admissions among NF residents. Plans will help facilitate Enrollees returning to community settings when possible and desired by the Enrollee. The plan may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to Enrollees.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-160 12 VAC 30-50-200 12VAC30-130-40 12 VAC 30-50-225 Chapter IV of the Rehabilitation Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), and audiology services. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define "acute conditions" as conditions that are expected to be of brief duration (less than 12 months) in which progress toward goals is likely to occur frequently. "Non-acute conditions" are defined as conditions that are of long duration (greater than 12 months) in which progress toward established goals is likely to occur slowly. PT, OT, SLP, and audiology services are covered regardless of where they are provided, with two exceptions. The plan shall be required to cover services rendered in a NF if the services are not offered as an in-house component of the facility. The plan shall also cover all Medically Necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).
Podiatry	12 VAC 30-50-150 Chapter IV of the Podiatry Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The plan is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Pregnancy-Related Services	12 VAC 30-50-220 12 VAC 30-50-280 12 VAC 30-50-290 12 VAC 30-50-410	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover services to pregnant women, including: a. Prenatal services, including patient education, nutritional assessment, counseling and homemaker services, as set forth in 12 VAC 30-50-510 and 12 VAC 30-50-290; b. Case management services for high-risk pregnant women, as set forth in 12 VAC 30-50-410 and 12 VAC 30-50-280. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit as indicated by the most recent "Guidelines for Perinatal Care" developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The early discharge follow-up visit shall be provided to all mothers, who meet the Department's criteria for early discharge, as set forth in 12 VAC 30-50-220. The early discharge follow-up visit shall be provided within forty-eight (48) hours of discharge and must include, at a minimum, a maternal assessment, as set forth in 12 VAC 30-50-220.
Prescription Drugs	12 VAC 30-50-210 12 VAC 30-50 §38.2-4312.1 of the Code of Virginia Chapter IV of the Pharmacy Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320 and in coordination with Medicare Part D)	The plan shall cover all Medicaid covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug including those prescribed by a provider during a physician visit or other visit covered by a third party payer including mental health visits. The plan is not required to cover Drug Efficacy Study Implementation (DESI) drugs. The plan may establish a formulary and shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if Medically Necessary and if Medicaid would cover them under fee-for-service. If the drug is prescribed for an Emergency Medical Condition, the plan must pay for at least a 72-hour supply of the drug to allow the plan time to make a decision. The plan shall cover therapeutic drugs even when they are prescribed as a result of non-covered services or carved-out services (e.g., narcotic analgesics after cosmetic surgery). The plan shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The plan is responsible for coverage of specific drug classes that are excluded by law under the Medicare Part D but covered under the currently established guidelines of the DMAS pharmacy benefit program. Drugs for the treatment of erectile dysfunction are not covered by Medicaid. Under the Demonstration, the plan may not impose co-payments on payments on Medicaid-covered prescription drugs.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover Medically Necessary prosthetic and orthotic services and devices. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The plan shall cover Medically Necessary prosthetics and orthotics for an Enrollee regardless of the Enrollee's age when recommended as part of an approved intensive rehabilitation program.
Telemedicine Services	Chapter IV of the Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall provide coverage for telemedicine services as detailed in 2.4.3.Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and state laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Temporary Detention Orders (TDOs) & Emergency Custody Orders (ECOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq. Code of Virginia § 37.2-808 and the Appropriations Act of 2006 - 2008, Item 300, B Appendix B of the Hospital Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for mental health services. The Medical Necessity of the TDO services is assumed by the Department to be established, and the plan may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the Enrollee is under TDO for mental health services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. When an out-of-network provider provides TDO services, the plan shall be responsible for reimbursement of these services. In the absence of a contract otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid fee-for-service rate in effect at the time the service was rendered. TDOs do not accrue toward the total number psychiatric visits. If it is determined by the judge, as the result of a hearing, that the Enrollee may be transferred without medically harmful consequences, the plan may designate an appropriate in-network or out-of-network facility for the provision of care. The plan will cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO. The plan shall provide, honor and be responsible for payment of Medically Necessary screenings and assessments for persons who are under an emergency custody order.
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 Chapter 4 of the Transportation Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall provide emergency transportation as well as non-emergency transportation to all Medicaid covered services. These modes include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The plan shall cover air travel for critical needs. The plan shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in 42 C.F.R. § 440.170(a). The plan shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The plan shall cover transportation to and from Medicaid covered community mental health and rehabilitation services.

Service	CFR, SPA or DMAS Manual Reference	Carved in (Included) or Carved out (Excluded) of Demonstration	Notes
Vision Services	12 VAC 30-50-210 Chapter iv of the Vision Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all Enrollees, shall be allowed at least once every two (2) years.

BEHAVIORAL HEALTH SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Non-covered	**The plan is not required to cover this service**. Individuals in State Psychiatric Hospitals are excluded from the Demonstration.

OUTPATIENT MENTAL HEALTH SERVICES ****The plan is responsible to cover outpatient mental health services. The benefit maximum for adults **in the first year of treatment** shall not be less than 52 visits, and 26 visits per year following the first year of treatment. Medication management visits are not to be counted against the number of outpatient psychiatric visits.			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Carved in (pursuant to 12VAC30-10-320)	****
Individual Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	****
Group Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiame	Carved in (pursuant to 12VAC30-10-320)	****

	dicaid.dmas.virginia.gov/wps/portal/ProviderManual)		
Family Medical Psychotherapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	****
Electroconvulsive Therapy	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
Psychological/ Neuropsychological Testing	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****
Pharmacological Management	12VAC30-50-140 12VAC30-50-150 12VAC30-50-180	Carved in (pursuant to 12VAC30-10-320)	****

COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430 \Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover Community Mental Health Services.
Community Mental Retardation Services	12VAC30-50-440 Chapter IV of the Mental Health/Intellectual Disability Community Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved out	**This service will be covered through a carve out.** The plan must provide information and referrals as appropriate to assist Enrollees in accessing these services. The plan shall cover transportation to and from State Plan Option services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES			
Service	State Plan Reference or Other Relevant Reference	Carved-in (Included) or Carved-out (Excluded) of Demonstration	Notes
Out-patient substance abuse treatment	12 VAC 30-50-141 12 VAC 30-50-151 12 VAC 30-50-181 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in (pursuant to 12VAC30-10-320)	The plan shall cover substance assessment and evaluation and outpatient services for substance abuse treatment for Enrollees. Emergency counseling services, intensive outpatient services, day treatment, opioid treatment, and substance abuse case management services are carved in this contract and shall be covered by the Contractor. Transportation and pharmacy services necessary for the treatment of substance abuse shall be the responsibility of the Contractor.
Residential Treatment for Pregnant Women	12VAC30-50-510 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover residential treatment for pregnant women.
Day Treatment for Pregnant Women	12VAC30-50-510 Chapter 4 of the Community Mental-Health Rehabilitation Services Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Carved in	The plan shall cover day treatment for pregnant women.

B.1 Definitions: Long-Term Services and Supports Provided Through the EDCD Waiver

B.1.1 Current services covered under the EDCD Waiver include: adult day health care, personal care (agency and consumer-directed (CD)), personal emergency response systems (with or without medication monitoring), respite care (agency and CD), transition services, and transition coordination.

B.1.2 The EDCD Waiver includes consumer-direction. Consumer-direction allows Enrollees to serve as the employer for the individual who provides personal care and respite care. Consumer-direction is optional for EDCD Waiver/Demonstration Enrollees.

B.1.3 Adult Day Health Care (ADHC) Services

B.1.3.1 Adult Day Health Care Services (ADHC) may be offered to elderly Enrollees and Enrollees with physical disabilities who have been assessed to be at risk of institutionalization, meet the criteria for NF care, and have been screened by a Pre-Admission Screening (PAS) Team for EDCD Waiver services and authorized. ADHC services offered through the EDCD waiver are defined as long-term maintenance or supportive services which are necessary to enable the Enrollee to remain at home rather than enter a NF.

B.1.3.2 ADHC services are designed to prevent institutionalization by providing Enrollees with health, maintenance, and rehabilitation services in a congregate daytime setting. The significant difference between ADHC and personal care is the congregate setting in which ADHC is rendered. The plan shall enter into participation agreements with qualified adult day care centers which are licensed by the Virginia DSS.

B.1.3.3 The services offered by the ADHC Center must be designed to meet the needs of the Enrollee. Thus, the range of services provided by the ADHC Center to each Enrollee may vary to some degree. There must, however, be a minimum range of available services, including: nursing services, rehabilitation services coordination, transportation, nutrition services, social services, recreation, and socialization services.

B.1.3.4 Service criteria are described in detail in the EDCD Waiver regulations at 12 VAC 30-120-940 and the provider manual at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual .

B.1.4 Personal Care Services: Agency -and Consumer-Directed

B.1.4.1 Personal care services may be provided in home and community settings to enable an Enrollee to maintain the health status and functional skills necessary to live in the community or to participate in community activities. The Enrollee must meet DMAS' requirements for assistance with activities of daily living (ADLs) in order for personal care services to be authorized. Personal care services are defined as direct assistance with and supervision of ADLs and instrumental activities of daily living (IADLs) and monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD).

B.1.4.2 The unit of service for personal care services is one hour. In the current DMAS EDCD Waiver program, payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved POC when the Enrollee is present. Personal care services are limited to the hours specified in the POC. The 2011 Virginia General Assembly approved budget bill language (Item 297 CCCCC) requires DMAS to develop and implement a 56 hour per week cap for personal care services under the EDCD Waiver. DMAS has implemented exception criteria for those Enrollees who require more than 56 hours per week of personal care services.

B.1.4.3 Personal assistance services include assistance with ADLs such as: bathing, dressing, transferring, and, toileting. This service does not include skilled nursing services, with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18 VAC 90-20-420 through 18 VAC 90-20-460. When specified in the POC, personal assistance services may include assistance with IADLs, such as housekeeping, shopping, meal preparation, etc., but does not include the cost of meals themselves. Assistance with IADLs must be essential to the health and welfare of the Enrollee, rather than the Enrollee's family. These services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. Provision of these services is not limited to the home.

B.1.4.4 Additional components of personal assistance are work-related and school-related personal assistance where the personal assistance and supports may be provided in the workplace and post-secondary educational institutions. This service is only available to Enrollees who require personal assistance services to meet their ADLs. Workplace or school supports through the EDCD Waiver are not provided if they are services provided by the Department for Aging and Rehabilitative Services, under IDEA, or if they are an

employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

B.1.4.5 Service criteria for agency-directed personal assistance and consumer-directed personal assistance are described in detail in the EDCD Waiver regulations at 12 VAC 30-120-950 and 12 VAC 30-120-980, respectively, and the EDCD Waiver provider manual at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

B.1.5 Personal Emergency Response System (PERS)

B.1.5.1 Personal Emergency Response System (PERS) is an electronic device that enables Enrollees to secure help in an emergency. PERS electronically monitors safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices.

B.1.5.2 PERS services are limited to Enrollees who live alone, are alone for significant parts of the day, have no regular caregivers for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency, and who would otherwise require extensive routine supervision. Enrollees must be receiving another EDCD Waiver service in order to be eligible to receive PERS services. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

B.1.5.3 Service criteria are described in detail in the EDCD regulations at 12 VAC 30-120-970 and the provider manual at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

B.1.6 Respite Care Services – Agency and Consumer-Directed

B.1.6.1 Respite services are personal care (AD or CD) or services of a nurse (AD) that are specifically designed to provide temporary, substitute care that is normally provided by the family or another unpaid primary caregiver. Respite is for the relief of the primary unpaid caregiver due to the physical burden and emotional stress of providing continuous support and care to the Enrollee. These services are provided on a short-term basis because of an emergency absence, or need for routine or periodic relief of the primary caregiver who lives in the home with the Enrollee.

B.1.6.2 The maximum amount of respite care services that an Enrollee may receive in the DMAS program is 480 hours in a state fiscal year. In the DMAS EDCD Waiver program, Enrollees who are receiving CD, AD, and facility-based respite services cannot exceed 480 hours per state fiscal year combined. Respite care can be authorized as a sole community-based care service, or it can be offered in conjunction with other EDCD Waiver services.

B.1.6.3 Respite services are usually provided by a personal care attendant. However, a licensed nurse may provide skilled respite in cases where the Enrollee has a skilled nursing need, provided the following circumstances are met:

B.1.6.3.1 A physician's order must be obtained prior to the start of skilled respite services and must be kept in the individual's record. The order must be renewed every six (6) months;

B.1.6.3.2 The Enrollee receiving care has a need for skilled care that cannot be provided by unlicensed personnel (e.g., patients on a ventilator, patients requiring nasogastric or gastrotomy feedings, suctioning, etc.);

B.1.6.3.3 No other individual in the recipient's support system is able to provide the skilled component of the Enrollee's care during the caregiver's absence; and,

B.1.6.3.4 The Enrollee is unable to receive skilled nursing visits from any other source, including home health, which could provide the skilled care usually given by the caregiver.

B.1.6.4 Service criteria for agency directed respite (non-skilled and skilled) and consumer-directed respite are described in detail in the EDCD regulations at 12 VAC 30-120-960 12 VAC 30-120-980, respectively, and the provider manual at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

B.1.7 Transition Services

B.1.7.1 Transition services are set-up expenses for Enrollees who are transitioning from an institution, licensed or certified provider-operated living arrangement, to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. For the purposes of transition services, an institution means an ICF/MR, a NF, a specialized care

facility/hospital as defined at 42 CFR 435.1009, Institutions for Mental Diseases (IMDs), Psychiatric Residential Treatment Facility (PRTF), or a combination thereof. Transition services do not apply to an acute care admission to a hospital. Services are available for one transition per Enrollee and must be expended within nine months from the date of authorization. The total cost of these services shall not exceed $5,000, per-person lifetime limit coverage.

B.1.7.2 In order to be provided, transition services shall be prior authorized. These services may include security deposits for rent or utilities, essential household furniture and appliances, services necessary for the individual's health and other reasonable expenses incurred as part of a transition. The plan shall ensure that the funding spent is reasonable that a minimum of $5,000 is available for each eligible Enrollee

B.1.7.3 Allowable costs include, but are not limited to:

B.1.7.3.1 Security deposits that are required to obtain a lease on an apartment or home;

B.1.7.3.2 Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;

B.1.7.3.3 Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;

B.1.7.3.4 Services necessary for the Enrollee's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;

B.1.7.3.5 Moving expenses;

B.1.7.3.6 Fees to obtain a copy of a birth certificate or an identification card or driver's license; and

B.1.7.3.7 Activities to assess need, arrange for, and procure needed resources.

B.1.7.4 The services are furnished only to the extent that they are reasonable and necessary as determined through the POC development process, are clearly identified in the POC and the Enrollee is unable to meet such expense or when the services cannot be obtained from another source. The expenses do not include monthly rental or mortgage expenses; food; regular utility

charges; and/or household items that are intended for purely diversional/recreational purposes. This service does not include services or items that are covered under other waiver services such as chore or homemaker services.

B.1.8 Transition Coordination

B.1.8.1 Transition coordination is available to Enrollees enrolled in the EDCD Waiver to support the Enrollee and his or her designated representative, as appropriate, with the activities associated with transitioning from an institution to the community pursuant to the EDCD Waiver.

B.1.8.2 Transition coordination services include, but are not limited to, the development of a transition plan; the provision of information about services that may be needed, in accordance with the timeframe specified in federal law, prior to the discharge date, and during and after transition; the coordination of community-based services with the care manager, if care management is available; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation; and the provision of ongoing support for up to twelve (12) months after discharge date.

B.1.8.3 The Enrollee's POC shall clearly reflect the Enrollee's needs for transition coordination provided to the Enrollee, his or her designated representative, and providers in order to implement the POC effectively.

B.2 Definitions-Medicaid Covered Behavioral Health Services

B.2.1 Providers who have the appropriate licensure and qualifications may provide the services below. Please refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations.

B.2.2 Crisis Intervention

B.2.2.1 Defined as immediate behavioral health care, available twenty-four (24) hours a day, seven (7) days a week, to assist Enrollees who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as Enrollees who are a danger to themselves or others. This service's objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the Enrollee, providing access to further immediate assessment and follow-up, and linking

the Enrollee and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

B.2.2.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

B.2.3 Crisis Stabilization

B.2.3.1 Is provided to non-hospitalized Enrollees experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation.

B.2.3.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

B.2.4 Day Treatment/Partial Hospitalization Services –

B.2.4.1 Sessions of two (2) or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for Enrollees with serious behavioral disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for Enrollees with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital.

B.2.4.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-60-61 and 12 VAC 30-50-226.A.

B.2.5 Intensive Community Treatment

B.2.5.1 An array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Intensive Community Treatment is provided

through a designated multi-disciplinary team of behavioral health professionals. It is available twenty-four (24) hours per day.

B.2.5.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-226 and 12 VAC 30-60-143.

B.2.6 Mental Health Support Services

B.2.6.1 Training and supports to enable Enrollees to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Medicaid reimbursement. These services may be authorized for six (6) consecutive months. This program shall provide the following services in order to be reimbursed by Medicaid: training in or reinforcement of functional skills and appropriate behavior related to the Enrollee's health and safety, ADLs, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

B.2.6.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-226.

B.2.7 Opioid Treatment

B.2.7.1 Services that are similar to substance abuse day treatment, but it is provided to persons with opioid dependence and who need medication to prevent withdrawal.

B.2.7.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

B.2.8 Psychosocial Rehabilitation - ("Clubhouse Model" for example)

B.2.8.1 Services for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a nonresidential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken,

watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually.

B.2.8.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual, and the Virginia Administrative Code at 12 VAC 30-50- 226.

B.2.9 Residential Substance Abuse Treatment for Pregnant and Post Partum Women

B.2.9.1 Services are for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The Enrollee's care is supervised by a nurse care manager. The Enrollee must agree to actively participate in her care. Services provided are substance abuse rehabilitation, counseling, and treatment, pregnancy and fetal development education, symptom and behavior management, and personal health care training. No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services are available while the Enrollee is participating in the program.

B.2.9.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-510.

B.2.10 Substance Abuse Crisis Intervention

B.2.10.1 Substance abuse treatment services, available twenty-four (24) hours a day, seven (7) days per week, to provide assistance to Enrollees experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are to prevent exacerbation of a condition; and injury to the Enrollee or others; and to provide treatment in the least restrictive setting. Crisis intervention services are provided following a marked reduction in the Enrollee's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress related to the use of alcohol or other substances.

B.2.10.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-420, 12 VAC 30-50-430 and 12 VAC 30-50-228.

B.2.11 Substance Abuse Day Treatment

B.2.11.1 Services of two (2) or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is twenty (20) hours with a maximum of thirty (30) hours per week. Substance abuse day treatment may not be provided concurrently with intensive outpatient or opioid treatment services.

B.2.11.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

B.2.12 Substance Abuse Day Treatment for Pregnant and Post Partum Women

B.2.12.1 Comprehensive intensive services in a central location lasting two (2) or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug-free lifestyle. Only behavioral health crisis intervention services or behavioral health crisis stabilization may be reimbursed for Enrollees of day treatment services. A billing unit is equal to a minimum of two (2) hours, but less than four (4) hours.

B.2.12.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-510.

B.2.13 Substance Abuse Intensive Outpatient Treatment

B.2.13.1 Services two(2) or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is nineteen (19) hours per week. This service should be provided to those Enrollees who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services.

B.2.13.2 Service criteria are described in detail in the Community Mental Health Rehabilitative Services Manual and the Virginia Administrative Code at 12 VAC 30-50-228.

B.2.14 Temporary Detention Orders (TDO)

B.2.14.1 A TDO is an order issued by a magistrate for a person who is in imminent danger to themselves or others as a result of behavioral illness or is so seriously behaviorally ill to care for self and is incapable or unwilling to volunteer for treatment.

B.2.14.2 The TDO's time duration shall not exceed forty-eight (48) hours prior to a commitment hearing unless the forty-eight (48) hours terminates on a Saturday, Sunday, legal holiday or there is an unusual circumstance. The hearing must be held on the next workday. Coverage and reimbursement is provided to the facility and for physician services provided that relates to emergency medical or psychiatric care. Medical screenings or services provided that do not relate to the behavioral illness are excluded from coverage.

B.2.14.3 Service criteria for TDOs as an inpatient acute hospitalization are described in detail in the Hospital Manual (see https://www.virginiamedicaid.dmas.virginia.gov/wps/portal).

B.3 Transportation

B.3.1 The Contractor shall cover emergency transportation and non-emergency transportation to ensure that Enrollees have necessary access to and from providers of all covered services for emergency or non-emergency services. Per 12 VAC 30-50-530, these modes of transportation include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The Contractor shall assess, and provide if necessary, Enrollee's needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services. "Hand to hand" service includes transporting the Enrollee from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some Enrollees with dementia or developmental disabilities, for example, may need to be transported "hand-to-hand." The Contractor shall cover air travel for critical needs.

B.3.2 The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in 42 C.F.R. § 440.170(a). The Contractor shall cover transportation to all covered services, even if those covered services are reimbursed by an out-of-network payer or are carved-out services as defined in Appendix A, which shall be paid by DMAS under fee-for service. DMAS allows the Contractor to subcontract for all transportation services. The Contractor shall assure that provider agreements (through the Contractor or the First Tier, Downstream or Related Entity) include the following language:

B.3.3 Requirements for Drivers: The Contractor shall assure that all drivers of vehicles transporting Enrollees meet the following requirements:

B.3.3.1 Are at least 18 years of age and have had a valid driver's license for at least one year.

B.3.3.2 All drivers shall have a current valid driver's license from the Commonwealth of Virginia.

B.3.3.3 Drivers shall not have been convicted of any crime as defined in § 37.2-314(B) Code of Virginia.

B.3.3.4 No driver or attendant shall use prescription medications that impact the ability to perform while on duty, alcohol, narcotics, or illegal drugs and no driver shall abuse alcohol or drugs at any time.

B.3.3.5 All drivers and attendants shall wear or have visible, easily readable proper identification.

B.3.3.6 Drivers shall not use mobile telephones (including texting) or headphones while the vehicle is in motion.

B.3.4 Requirements for Vehicles

B.3.4.1 All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. Each vehicle shall utilize child safety seats when transporting children under age eight.

B.3.4.2 All vehicles shall have a functioning speedometer, odometer, heating and air-conditioning systems.

B.3.4.3 All vehicles shall have the transportation provider's name, vehicle number (if applicable), and the Contractor's phone number prominently displayed within the interior of each vehicle.

B.3.4.4 Smoking is prohibited in all vehicles while transporting Enrollees. All vehicles shall post "no smoking" signs in all vehicle interiors, easily visible to the passengers.

B.3.4.5 All vehicles shall be equipped with a first aid kit.

B.3.4.6 All vehicles must meet State, Federal, local, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles.

B.3.4.7 Vehicles shall comply with the ADA specifications for transportation, 49 C.F.R. § 38, subparts A and B.

APPENDIX C. Enrollee Rights

C.1 The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the state Memorandum of Understanding (MOU).

C.2 Specifically, Enrollees must be guaranteed:

C.2.1 The right to be treated with dignity and respect.

C.2.2 The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.

C.2.3 The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.

C.2.4 The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.

C.2.5 The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.

C.2.6 Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.

C.2.7 The right to choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.

C.2.8 The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way contract.

C.2.9 The right to participate in all aspects of care and to exercise all rights of appeal.

C.2.10 Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:

C.2.10.1 Receive a Health Risk Assessment upon enrollment in a plan and to participate in the development and implementation of a Plan of Care. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordinating Enrollees' care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.

C.2.10.2 Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.

C.2.10.3 Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

C.2.10.3.1 Before enrollment.

C.2.10.3.2 At enrollment.

C.2.10.3.3 At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.

C.2.10.4 Be encouraged to involve caregivers or family members in treatment discussions and decisions.

C.2.10.5 Have advance directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.

C.2.10.6 Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

C.2.10.7 Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

C.2.10.8 The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the

Enrollee's language and culture, and in an appropriate care setting, including the home and community.

C.2.10.9 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

C.2.10.10 Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the State Agency treat the Enrollee.

C.2.10.11 The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and , the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.

C.2.10.12 The right to be protected from liability for payment of any fees that are the obligation of the Contractor.

C.2.10.13 The right not to be charged any cost sharing for Medicare Parts A and B services.

APPENDIX D. Relationship With First Tier, Downstream, And Related Entities

D.1 Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, 438.6(l), and 438.230(b)(1).

D.2 Contractor shall specifically ensure:

D.2.1 HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect all books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and

D.2.2 HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

D.3 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:

D.3.1 Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;

D.3.2 Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DMAS;

D.3.3 Language that specifies the delegated activities and reporting requirements;

D.3.4 Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DMAS or the Contractor determine that such parties have not performed satisfactorily;

D.3.5 Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;

D.3.6 Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and

D.3.7 Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.

D.4 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:

D.4.1 The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or

D.4.2 The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

D.5 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

D.6 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall require the provider to provide at least 60 days' notice to the Contractor and assist with transitioning Enrollees to new providers, including sharing the Enrollee's Medical Record and other relevant Enrollee information as directed by the Contractor or Enrollee.

D.7 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.

D.8 Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

D.8.1 Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;

D.8.2 Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;

D.8.3 Language that medical providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;

D.8.4 Language that medical providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;

D.8.5 Language that medical providers maintain Enrollee Medical Records and information in an accurate and timely manner;

D.8.6 Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and

D.8.7 Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

D.8.8 Language that clearly state the medical providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

D.8.9 Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

D.8.10 Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

D.8.10.1 Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or

D.8.10.2 Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.

D.8.11 Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.

D.8.12 Language that states the Contractor shall require providers to comply with the Contractor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

D.8.13 Language that states the Contractor shall notify providers in writing of modifications in payments, modifications in Covered Services or modifications in the Contractor's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 30 days before the effective date of such modification unless such other date for notice

is mutually agreed upon between the Contractor and the provider or unless such change is mandated by CMS or DMAS without 30 days prior notice.

D.8.14 Language that states that providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.

D.8.15 Language that states that No payment shall be made by the Contractor to a provider for a Provider Preventable Condition; and

D.8.16 As a condition of payment, the provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by the Contractor. The provider shall comply with such reporting requirements to the extent the Provider directly furnishes services.

D.9 Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical providers do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;

D.9.1 The provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.

D.9.2 The Contractor shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.

D.10 Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph D.11, below.

D.11 The Contractor shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers includes language that prohibits the Contractor from imposing a financial risk on medical Providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care Provider unless such contract includes specific provisions with respect to the following:

D.11.1 Stop-loss protection;

D.11.2 Minimum patient population size for the Physician or Physician group; and

D.11.3 Identification of the health care services for which the Physician or Physician group is at risk.

D.12 The Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include

an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

D.13 Nothing in this section shall be construed to restrict or limit the rights of the Contractor to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for religious non-medical Providers.

APPENDIX E. Part D Addendum

ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS") and Humana Health Plan, Inc. (hereinafter referred to as "Contractor"), The Commonwealth of Virginia, acting by and through the Department of Medical Assistance Services (DMAS), and a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract H3480 governing Contractor's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

ARTICLE I
VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application* , released on March 29, 2012 (hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DMAS, and CMS.

ARTICLE II
FUNCTIONS TO BE PERFORMED BY CONTRACTOR

A. ENROLLMENT

Contractor agrees to enroll in its Medicare-Medicaid plan only Eligible Beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have met Commonwealth Coordinated Care Demonstration requirements and have elected to or have been passively enrolled in Contractor's Capitated Financial Alignment benefit.

A. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

B. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

C. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

D. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

E. PAYMENT TO CONTRACTOR

Contractor and CMS and DMAS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

F. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DMAS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

G. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

H. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DMAS (as defined in Appendix J) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DMAS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

I. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

J. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

K. Enrollee Financial Protections

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

L. Relationship with first tier, downstream, and related Entities

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

M. Certification of Data That Determine Payment

1. Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

N. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of

an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

ARTICLE III
RECORD RETENTION AND REPORTING REQUIREMENTS

A. Record Maintenance and access

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS and Virginia License For Use of Contractor Formulary

Contractor agrees to submit to CMS and DMAS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

ARTICLE IV
HIPAA PROVISIONS

A. Contractor agrees to comply with the confidentiality and Enrollee medical record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

ARTICLE V
ADDENDUM TERM AND RENEWAL

A. Term of ADDENDUM

1. This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2014 This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. Qualification to renew ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or DMAS with a notice of intention not to renew in accordance with Article VII of this addendum, and

   (b) CMS or DMAS has not provided Contractor with a notice of intention not to renew.

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DMAS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VI
NONRENEWAL OF ADDENDUM

A. Nonrenewal by CONTRACTOR

Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VII
MODIFICATION OR TERMINATION OF ADDENDUM BY MUTUAL CONSENT

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE VIII
TERMINATION OF ADDENDUM BY CMS

1. CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE IX
TERMINATION OF ADDENDUM BY CONTRACTOR

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under Section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

ARTICLE X
RELATIONSHIP BETWEEN ADDENDUM AND CAPITATED FINANCIAL ALIGNMENT CONTRACT

A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.

C. In the event that Contractor's Capitated Financial Alignment contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, Contractor, DMAS and CMS shall provide notice to Enrollees and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

ARTICLE XI
INTERMEDIATE SANCTIONS

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

ARTICLE XII
SEVERABILITY

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

ARTICLE XIII
MISCELLANEOUS

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND DMAS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DMAS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DMAS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

APPENDIX F. Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare data obtained from CMS and DMAS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DMAS to administer. The Contractor shall only maintain data obtained from CMS and DMAS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DMAS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DMAS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DMAS.

The Contractor further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the Contractor may provide information about health-related services without obtaining prior Enrollee consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Enrollees beyond the scope for which CMS and the DMAS have authorized under this agreement. A termination of this data use agreement may result in CMS or DMAS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an MMP. This agreement shall remain in effect as long as the Contractor remains an MMP sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DMAS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

- Automated Plan Payment System (APPS)
- Common Medicare Environment (CME)
- Common Working File (CWF)
- Coordination of Benefits Contractor (COBC)
- Drug Data Processing System (DDPS)
- Electronic Correspondence Referral System (ECRS)
- Enrollment Database (EDB)
- Financial Accounting and Control System (FACS)
- Front End Risk Adjustment System (FERAS)

- Health Plan Management System (HPMS), including Complaints Tracking and all other modules
- HI Master Record (HIMR)
- Individuals Authorized Access to CMS Computer Services (IACS)
- Integrated User Interface (IUI)
- Medicare Advantage Prescription Drug System (MARx)
- Medicare Appeals System (MAS)
- Medicare Beneficiary Database (MBD)
- Payment Reconciliation System (PRS)
- Premium Withholding System (PWS)
- Prescription Drug Event Front End System (PDFS)
- Retiree Drug System (RDS)
- Risk Adjustments Processing Systems (RAPS)

APPENDIX G. Data Use Agreement Supplement

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that the provisions of this Attachment are inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

Use of the Information

Section A-1

Users are defined as the State Medicaid Agencies and downstream entities that are Health Insurance Portability and Accountability Act (HIPAA) Covered Entities that are given individually identifiable data to carry out care coordination and quality improvement work, as well as the business associates of such entities and any sub-contractor Business Associates of such entities.

Users may include providers and care coordination organizations that wish to use individually identifiable data about beneficiaries of the Medicare and Medicaid programs (Medicare-Medicaid enrollees) to provide care coordination and quality improvement programs on behalf of the State Medicaid Agency and/or one or more HIPAA Covered Entity providers. Such work would need to be done subject to a HIPAA business associate agreement with that State Medicaid Agency and/or those HIPAA Covered Entity providers.

The Users must use any individually identifiable information that they receive under A-1 to further the delivery of seamless, coordinated care for individuals who are Medicare-Medicaid enrollees to promote better care, better health, and lower growth in expenditures.

Section A-2

Subject to the limitations described below, users may reuse original or derivative data from the files specified in Section 5 of the Data Use Agreement, with or without direct identifiers, without prior written authorization from CMS, for clinical treatment, case management and care coordination, and quality improvement activities. Information derived from the files specified in Section 5 of the Data Use Agreement may be shared and used within the legal confines of the Users authority in a manner consistent with this section to improve care integration. When using or disclosing protected health information (PHI) or personally identifiable information (PII), obtained under the Data Use Agreement, Users must make "reasonable efforts to limit" the information that is used or disclosed to the "minimum necessary" to accomplish the intended purpose of the use or disclosure. Users shall limit disclosure of information to that which CMS would be permitted to disclose under the established Privacy Act "routine uses," which are categories of disclosures or uses permitted by CMS's system of records notice available at CMS's Senior Agency Official for Privacy website (http://www.cms.hhs.gov/privacy), as well as other permitted disclosures found in the Privacy Act at 5 U.S.C. § 552a(b)(1) through (b)(12).

Section A-3

Nothing in the Data Use Agreement, including but not limited to Section 9, governs the use and/or disclosure of any information that is obtained independent of the Data Use Agreement, regardless of whether the information was also obtained or could also be derived from the files specified in Section 5 of the Data Use Agreement.

Section A-4

Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section A-2. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

Potential Penalties

Section A-5

Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

Cynthia Tanno 1/24/14

State Medicaid Agency Signature

Timothy A. Wheatley
President – Medicare, Medicaid
Humana Health Plan

Section A-3

Nothing in the Data Use Agreement, including but not limited to Section 9, governs the use and/or disclosure of any information that is obtained independent of the Data Use Agreement, regardless of whether the information was also obtained or could also be derived from the files specified in Section 5 of the Data Use Agreement.

Section A-4

Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in Section 5 in a manner consistent with Section A-2. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in Section 5 to other files.

Potential Penalties

Section A-5

Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement and this attachment.

State Medicaid Agency Signature

12-11-2013

Provider, Care Coordination Organization, or Administrative Contractor Signature

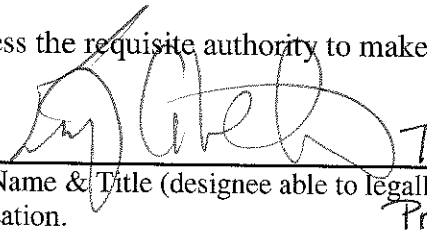
Timothy A. Wheatley
President - Medicare, Medicaid

APPENDIX H. Model File & Use Certification Form

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the Commonwealth of Virginia, acting by and through the Department of Medical Assistance Services (DMAS), and Humana Health Plan, Inc., hereafter referred to as the Contractor, governing the operations of the following health plan: (insert health plan name and Contract number), the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DMAS to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 CFR §422.2260 – §422.2276 and 42 CFR §422.111 for MMPs and the Medicare Marketing Guidelines.

I agree that CMS or DMAS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DMAS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor



Timothy A. Wheatley — 12-11-2013

Insert Name & Title (designee able to legally bind the organization.) President-Medicare, Medicaid — Date

On behalf of Humana Health Plan, Inc.

APPENDIX I. Medicare Mark License Agreement

THIS AGREEMENT is made and entered into December 4, 2013

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Humana Health Plan, Inc. (hereinafter "Licensee"),

with offices located at 321 West Main Street, 12th Floor, Louisville, KY 40202

CMS Contract ID: H3480

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning March 1, 2014.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.

2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.

3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.

4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.

5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.

6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2014, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2014, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.

8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.

9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.

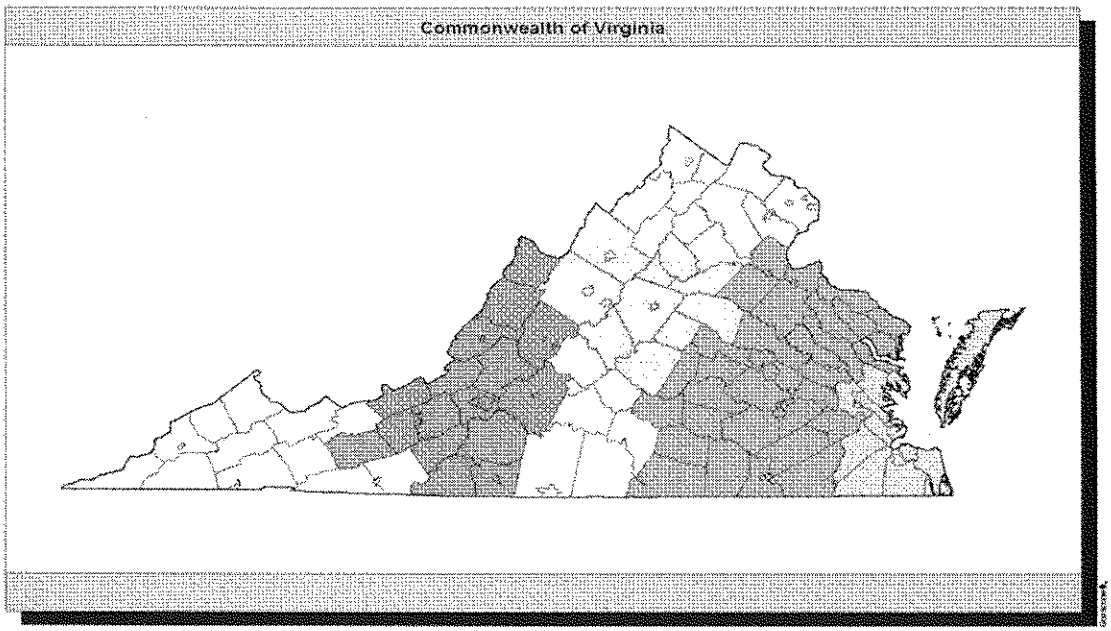
10. Federal law shall govern this Agreement.

APPENDIX J. Service Area

The Service Area outlined below is contingent upon the Contactor meeting all Readiness Review requirements in each county. CMS and the Department reserve the right to amend Appendix J to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DMAS.

The Demonstration area consists of five (5) regions, as highlighted and illustrated in the map below.

Virginia *Commonwealth Coordinated Care* Service Regions



Central Virginia

FIPS	Locality
7	Amelia
25	Brunswick
33	Caroline
36	Charles City
41	Chesterfield
49	Cumberland
53	Dinwiddie
57	Essex
75	Goochland
81	Greensville
85	Hanover

87	Henrico
97	King and Queen
99	King George
101	King William
103	Lancaster
111	Lunenburg
117	Mecklenburg
119	Middlesex
127	New Kent
133	Northumberland
135	Nottoway
145	Powhatan
147	Prince Edward
149	Prince George
159	Richmond Co.
175	Southampton
177	Spotsylvania
179	Stafford
181	Surry
183	Sussex
193	Westmoreland
570	Colonial Heights
595	Emporia
620	Franklin City
630	Fredericksburg
670	Hopewell
730	Petersburg
760	Richmond City

Tidewater

FIPS	Locality
73	Gloucester
93	Isle Of Wight
95	James City County
115	Mathews
131	Northampton
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

Northern Virginia

FIPS	Locality
13	Arlington
47	Culpeper
59	Fairfax County
61	Fauquier
107	Loudoun
153	Prince William
510	Alexandria
600	Fairfax City
610	Falls Church
683	City of Manassas
685	Manassas Park

Western/Charlottesville

FIPS	Locality
3	Albemarle
15	Augusta
29	Buckingham
65	Fluvanna
79	Greene
109	Louisa
113	Madison
125	Nelson
137	Orange
165	Rockingham
540	Charlottesville
660	Harrisonburg
790	Staunton
820	Waynesboro

Roanoke

FIPS	Locality
005	Alleghany
017	Bath
019	Bedford County
023	Botetourt
045	Craig
063	Floyd
067	Franklin County
071	Giles
089	Henry
091	Highland
121	Montgomery
141	Patrick
155	Pulaski
161	Roanoke County

163	Rockbridge
197	Wythe
515	Bedford City
530	Buena Vista
580	Covington
678	Lexington
690	Martinsville
750	Radford
770	Roanoke City
775	Salem

APPENDIX K. Small Businesses Subcontracting and Evidence of Compliance

A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential Offerors are required to submit a Small Business Subcontracting Plan. If the Offeror is not a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the Contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No Offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) as of the due date for receipt of proposals. If small business subcontractors are used, the prime Contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount subcontracted, applicable category type(s) (small, women-owned, and/or minority-owned), and type of product/service provided.

B. Each prime Contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon completion of the contract, the Contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, applicable category type(s) (small, women-owned, and/or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.

C. Each prime Contractor who wins an award valued over $200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the Contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

APPENDIX L. Small Business and Subcontracting Plan

Note: The text of definitions section below comes directly from APSPM Annex 7-G. This text shall not be construed to reflect independent definitions or status decisions by the Department. Reference §9.1 of the RFP

Definitions

Small Business: "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of $10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

Women-Owned Business: Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

Minority-Owned Business: Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at www.dmbe.virginia.gov **(Customer Service).**

Offeror Name: Humana Health Plan, Inc.

Preparer Name: Timothy A. Wheatley Date: 12/11/13

Instructions

A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.

B. If you are not a DMBE-certified small business, complete Section B of this form. For the Offeror to receive credit for the small business subcontracting plan evaluation criteria, the

Offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified small business in this section. Points will be assigned based on each Offeror proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the Offeror's total price.

Section A

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a **(check only one below)**:

_____ Small Business
_____ Small and Women-owned Business
_____ Small and Minority-owned Business

Certification number:_____
Certification Date:_____

Section B

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement

Small Business Name & Address **DMBE Certificate #**	**Status if Small Business is also: Women (W), Minority (M)**	**Contact Person, Telephone & Email**	**Type of Goods and/or Services**	**Planned Involvement During Initial Period of the Contract**	**Planned Contract Dollars During Initial Period of the Contract**
IN ACCORDANCE WITH THE PROVISIONS OF APPENDIX K, CONTRACTOR IS REVIEWING PROVIDERS (INCLUDING ALL FIRST TIER, DOWNSTREAM AND RELATED ENTITIES) TO BE UNDER CONTRACT WITH CONTRACTOR AND SHALL SUBMIT ITS FIRST QUARTERLY REPORT ON MARCH 30, 2014. QUARTERLY REPORTS SHALL INCLUDE IDENTIFICATION OF SMALL BUSINESSES THAT ARE					

NOT DMBE-CERTIFIED.					
Totals $					

APPENDIX M. Health Risk Assessment and Plan of Care Expectations

Population	Implementation Health Risk Assessment (at program launch[1])	Implementation of MCO Plan of Care (at program launch)	Initial Health Risk Assessment (for new Enrollees after program launch)	Initial Plan of Care (for new Enrollees after program launch)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Community Well	Within 90 days of plan enrollment[2]	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.[3])	Within 60 days of enrollment	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner,)	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Vulnerable Subpopulation[4] (Excluding EDCD & nursing facility)	Within 60 days of plan enrollment	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.)	Within 60 days of enrollment	Within 60 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner,)	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
EDCD Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face)	Within 90 days of enrollment. (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner.) The POC must be developed and implemented by the MCO no later than the end date of any existing PA.	Within 30 days of enrollment (must be face-to-face)	Within 30 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner,)	By POC anniversary date, not to exceed 365 days[5] (must be face-to-face)	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan conducts annual face to face assessment (functional) for continued eligibility for the EDCD Waiver.[6]
Nursing Facility Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face and incorporate MDS)	Within 90 days of enrollment. (Plan must honor all existing POCs for 180 days from enrollment.).)	Within 60 days of enrollment (must be face-to-face)	Within 60 days of enrollment (Plans must honor all existing POCs for 180 days from enrollment.)	Follow MDS guidelines/time frames for quarterly and annual POC development	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan works with facility on annual assessment (functional) for continued nursing facility placement.

[1] "At Program Launch" includes the opt-in period and passive enrollment period during year 1 of the demonstration.
[2] The clock starts at the effective date of enrollment and days are measured in calendar days.
[3] Prior authorizations for Medicaid services will be provided in the enrollee's transition report.
[4] Vulnerable Subpopulation is defined in Section 1 (Definition of Terms) of the Contract.
[5] Plans must comply with requirements for the EDCD Waiver as established in 12 VAC 30-120-900 et. seq.
[6] Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE).