COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MEDALLION 3.0
MANAGED CARE CONTRACT

JULY 1, 2014 - JUNE 30, 2015

VIRGINIA

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1. DEFINITIONS AND ACRONYMS

1.1 DEFINITIONS

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

"Accreditation" The process of evaluating an organization against a set number of measures of performance, quality, and outcomes by a recognized industry standard accrediting agency, such as NCQA. The accrediting agency certifies compliance with the criteria, assures quality and integrity, and offers purchasers and members a standard of comparison in evaluating health care organizations.

"Action" also known as "Adverse Action" Consistent with 42 C.F.R. § 438.400, action refers to the denial of a service authorization request; or the reduction, suspension, or termination of a previously authorized service; denial in whole or in part of a payment for a covered service (except where the provider's claim is denied for technical reasons including but not limited to service authorization rules, referral rules, late filing, invalid codes, etc); or failure to provide services within the timeframes required in Section 4 and Section 7.1 of this Contract; or the denial of a member's request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) (described in Section 7.1 of this Contract) to obtain services outside of the network.

"Actuarially Sound Capitation Rates" As defined in 42 C.F.R. § 438.6 means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; and have been certified as actuarially sound by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

"Adoption Assistance" A social services program, under Title XX of the Social Security Act, that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the Commonwealth of Virginia.

"Ameliorate" Necessary to improve or to prevent the condition from getting worse, with regard to EPSDT services.

"Annually" For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.

"Appeal" In accordance with 42 C.F.R. § 438.400, an appeal is defined as a request for review of an action, as "action" is defined in this Contract.

"Assessment" The Contractor's appraisal and evaluation of its members to determine health assessment and interventions as may be appropriate. A successful assessment is considered a contact by the health plan that results in a fully completed health assessment questionnaire which assesses health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs with completion of an approved assessment tool.

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

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

"**Behavioral Health Services Administrator (BHSA)"** An entity that manages or directs a behavioral health benefits program on behalf of the program's sponsor. The BHSA is responsible for administering the Department's behavioral health benefits on a statewide basis for Title XIX Medicaid members and Title XXI FAMIS members, to include care coordination, provider management, and reimbursement of such behavioral health services for: 1) the full spectrum of behavioral health services for individuals who are not currently enrolled in one of the Department's MCO Programs/contracts; and, 2) the subset of community mental health rehabilitation services that are carved out of the Department's contracts with MCOs.

"Behavioral Health and Substance Abuse Treatment Services (BHS)" An array of therapeutic and rehabilitation services provided in inpatient and outpatient psychiatric and community mental health settings to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance abuse disorder. Under this contract, the Department categorizes BHS as traditional and non-traditional services.

> ***"Traditional Behavioral Health & Substance Abuse Treatment Services"*** are defined as inpatient and outpatient behavioral health and substance abuse treatment services, including care coordination services that are covered by the Contractor under the terms of this contract.
>
> ***"Non-Traditional Behavioral Health & Substance Abuse Treatment Services"*** are defined as the subset of community mental health and rehabilitation services that are covered by the Department or its designee in accordance with the Department's established criteria and guidelines.

"Business Associate" Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program.

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

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

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

"Care Coordination" The process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

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

"Case Management" The process of identification of patient needs and the development and implementation of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

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

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

"Children With Special Health Care Needs" or "CSHCN" Children with special needs have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in the eligibility category of SSI, foster care, and adoption assistance. CSHCN shall include members with childhood obesity.

"Claim" An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the HCFA 1500 or UB-92.

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

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

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

"Complaint" A grievance.

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

"Contract" This signed and executed document.

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

"Contractor" Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department's capability for effective administration of the program.

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

"Cost Avoidance" The application of a range of tools to identify and prevent inappropriate or medically unnecessary charges before they are actually paid. This may include service authorization, second surgical opinions, medical necessity review, and other pre-and post-payment / service reviews.

"Cost Sharing" Co-payments paid by the member in order to receive medical services.

"Cultural Competency" The ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter.

"Data Analysis" Tool for identifying potential payment errors and trends in utilization, referral patterns, formulary changes, and other indicators of potential fraud, waste or abuse. Data analysis compares claim information and other related data to identify potential errors and /or potential fraud by claim individually or in the aggregate. Data analysis is an integrated, on-going component of fraud detection and prevention activity.

"Days" Business days, unless otherwise specified.

"Department" also referred to as "DMAS" The Virginia Department of Medical Assistance Services.

"Disease Management" System of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

"Disenrollment" The process of changing enrollment from one MCO plan to another MCO.

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

"Early Intervention" or "EI" Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, and in accordance with 42 C.F.R. § 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EI services are distinguished from similar rehabilitative services available through EPSDT to individuals aged three and older in that EI services are specifically directed towards children from birth to age three. EI services are not medically indicated for individuals aged three and above.

"Early Periodic Screening, Diagnosis, and Treatment" or "EPSDT" The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program benefit for individuals under the age of 21 and provides coverage for children with a comprehensive set of screenings, interventions, and other support services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT member even if the service is not available under the state's Medicaid plan to the rest of the Medicaid population. See also, 42 C.F.R**.** § 441 Subpart B (Sections 50-62).

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

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

"Emergency Room Assessment Fee" or "Triage Fee" The fee paid for all non-emergency claims for services delivered in the emergency room. The fee has two (2) components: a facility component and a physician component. The facility component is reimbursed using an all-inclusive fee that approximates the fee for an intermediate emergency room visit. The physician component is reimbursed using an all-inclusive fee that approximates the fee for a brief physician office visit for a new patient.

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

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

"Encounter Submission Calendar" The Department's schedule for the Contractor to submit encounters.

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

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

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

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

"Enrollment Broker" An independent broker who enrolls members in the Contractor's health plan and who is responsible for the operation and documentation of a toll-free member service helpline. The responsibilities of the enrollment broker include, but are not limited to, member

education and enrollment, assistance with and tracking of member's grievance resolution, and may include member marketing and outreach.

"Enrollment Period" The time that a member is enrolled in a Department approved MCO during which they may not disenroll or change MCOs unless disenrolled under one of the conditions described in Section 5 of this Contract and pursuant with Section 1932 (a)(4)(A) of Title XIX. This period may not exceed twelve months.

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

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

"Excluded Entity" Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined in Section 13.3 of this Contract.

"Excluded Parties List System" or "EPLS" The General Services Administration (GSA) maintains the EPLS, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the EPLS on parties they have debarred or suspended as described above; 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.

"Exclusion from Managed Care/Exclusion from Medallion 3.0" The removal of a member from the Medallion 3.0 Program on a temporary or permanent basis.

"Expedited Appeal" The process by which an MCO must respond to an appeal by a member if a denial of care decision by an MCO may jeopardize life, health or ability to regain maximum function. The decision must be rendered within three (3) business days of the member appeal.

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

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

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

"FAMIS MOMS Members" Members who are uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level, and who are assigned and enrolled in the aid category of 05. Covered services for FAMIS MOMs are the same as the covered services for Medallion 3.0 members. Per 12 VAC 30 – 141, FAMIS MOMS are not subject to exemption from MCO participation (e.g., for being hospitalized at the time of MCO enrollment). Other MCO exemptions are specific to the Medicaid Medallion 3.0 program. Please note that new enrollment for this program ended December 31st, 2013.

"Federally Qualified Health Centers" or "FQHCs" Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.

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

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

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

"**Formulary**" A list of drugs that the MCO has approved. Prescribing some of the drugs may require service authorization.

"Foster Care" Pursuant to 45 C.F.R. §1355.20, a "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility." Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is predicated upon the child being placed outside of the home and with an individual who has "placement and care" responsibility for the child. The term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. Pursuant to the Affordable Care Act, Virginia must provide Medicaid coverage to additional foster care individuals (formerly Title IV-E or non-Title IV-E) when the following conditions occur: the individual was under the responsibility of a Virginia-based foster care agency and receiving Medicaid until discharge from foster care upon turning 18 years or older,

the individual is not eligible for Medicaid in another mandatory Medicaid covered group, and the individual is under age 26 years.

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

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

"Grievance" In accordance with 42 C.F.R. § 438.400, grievance means an expression of dissatisfaction about any matter other than an "action." Grievance is also used to refer to the overall system that includes grievances and appeals handled at the MCO level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.)

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

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

"Home and Community-Based Care Services" or "HCBS" Medicaid community-based care programs operating in the Commonwealth under the authority of §1915(c) of the Social Security Act, 42 U.S.C. §1396 n (c) including, but not limited to, the waivers for Elderly or Disabled with Consumer Direction (EDCD), Individuals with Intellectual Disability, Alzheimer's, Technology Assisted, Individual and Family Developmental Disabilities Support (DD), and Day Support.

"Hospital" A facility that meets the requirements of 42 C.F.R. § 482, as amended.

"Individualized Education Program" or "IEP" Means a written statement for a child with a disability that is developed, reviewed, and revised in a team meeting in accordance with (34 C.F.R. 300.22). The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child's educational needs.

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

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

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

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

"Inquiry" An oral or written communication usually received by a Member Services Department or telephone helpline representative made by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirements or materials received, etc; 2) provision of information regarding a change in the member's status such as address, family composition, etc; or 3) a request for assistance such as selecting or changing a PCP assignment, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.

"Intensive Outpatient Services" Services shall include the major psychiatric, psychological and psycho-educational modalities to include: individual, group counseling and family therapy; education about the effects of alcohol and other drugs on the physical, emotional, and social functioning of the individual; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for members are provided in a nonresidential setting and shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to provide a minimum of 4 hours and a maximum of 19 hours of skilled treatment services per week.

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

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

"List of Excluded Individuals and Entities" or "LEIE" When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG 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).

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

"Local Education Agency" Means a local school division governed by a local school board, a state-operated program that is funded and administered by the Commonwealth of Virginia or the Virginia School for the Deaf and the Blind at Staunton. Neither state operated programs nor the Virginia School for the Deaf nor the Blind at Staunton are considered a school division as that term is used in these regulations. (§ 22.1-346 C of the *Code of Virginia*; 34 C.F.R. 300.28)

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

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

"Managed Care Organization" or "MCO" An organization which offers managed care health insurance plans (MCHIP), as defined by *Code of Virginia* § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products

and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 C.F.R. § 438.2, means an entity that has qualified to provide the services covered under this Contract to qualifying Medallion 3.0 members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area served, and meets the solvency standards of 42 C.F.R. § 438.116.

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

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

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

"Medallion 3.0" A statewide mandatory Medicaid program which utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver.

"(Medallion 3.0) Carved-Out Services" The subset of Medicaid covered services which the Contractor shall not be responsible for covering under the program.

"(Medallion 3.0) Covered Services" The subset of Medicaid covered services which the Contractor shall be responsible for covering under the program.

"Medallion Care System Partnership" or "MCSP" An arrangement, such as a medical home, with the goal of improving health outcomes for Medicaid members whereby the Managed Care Organizations form partnerships and contractual arrangements tied to gain and/or risk sharing, performance-based incentives, and other Commonwealth-approved quality metrics and financial performance in an effort to increase participation of integrated provider health care delivery systems.

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

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

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

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

"Medicaid Member" Any individual enrolled in the Virginia Medicaid program.

"Medicaid Works" also known as " Medicaid Buy-In program" Medicaid Works allows working people with disabilities whose income is no greater than 80% Federal Poverty Level (FPL) to pay a premium to participate in the Medicaid program. Certain services will be provided through a State Plan Amendment/ Fee-for-Service Medicaid and are carved-out of this Contract.

"Medical Necessity" or "Medically Necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience. As defined in 42 C.F.R. § 440.230, services must be sufficient in amount, duration and scope to reasonably achieve their purpose. For children under age 21, medical necessity review must fully consider Federal EPSDT guidelines.

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

> Effective September 2012, these members would gradually be put in appropriate non-medically needy aid categories unless they are spend-down. As a result, these individuals may qualify for managed care enrollment.

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

"Member" A person eligible for Medicaid who is enrolled with a MCO Contractor to receive services under the provisions of this Contract.

"Member Handbook" Document required by the Contract to be provided by the MCO to the member prior to the first day of the month in which their enrollment starts. The handbook must include all of the following sections: table of contents, member eligibility, choosing or changing

an MCO, choosing or changing a PCP, making appointments and accessing care, member services, emergency care, member identification cards, member responsibilities, MCO responsibilities, grievances (complaints), and appeals, translation services, and program or site changes.

"Monthly" For the purposes of contract reporting requirements, monthly shall be defined as the 15th day of each month for the prior month's reporting period. For example, January's monthly reports are due by February 15th; February's are due by March 15th, etc.

"National Practitioner Data Bank" or "NPDB" The NPDB, maintained by the Health Resources and Services Administration, is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. OIG reports exclusions to the NPDB monthly. Although the NPDB includes unique identifiers, to protect sensitive information it is available only to registered users whose identities have been verified. The NPDB will also include information that is in the Healthcare Integrity and Protection Data Bank (HIPDB) when the two data banks are consolidated. The HIPDB is also a source of exclusion information.

"National Provider Identifier" or "NPI" NPI is a national health identifier for all typical health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of 9 numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire.

"Network Provider" The health care entity or health care professional who is either employed by or has executed an agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to members.

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

"Non-participating Provider" A health care entity or health care professional not in the Contractor's participating provider network.

"Open Enrollment" The time frame in which members are allowed to change from one MCO to another, without cause, at least once every 12 months per 42CFR438.56 (c)(2) and (f)(1). For Medallion 3.0 members, open enrollment timeframes are based upon the Department's regional open enrollment effective date, per Attachment VI of this contract. Within sixty (60) days prior to the open enrollment effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within sixty (60) days of the open enrollment period shall remain in his or her current health plan selection until their next open enrollment effective date.

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

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

"Party in Interest" Any director, officer, partner, agent, or employee responsible for management or administration of the Contract; any person who is directly or indirectly the beneficial owner of more than five (5) percent of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than five (5) percent of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation or other nonprofit organization, an incorporation or member of such corporation under applicable State corporation law. Additionally, any organization in which a person previously described is a director, officer or partner, that has directly or indirectly a beneficial interest of more than five (5) percent of the equity of the Contractor or has a mortgage, deed of trust, note, or other interest valuing more than five (5) percent of the assets of the Contractor; any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or any spouse, child, or parent of a previously described individual.

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

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

"Plan First" The Medicaid fee-for-service family planning program. The purpose of this program is to reduce unplanned pregnancies, increase spacing between births, reduce infant mortality rates, and reduce the rates of abortions due to unintended pregnancies. Men and women not eligible for full benefit Medicaid or FAMIS/FAMIS MOMS, who have income less than or equal to 100 percent of the federal poverty level and meet citizenship and identity requirements may be eligible for Plan First.

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

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

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

"Potential Member" A Medicaid member who is subject to mandatory enrollment in a given managed care program. [42 C.F.R. § 438.10(a)]

"Previously Authorized" As described in 42 C.F.R. § 438.420, in relation to continuation of benefits, previously authorized means a prior approved course of treatment, and is best clarified by the following example. If the Contractor authorizes 20 visits and then later reduces this authorization to 10 visits, this exemplifies a "previously authorized service" that is being reduced. Conversely, "previously authorized" does not include the example whereby (1) the MCO authorizes 10 visits; (2) the 10 visits are rendered; and (3) another 10 visits are requested but are denied by the MCO. In this case, the fact that the Contractor had authorized 10 visits on a prior request for authorization is not germane to continuation of benefits requirements for previously authorized services that are terminated, suspended or reduced.

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

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

"Quality Compass", or "NCQA Quality Compass" NCQA's comprehensive national database of health plans' HEDIS and CAHPS results, containing plan-specific, comparative and descriptive information on the performance of hundreds of managed care organizations. Provides benefit managers, health plans, consultants, the media, and others with the ability to conduct a detailed market analysis and comprehensive information about health plan quality and performance.

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

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

"Quarters" Calendar quarters starting on January 1, April 1, July 1, and October 1.

"Residential Treatment Facilities (Level C)" A facility as defined in 12 VAC 30-130-860, as amended.

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

"Rural Exception" A rural area as designated in the 1915(b) managed care waiver, pursuant to 1935(a)(3)(B) of the Social Security Act and 42 C.F.R. § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying members are mandated to enroll in the one available contracted MCO.

"Rural Health Clinic" A facility as defined in 42 C.F.R. § 491.2, as amended.

"School Health Services" Are defined as medical and/or mental health services identified through the child's individualized education program (IEP). These services include physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, nursing services, medical assessments, audiology services, personal care services, medical evaluation services, and IEP-related transportation on specially adapted school buses. School health services that are rendered in a public school setting or on school property, (including Head Start Services) and are included on the child's IEP, are carved out of this contract and are reimbursed directly by DMAS. (Reference Section 7.5.A for coverage guidelines.)

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

"Sentinel Event" An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "Sentinel" because they signal the need for immediate investigation and response.

"Service authorization (SA) Program" also known as "Service Authorization (SA)" The Department's service authorization program for fee-for-service Medicaid and for carved-out services.

"Service Authorization Request" A managed care member's request for the provision of a service.

"State Fair Hearing" The Department's evidentiary hearing process. Any "action" or appeal decision rendered by the MCO may be appealed by the member to the Department's Client Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-380. Provider appeals to DMAS will be conducted in accordance with the requirements set forth in 12 VAC 30-20-500 et. seq.

"State Plan for Medical Assistance" or "State Plan" - The comprehensive written statement submitted to CMS by the Department describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under *Code of Virginia* § 32.1-325, as amended.

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

"Subcontractor" A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities under this Contract. For the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.

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

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

"Telemedicine" The real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services.

"Temporary Detention Order" or "TDO" An emergency custody order issued following sworn petition to any magistrate that authorized law enforcement to take a person into custody and transport that person to a facility designed on the order to be evaluated, where such person is believed to be mentally ill and in need of hospitalization or treatment pursuant to 42 C.F.R. § 441.150 and *Code of Virginia*, §§ 16.1- 335et seq. (minors) and §§ 37.2-801 et seq (adults).

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

"Urban Area" Places of 2,500 or more persons incorporated as cities, villages, boroughs, and towns but excluding the rural portions of "extended cities" according to the US Department of Commerce, Bureau of the Census.

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

a) Placing the patient's health in serious jeopardy;
b) Serious impairment to bodily function;
c) Serious dysfunction of any bodily organ or part; or
d) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

"Virginia's Acute and Long Term Care Program" or "VALTC" – Delivery system other than traditional Medicaid, for the administration of long-term care services where third party contractors have entered into agreement with the Department to serve eligible long term care members. (Acute and long-term care integrates acute care and long term care services.) Members already MCO-enrolled who then become eligible for Home and Community-Based Waiver programs except for the Technology Assisted Waiver will remain in their MCO for acute care services

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

"Virginia Independent Clinical Assessment Program" or "VICAP" The Independent Clinical Assessment (ICA) process is an administrative Medicaid pilot program that is required as a part of the service authorization process for individuals under 21 years of age receiving Community Mental Health Rehabilitative Services (CMHRS). The Department's behavioral health services administrator currently contracts with local Community Services Boards (CSBs) or the Behavioral Health Authority (BHA) to conduct the independent clinical assessment for youth receiving or referred for Intensive In Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Skill-building Services (MHSS). Children and adolescents who are being discharged from residential treatment (DMAS Levels A, B, or C) or an inpatient psychiatric hospitalization do not need an independent clinical assessment to access IIH, TDT, or MHSS, but are required to have an independent clinical assessment as part of the first service reauthorization.

"Waste" The rendering of unnecessary, redundant, or inappropriate services and medical errors and incorrect claim submissions. Generally not considered criminally negligent actions but rather misuse of resources.

1.2 ACRONYMS

AA -- Adoption Assistance
ABD -- Aged, Blind, and Disabled Population
ACIP -- Advisory Committee on Immunization Practice
ADHD – Attention-Deficit/Hyperactivity Disorder
ANSI -- American National Standards Institute
APIN -- Administrative Provider Identification Number
ASP -- Application Service Provider

BBA -- Balanced Budget Act of 1997
BHSA – Behavioral Health Services Administrator
BMI -- Body Mass Index
BOI -- Bureau of Insurance of the Virginia State Corporation Commission

CAD -- Coronary Artery Disease
CAHPS® -- Consumer Assessment of Healthcare Providers and Systems
CAP -- Corrective Action Plan
C.F.R. -- Code of Federal Regulations
CHF -- Congestive Heart Failure
CHIPRA -- Children's Health Insurance Program Reauthorization Act
CMS -- Centers for Medicare and Medicaid Services
CMS 1500 –Standard Professional Paper Claim Form
CMHRS – Community Mental Health Rehabilitative Services
COB -- Coordination of Benefits
COPD -- Chronic Obstructive Pulmonary Disease
CORFs -- Comprehensive Outpatient Rehabilitation Facilities
CPT -- Current Procedural Terminology
CSB -- Community Service Board
CSHCN -- Children with Special Health Care Needs
CY -- Calendar Year

DBA -- Dental Benefits Administrator
DBHDS -- Department of Behavioral Health and Developmental Services
DD -- Individual and Family Developmental Disabilities Support
DESI -- Drug Efficacy Study Implementation
DHHS -- Department of Health and Human Services
DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DOB -- Date of Birth
DOD -- Date of Death
DRG -- Diagnosis Relative Grouping
DSP -- Data Security Plan
DSS -- Department of Social Services

EDCD -- Elderly or Disabled with Consumer Direction

EI -- Early Intervention
EN -- Enteral Nutrition
EOC -- Evidence of Coverage
EOM -- End of Month
EPA -- Environmental Protection Agency
EPLS – Excluded Parties List System
EPSDT -- Early Periodic Screening, Diagnosis, and Treatment
EQR -- External Quality Review
EQRO -- External Quality Review Organization
ER -- Emergency Room

FAMIS -- Family Access to Medical Insurance Security
FAMIS Plus -- Another name for Children's Medicaid
FC -- Foster Care
FIPS -- Federal Information Processing Standards
FOIA -- Freedom of Information Act
FQHC -- Federally Qualified Health Centers
FTE -- Full-Time Equivalent
FTP -- File Transfer Protocol
FY-- Fiscal Year

GAAP -- Generally Accepted Accounting Principles

HCBS -- Home and Community-Based Care Services
HEDIS -- Healthcare Effectiveness Data and Information Set
HIPAA -- Health Insurance Portability and Accountability Act of 1996
HIV/AIDS -- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HR -- Healthy Returns

IBNR -- Incurred But Not Reported
ICF/IID-- Intermediate Care Facility/Individuals with Intellectual Disabilities

ID -- Identification
IDEA -- Individuals with Disabilities Education Act.
IDEA – EIS -- Individuals with Disabilities Education Act - Early Intervention Services
IEP -- Individual Education Plan
IFSP -- Individual Family Service Plan

LCSW -- Licensed Clinical Social Worker
LEIE -- Listing of Excluded Individuals and Entities
LIFC - - Low Income Families and Children
LSH -- Long-Stay Hospital
LTAC -- Long-Term Acute Care

MATE -- Medical Assistance to Employment
MCHIP -- Managed Care Health Insurance Plans

MCSP -- Medallion Care System Partnership
MCO -- Managed Care Organization
MED -- Medicare Exclusions List
MMIS -- Medicaid Management Information System (also known as VAMMIS)

NCPDP -- National Council for Prescription Drug Programs
NCQA -- National Committee for Quality Assurance
NPDB – National Practitioner Data Bank
NPI -- National Provider Identifier

OB/GYN -- Obstetrician and Gynecologist
OIG –Office of Inspector General
OT -- Occupational Therapy

PA -- Prior Authorization (also known as Service Authorization)
PACE -- Program of All-inclusive Care for the Elderly
Part C -- Part C of the Individuals with Disability and Education Act (also known as Early Intervention)
PCP -- Primary Care Provider
PHI -- Protected Health Information
PIP -- Physician Incentive Plan
PIRS -- Patient Intensity Rating Survey
PMV - Performance Measure Validation
POC -- Plan of Care
PSA -- Prostate Specific Antigen
PT -- Physical Therapy

QI -- Quality Improvement
QIP -- Quality Improvement Program
OSR – Operational Systems Review

RFP -- Request For Proposal
RHC -- Rural Health Clinics
RN -- Registered Nurse
RTF -- Residential Treatment Facility

SA - Service Authorization (formally known as Prior Authorization)
SLP -- Speech-Language Pathology
SPO -- State Plan Options
SSI -- Social Security Income
SSN -- Social Security Number

TB -- Tuberculosis
TDO -- Temporary Detention Order
TFCCM -- Treatment Foster Care Case Management
TMJ -- Temporomandibular Joint (disorder)

TPL -- Third-Party Liability
TPN -- Total Parenteral Nutrition
Title XIX -- Medicaid
Title XXI -- CHIP
TTY/TDD -- Teletype/Telecommunication Device for the Deaf

UB-92 -- Universal Billing 1992 claim form
UM -- Utilization Management
U.S.C. -- United States Code

VAC -- Virginia Administrative Code
VALTC --Virginia Acute and Long-Term Care Integration
VAMMIS -- Virginia Medicaid Management Information System
VAN --Value Added Network
VICAP – Virginia Independent Clinical Assessment Process or ICA (Independent Clinical Assessment)
VPN -- Virtual Private Network
VVFC – Virginia Vaccines for Children Program

WIC -- Special Supplemental Nutrition Program for Women, Infants, and Children."

XYZ -- Any Named Entity

2. REQUIREMENTS FOR OPERATIONS

2.1 LICENSURE

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

2.2 CERTIFICATION

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 .

2.3 ACCREDITATION

The Contractor must obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA). The Contractor must report to the Department any deficiencies noted by NCQA within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest. Denial or revocation of NCQA accreditation status or a status of "Provisional" may be cause for the Department to impose remedies or sanctions to include suspension, depending upon the reasons for denial by NCQA.

Any new plan that has been approved by the Department and is seeking NCQA accreditation for its Virginia Medicaid line of business must agree to, adhere to, and meet a timeline of milestones set by the Department as a condition of operation. The Contractor must adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Recredentialing, Standards for Members' Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and CAHPS survey.

2.3.A Milestones for New Managed Care Organizations

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

2.3.A.I EQRO Comprehensive onsite review at least annually, at dates to be determined by the Department.

2.3.A.II Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to Virginia Medicaid/CHIP members).

2.3.A.III Obtain NCQA accreditation status of at least Accredited within 36 months of the onset of delivering care to members.

2.3.B Mergers and Acquisitions

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

2.4 READINESS REVIEW

The Department and/or its duly authorized representative may conduct readiness review(s) which will include a minimum of one site visit. This review may be conducted prior to enrollment of any members in the MCO, prior to the renewal of the Contract, and shall commence within thirty (30) calendar days of the execution of this Contract. The purpose of the review is to provide the Department with assurances that the MCO is able and prepared to perform all administrative functions and to provide high-quality services to enrolled members.

The review will document the status of the MCO with respect to meeting program standards set forth in the BBA and this Contract, as well as any goals established by the Department. The readiness review activities will be conducted by the Department's External Quality Review Organization (EQRO), and/or by a multidisciplinary team appointed by the Department. The scope of the readiness review(s) will include, but not be limited to, review and/or verification of: network provider composition and access; staffing; content of provider agreements; policies and procedures consistent with the Medallion 3.0 contractual standards; pregnancy and complex care management programs; EPSDT plan; financial solvency; and information systems performance and interfacing capabilities. In the event of Medicaid Expansion, the Contractor must agree to meet any expansion criteria as may be required by the Department. The readiness review(s) may assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

The Department will provide the Contractor with a summary of the findings as well as areas requiring remedial action.

2.5 BASE OF OPERATIONS

The Contractor shall have a dedicated Virginia Medicaid project manager located in an operations/business office within the Commonwealth of Virginia. The Virginia Medicaid project manager shall be authorized and empowered to make contractual, operational, and financial decisions including rate negotiations for Virginia business, claim payment, and provider relations/contracting. The project manager shall be able to make decisions about managed care policy and program issues and shall represent the Contractor at the Department's meetings.

Additionally, the Virginia Medicaid project manager must be solely responsible to the Contractor (not to a third party administrator) and attend all required meetings as well as comply with all requirements of this Contract in that capacity. The Virginia-based location must include a designee who can respond to issues involving systems and reporting, appeals, quality improvement, member services, EPSDT services management, pharmacy management, medical management, and case management. The Virginia office shall include a Virginia licensed and Virginia based medical director and dedicated staff able to perform member advocacy and provider network development. Provider relations staff shall be located within the geographic region where the Contractor operates. Member Services staff must assist members in writing complaints and are responsible for monitoring the complaint through the Contractor's complaint process. The Department does not require claims utilization management, customer service, pharmacy management, or member services to be physically located in Virginia.

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

See Section 14 "Terms & Conditions" in its entirety, with particularly emphasis on Sections 14.6 "Changes in Key Staff Positions & Organization", 14.7 "Conflict of Interest", and 14.20 "Meetings" for additional personnel-related and business arrangement conditions of doing business with the Department.

3. ACCESS TO CARE & NETWORK STANDARDS

In accordance with 42 C.F.R. § 438.206, the Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide timely and adequate access to all services covered under this Contract.

3.1 PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion, impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and members, including but not limited to the proposed provider's past performance. The Contractor shall submit any new network provider agreement at least thirty (30) days prior to the effective date for review, and upon request thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of members is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

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

3.1.A (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid contract) with the Department of Medical Assistance Services.

3.1.B No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract.

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

3.2 NETWORK PROVIDER COMPOSITION

3.2.A The Contractor shall be solely responsible for arranging for and administering covered services to enrolled members and must ensure that its delivery system will provide available, accessible and adequate numbers of facilities, locations and personnel for the

provision of covered services. In establishing and maintaining the network, the Contractor shall consider all of the following:

3.2.A.I The anticipated Medicaid enrollment;

3.2.A.II The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid population to be served;

3.2.A.III The numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;

3.2.A.IV the numbers of network providers not accepting new Medicaid members;

3.2.A.V The geographic location of providers and members, considering distance, travel time, and the means of transportation ordinarily used by Medicaid members; and

3.2.A.VI Whether the location provides physical access for members with disabilities.

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

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

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

3.2.D The Contractor shall submit to the Enrollment Broker a complete provider file in a Department approved electronic format thirty (30) days prior to the effective date of the Contract. An updated file with all of the changes to the network will be submitted monthly thereafter or more frequently, if needed, during MCO expansions to the Enrollment Broker.

3.2.E The Contractor shall submit to the Department a complete provider file quarterly, or on a more frequent basis as requested by the Department. The Managed Care Technical Manual details the required reporting data elements. Additional required elements to be included in this report may be identified by the Department.

3.2.F Network provider composition standards set forth in this Section are not the minimum standards for network development for entry into new or existing managed

markets. These standards shall be considered as operational guidelines. The Department shall be the sole determiner of Contractor network sufficiency. Additional network and expansion requirements are set forth in Attachment X, DMAS Managed Care Expansion Requirements. Attachment X details notification and expansion requirements required by the Department to assure that appropriate IT, network development, budget and personnel resources are available for introducing managed care into new areas.

3.3 PROVIDER ENROLLMENT INTO MEDICAID

The Contractor will make best effort as part of its credentialing process, to encourage all providers, including ancillary providers, (i.e. vision, pharmacy, etc.), to apply for enrollment in the Medicaid program. The Contractor shall be required to have an NPI or an Administrative Provider Identification Number (APIN).

3.4 NETWORK PROVIDER LICENSING AND CERTIFICATION STANDARDS

Each Contractor must have the ability to determine whether physicians and other health care professionals are licensed by the State and have received proper certification or training to perform medical and clinical services contracted for under this Contract. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or employment contracts**.**

3.4.A Credentialing/Recredentialing Policies and Procedures

The Contractor shall have the proper provisions to determine whether physicians and other health care professionals who are licensed by the Commonwealth and who are under contract with the Contractor or its subcontractor(s) are qualified to perform their medical or clinical services. The Contractor shall have written policies and procedures for the credentialing process that matches the credentialing and recredentialing standards of the most recent guidelines from NCQA and in accordance with 12 VAC 5-408-170. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor 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. The Contractor shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application, this includes program integrity-related and adverse actions (See the Managed Care Technical Manual). The Contractor shall require its providers and subcontractors to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455 Subpart B and Sections 13 and 14 of this Contract.

3.5 MEMBER-TO-PCP RATIOS

As a means of measuring accessibility, the Contractor must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid members, and there must be one (1) FTE PCP with pediatric training and/or experience for every 2,500 members under the age of eighteen (18). No PCP may be assigned members in excess of these limits, except where mid-level practitioners are used to support the PCP's practice.

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

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

3.6 CHOICE OF PRIMARY CARE PHYSICIAN (PCP)

The Contractor must have written policies and procedures for assigning each of its members to a PCP. (See below.) Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department. These policies and procedures shall include the features listed below:

3.6.A Providers Qualifying as PCPs:

- **3.6.A.I** Pediatricians;
- **3.6.A.II** Family and General Practitioners;
- **3.6.A.III** Internists;
- **3.6.A.IV** Obstetrician/Gynecologists;
- **3.6.A.V** Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or
- **3.6.A.VI** Other providers approved by the Department.

3.6.B Specialists as PCPs

Members with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children for whom the PCP is a specialist receives EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these members or shall grant these PCP requests,

as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

3.6.C Member Choice of PCP

The Contractor shall offer each member covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the extent that open panel slots are available pursuant to travel time and distance standards described in Section 3.11. See also Section 5.13 "Rural Exception."

3.6.D Default Assignment of PCP

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

3.6.E Timing of PCP Assignment

The member must have an assigned PCP from the date of enrollment with the plan.

3.6.F Change in PCP

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

3.7 SPECIALIST SERVICES

The Contractor shall maintain in its network and in its referral listing a number of specialists in the following specialties which is adequate to support medically necessary needs to its Medallion 3.0 members. See list in Attachment XI for minimum specialty requirements.

3.8 INPATIENT HOSPITAL ACCESS

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

3.9 POLICY OF NONDISCRIMINATION

The Contractor shall ensure that its providers provide contract services to members under this Contract in the same manner as they provide those services to all non-Medicaid members. Additionally, in accordance with 42 C.F.R. § 438.206, the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.

3.10 TWENTY FOUR-HOUR COVERAGE

The Contractor shall maintain adequate provider network coverage to serve the entire eligible populations in geographically accessible locations within the region twenty-four (24) hours per day, seven (7) days a week. The Contractor shall make arrangements to refer members seeking care after regular business hours to a covering physician or shall direct the member to go to the emergency room when a covering physician is not available. Such referrals may be made via a recorded message.

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

3.11 TRAVEL TIME AND DISTANCE STANDARD

3.11.A Travel Time Standard

The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than thirty (30) minutes travel time from any member in urban areas unless the Contractor has a Department-approved alternative time standard. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than sixty (60) minutes travel time from any member in rural areas unless the Contractor has a Department-approved alternative time standard. The Contractor shall ensure that obstetrical services are available within no more than forty-five (45) minutes travel time from any pregnant member in rural areas unless the Contractor has a Department approved alternative time standard.

3.11.B Travel Distance Standard

The Contractor shall ensure that each member shall have a choice of at least two (2) PCPs located within no more than a fifteen (15) mile radius in urban areas and thirty (30) miles in rural areas unless the Contractor has a Department-approved alternative distance standard. The Contractor must ensure that a member is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from specialists, hospitals, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, and physicians, or other necessary providers, unless the member so chooses. An exception to this standard may be granted when the Contractor has

established, through utilization data provided to the Department, that a normal pattern for securing health care services within an area falls beyond the prescribed travel distance or the Contractor, and its PCPs are providing a higher skill level or specialty of service that is unavailable within the service area such as treatment of cancer, burns, or cardiac diseases.

3.12 APPOINTMENT STANDARDS

3.12.A The Contractor must arrange to provide care as expeditiously as the member's health condition requires and according to each of the following appointment standards:

3.12.A.I Appointments for emergency services shall be made available immediately upon the member's request.

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

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

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

3.12.B.I First trimester - within fourteen (14) calendar days of request

3.12.B.II Second trimester - within seven (7) calendar days of request

3.12.B.III Third trimester - within three (3) business days of request

3.12.C Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

3.13 EMERGENCY SERVICES COVERAGE

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

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

3.14 MEDICAL HELP LINE ACCESS STANDARDS

The Contractor must provide a toll-free telephone line twenty-four (24) hours a day, seven (7) days a week, staffed by medical professionals to assist members. The Contractor must have

mechanisms in place to promote the Medical Helpline to its Medicaid members. Mechanisms must include ways to distribute periodic reminders of the Helpline, and cannot be exclusive to information only being provided in the Member Handbook.

3.15 ASSURANCES THAT ACCESS STANDARDS ARE BEING MET

The Contractor must establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must be prepared to demonstrate to the Department that these access standards have been met.

3.16 SUBCONTRACTOR MANAGEMENT & MONITORING

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

The Contractor must ensure that subcontractors and providers in their networks are licensed by the State and have received proper certification or training to perform the specific services for which they are contracted. The Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs. See also Section 13.3 "Prohibited Actions" and Section 14.6 "Changes in Key Staff Positions and Organization."

3.16.A Delegation and Monitoring Requirements

In accordance with 42 C.F.R. § 438.230, all subcontracts entered into pursuant to this Contract shall meet the following delegation and monitoring requirements.

3.16.A.I Delegation Requirements

3.16.A.I.a All subcontracts shall be in writing;

3.16.A.I.b Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations;

3.16.A.I.c Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor; and,

3.16.A.I.d Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

3.16.A.II Monitoring Requirements

3.16.A.II.a The Contractor shall perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements.

3.16.A.II.b The Contractor shall perform a formal review of all subcontractors at least annually.

3.16.A.II.c The Contractor shall monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, member and provider identification numbers, dates of service, diagnosis and procedure codes, etc.

3.16.A.II.d The Contractor shall monitor the subcontractor's provider enrollment, credentialing, and recredentialing policies and procedures to assure compliance with Federal disclosure requirements described in Section 13.3 of this Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against Federally funded health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federally related health care programs as described in Section 13 and Section 4.6 of this Contract.

3.16.A.II.e As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement, and shall require the subcontractor to take appropriate corrective action.

3.16.B Review Requirements for Subcontractors

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

All subcontracts are subject to the Department's written approval. The Department may revoke such approval if the Department determines that the subcontractors fail to meet the requirements of this Contract. Subcontracts which require the subcontractor to be responsible for the provision of covered services must include the terms set forth in the Managed Care Technical Manual, and, for the purposes of this Contract, that subcontractor shall be considered both a subcontractor and network provider. Subcontracts will be considered approved if the Department has not responded within thirty (30) calendar days of

the date of Departmental receipt of the request. Contractor shall adhere to subcontractor specific restrictions found herein Sections 13 and 14.

4. PROVIDER RELATIONS

4.1 PROVIDER ENROLLMENT

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

4.1.B The Contractor shall not require as a condition of participation/contracting with physicians, etc. in their Medicaid network to also participate in the Contractor's commercial managed care network. However, this provision would not preclude a Contractor from requiring their commercial network providers to participate in their Medicaid provider network.

4.1.C The Contractor shall not require as a condition of participation/contracting with physicians, etc. in the Medicaid network a provider's terms of panel participation with other MCOs.

4.1.D A Contractor licensed in Virginia may include, in its provider network, providers which are located across State boundaries, as long as all such providers are necessary for the delivery of services to members in a particular locality. The Contractor may also utilize non-participating in-state and out-of-state providers who are not enrolled as Virginia Medicaid providers; however, the Contractor must make a best effort to have all network participating providers in Virginia apply to be a Medicaid provider.

4.2 ANTI-DISCRIMINATION

Pursuant to Section 1932 (b)(7) of the SSA, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Additionally, consistent with 42 C.F.R. § 438.214(c), provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. [42 C.F.R. § 438.12(a)]

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

4.3 PROVIDER EDUCATION

4.3.A The Contractor shall ensure that all providers receive proper education and training regarding the Medallion 3.0 managed care 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:

- **4.3.A.I** All Medallion 3.0 covered services, carved-out and enhanced services, policies, procedures, and any modifications to these items;
- **4.3.A.II** Eligibility standards, eligibility verification, and benefits;
- **4.3.A.III** The role of the enrollment broker regarding enrollment and disenrollment;
- **4.3.A.IV** Special needs of members in general that may affect access to and delivery of services, to include, at a minimum, transportation needs;
- **4.3.A.V** The rights and responsibilities of the enrolled;
- **4.3.A.VI** Grievance and appeals procedures;
- **4.3.A.VII** Procedures for reporting fraud, waste and abuse;
- **4.3.A.VIII** References to Medicaid manuals, memoranda, and other related documents;
- **4.3.A.IX** Payment policies and procedures;
- **4.3.A.X** Billing instructions which are in compliance with the Department's encounter data submission requirements; and,
- **4.3.A.XI** Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

4.4 PROVIDER PAYMENT

In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 C.F.R. § 447.45 and Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered members who are enrolled with the Contractor. 42 C.F.R. § 447.45 defines timely processing of claims as:

4.4.A Adjudication (pay or deny) of ninety percent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt.

4.4.B Adjudication (pay or deny) of ninety-nine percent (99%) of all Virginia Medicaid clean claims within ninety (90) calendar days of the date of receipt.

4.4.C Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 C.F.R. § 447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

The Contractor shall notify the Department 45 days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations. Any expenses incurred by the Department or its contractors to adapt to the Contractor's claims

processing operational changes (including but not limited to costs for site visits) shall be borne by the Contractor.

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

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

To the extent the Governor and/or General Assembly implement a specified rate increase for Medicaid services/providers and as identified by the Department, and these rate adjustments are incorporated into the Medallion 3.0 capitation payment rates during the Contract period, where required by the Department and/or regulation, the Contractor is required to increase its reimbursement to providers at the same percentage as Medicaid's increase as reflected in the revised fee-for- service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed to by the Department. The Department shall make every reasonable effort to provide at least 30 days advance notice of such increases. The Contractor shall provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format. A copy of such notification shall be provided to the Department 60 days before the Contractor's mailing of such notice.

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.

4.5 PROVIDER DISENROLLMENT

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

4.5.A Procedures to provide a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each member who received care on a regular basis from the terminated provider. [42 C.F.R. § 438.10(f)(5)]

4.5.B Procedures to provide a good faith effort to transition PCP panel members to new PCPs at least thirty (30) calendar days prior to the effective date of provider disenrollment;
4.5.C Procedures for the reassessment of the provider network to ensure it meets access standards established in its Contract;
4.5.D Procedures for notifying the Department within the time frames set forth in this Contract; and
4.5.E Procedures for temporary coverage in the case of unexpected PCP absence (e.g., due to death or illness).

4.6 INELIGIBLE PROVIDERS OR ADMINISTRATIVE ENTITIES

See Section 13.3, entitled "Prohibited Actions."

4.7 PHYSICIAN INCENTIVE PLAN

The Contractor shall comply with 42 C.F.R. §§ 422.208 and 422.210 as amended specifying the requirements for Physician Incentive Plans (PIP). The Contractor shall also comply if the Contractor enters into subcontracting arrangements. If a physician financial arrangement is determined by the Department to potentially avoid costs by limiting referral specialty care for members, the Contractor must demonstrate to the Department that all medically necessary referrals were authorized during the contract period. The Contractor is prohibited from making any payment under a PIP as an inducement to limit or reduce medically necessary services to a member. The Physician Incentive Plan should be submitted annually to the Department.

The Contractor shall report annually whether services not furnished by physician/group are covered by PIP or incentive arrangement that includes withhold, bonus, capitation, and percent of withhold or bonus, if applicable.

4.8 PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS

The Contractor must not prohibit or restrict a health care professional from advising a member about his or her health status, medical care, or treatment, regardless of whether benefits for such are provided under the Contract, if the provider is acting within the lawful scope of practice as described in Section 4704 (b)(3) of Public Law 105-33.

4.9 PROVIDER INQUIRY PERFORMANCE STANDARDS

The Contractor shall answer telephonic provider inquiries, including requests for referrals and prior-authorizations with a monthly average speed of answer (ASA) of less than three (3) minutes. Provider call abandonment rates shall average less than 10% each month. Upon request, the Contractor will provide a report of these measures to include total call volume, wait time in seconds, and abandonment percentage rate to the Department.

4.10 PROVIDER ADVISORY COMMITTEE

In accordance with NCQA requirements, the Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve members. At least two providers on the committee shall maintain practices that predominantly serve Medicaid members and other indigent populations, in addition to at least one other participating provider on the committee who has experience and expertise in serving members with special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management and activities and policy and operations changes. The Department may conduct on-site reviews of the membership of this committee, as well as the committee's activities throughout the year.

4.11 PROVIDER SATISFACTION SURVEY

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

4.12 CONTRACTOR REFERRAL RESPONSIBILITIES

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

- **4.12.A.I** Establish referral mechanisms to link members with providers and programs not covered through Medallion 3.0 or Medicaid.
- **4.12.A.II** Maintain a current list of providers, agencies, and programs and provide that list to members who have needs for those programs; and
- **4.12.A.III** Refer members to the Department for carved-out and excluded services pursuant to Section 7.5 of this Contract.
- **4.12.A.IV** Refer members to the Department who are transitioning to residential treatment.

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

- **4.12.B.I** **Part C of IDEA** - The Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS) program (as described in 20 U.S.C. § 1471 and 34 C.F.R. § 303.12) is administered by the Virginia Department of Behavioral Health and Developmental Services. Early Intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The Contractor shall refer members who are

potentially eligible for or qualify for Early Intervention Services to local interagency councils. The Contractor shall maintain a listing of local interagency councils and shall make that listing available to all qualified members.

4.12.B.II **WIC Programs** - Section 1902(a)(11)(C) of the Social Security Act, as amended, requires the State Plan to provide for the coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and is administered by the Virginia Department of Health. The Contractor shall provide for the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by providers working within Medallion 3.0 managed care plans to the WIC Program.

The Contractor is not responsible for covering WIC specialized infant supplemental nutrition. The Contractor shall refer members who are potentially eligible for WIC to the Virginia Department of Health (VDH) who shall bill The Department for services provided.

4.12.B.III **Head Start** - The Head Start program is authorized under the Head Start Act, 42 U.S.C. § 9831 et seq., as amended.

4.12.B.IV **Service authorization (SA)** - The Contractor shall refer providers, on behalf of members, to the Department's SA contractor, and/or BHSA, as needed.

4.12.B.V **Lead Environmental Investigation** - The Contractor shall refer members who require a lead environmental investigation to the local health department for assistance.

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

5. ELIGIBILITY, ENROLLMENT & GENERAL RESPONSIBILITIES

5.1 ELIGIBILITY AND ENROLLMENT

5.1.A Eligibility

The Department shall have sole responsibility for determining the eligibility of a member for Medicaid funded services. The Department shall have sole responsibility for determining enrollment in the Contractor's plan.

5.1.B Enrollment

The Department shall have sole authority and responsibility for enrollment into the Medallion 3.0 program and for excluding members from Medallion 3.0, including those members meeting the criteria in Section 5.2 below. The Contractor shall promptly notify the Department upon learning that a member meets one or more of these exclusion criteria. There shall be no retroactive enrollment in managed care. The only exception will be babies born to MCO-enrolled mothers when the child's eligibility is added back to their date of birth.

In conducting any enrollment-related activities permitted by this Contract or otherwise approved by the Department, the Contractor shall assure that member enrollment is voluntary and without regard to health status, physical or mental condition or handicap, age, sex, national origin, race, or creed. Members shall be enrolled in the order that the members apply to the Enrollment Broker, up to the limits (if any) specified in this Contract. The Contractor shall notify the member of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the member handbook. Upon disenrollment from the plan, the Contractor shall notify the member through a disenrollment notice that coverage in the Contractor's plan will no longer be effective. The disenrollment notice should identify the effective date of disenrollment and, whenever possible, should be mailed prior to the member's actual date of disenrollment.

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

The Department may establish alternate or contingent enrollment strategies as allowed by federal waiver requirements which support transition of enrollment for new and existing populations and health plans into and from managed care.

5.1.C Member Selection of MCO

5.1.C.I At the time a member is enrolled, a new VAMMIS generated letter will be sent to individuals stating that the individual will likely be managed care eligible, and that the individual may pre-select an MCO.

5.1.C.II At the time a member is assigned, an assignment letter will be generated by VAMMIS, either confirming the pre-selected MCO from 5.1.C.a, or assigning the member to an MCO for enrollment (See 5.1.D, below). At that time, the member may call the enrollment broker to change or select a different MCO.

5.1.C.III After this period, a member can disenroll from the assigned MCO and select another MCO within the first ninety (90) days of enrollment without cause.

5.1.D Assignment to MCOs

In accordance with 12 VAC 30-120-370, the Department will assign members to MCOs using an assignment system.

The following assignment process is to be followed during routine business months. The Department reserves the right to revise this process, as needed. Members will be assigned to MCOs through system algorithms, congruent with State conflict of interest safeguards described in 1932(d)(3) of the Social Security Act, based upon the client's history with a contracted MCO as follows:

5.1.D.I All eligible members, except those meeting one of the exclusions of Section 5.2 shall be enrolled in Medallion 3.0.

5.1.D.II Once members are enrolled in Medicaid, they will receive a letter indicating their eligibility for managed care and the effective date of enrollment. The letter will also include the enrollment broker phone number, a link to the managed care website, and instructions to contact the toll-free managed care helpline number to select an available MCO, or for assistance with questions. Members are encouraged to exercise their selection choice.

5.1.D.III Members shall be assigned to an MCO as follows:

5.1.D.III.a Members that have a previous enrollment history with a currently contracted MCO will be assigned to that MCO.

5.1.D.III.b Members not assigned pursuant to subsection 1 above will be assigned to the MCO of another family member, if applicable.

5.1.D.III.c All other members will be randomly assigned to an MCO in approximately equal numbers by MCO in each locality.

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

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

5.2 EXCLUSIONS FROM MEDALLION 3.0 PARTICIPATION

The Contractor shall cover all Medicaid eligible members, with the exception of excluded members as defined in 12 VAC 30-120-370 B.

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

5.2.A Members who are inpatients in State mental hospitals including but not limited to those listed below:

5.2.A.I Catawba Hospital,
5.2.A.II Central State Hospital,
5.2.A.III The Commonwealth Center for Children and Adolescents,
5.2.A.IV Eastern State Hospital,
5.2.A.V HW Davis Medical Center,
5.2.A.VI Northern Virginia Mental Health Institution,
5.2.A.VII Piedmont Geriatric Hospital
5.2.A.VIII Southern Virginia Mental Health Institution,
5.2.A.IX Southwestern State HM&S,
5.2.A.X Southwestern VA Mental Health Institution,
5.2.A.XI Western State HM&S, and
5.2.A.XII Western State Hospital.

5.2.B Members who are approved by the Department as inpatients in long-stay hospitals (the Department recognizes two facilities as long-stay hospitals: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]), nursing facilities, or intermediate care facilities for the intellectually disabled.

5.2.C Members who are placed on spend-down.

5.2.D Members who are participating in Federal Waiver Programs for home-based and community based Medicaid coverage prior to managed care enrollment.

5.2.E Members, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those members placed there for medically necessary services funded by the Contractor or other MCO.

5.2.F Members who receive hospice services in accordance with Department criteria.

5.2.G Members with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program, except as set forth in this Contract. (Veteran's Affairs (VA) benefits are not considered "other insurance" and do not qualify as an exclusion from Managed Care).

5.2.H Newly eligible members who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician, certified nurse midwife or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests under this paragraph shall be made by the member, MCO, or obstetrical provider.

5.2.I Members under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC 30-130-860.

5.2.J Members who have been assigned to the Contractor but whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion 3.0. Requests must be made during the assignment period.

5.2.K Members who are inpatients in hospitals, other than those listed in 5.2.A and 5.2.B above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This does not apply to newborns unless there is a break in coverage. (See also Section 5.9 "Delay of Enrollment due to Hospitalization").

5.2.L Certain members between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et. Seq.), who are granted an exception by the Department.

5.2.M Members who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund.

5.2.N Members who have an eligibility period that is less than three (3) months

5.2.O Members who are enrolled in the Commonwealth's Title XXI SCHIP program.

5.2.P Members who have an eligibility period that is only retroactive.

Members enrolled with a MCO that subsequently meets one or more of these criteria during MCO enrollment shall be excluded from MCO participation as appropriate by DMAS, with the exception of those who subsequently become members in the federal long-term waiver programs, as otherwise defined elsewhere in this section, for home and community-based Medicaid coverage (Individual and Family Development Disabilities Supports, Individuals with Intellectual disability, Elderly or Disabled with Consumer Direction, Day Support, Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

The Department shall, upon new State or Federal regulations or Department policy, exclude other members as appropriate.

5.3 AUTO-ASSIGNMENT

The Contractor will accept automatic assignment for any eligible member.

5.4 AUTOMATIC RE-ENROLLMENT

Members who have been previously enrolled with the Contractor who regain eligibility for Medallion 3.0 enrollment within sixty (60) calendar days of the effective date of exclusion or disenrollment and who do not select another MCO will be reassigned to the Contractor, as appropriate, (provided sufficient member slots are available under this Contract) and without going through the selection or assignment process.

5.5 ENROLLMENT PERIOD & EFFECTIVE TIME

5.5.A Enrollment Period

For the initial ninety (90) calendar days following the effective date of enrollment, the member will be permitted to disenroll from one health plan and enroll in another health plan without cause. This ninety (90) day time frame during which a member may disenroll

without cause applies to the member's initial period of enrollment and to any subsequent enrollment periods when they enroll in a new MCO.

If the member does not disenroll during the ninety (90) day period, he/she may not disenroll without cause for the remainder of the enrollment period.

Following their initial 90 day enrollment period, members who are not Foster Care children shall be restricted to their health plan selection until the open enrollment period for their locality, unless disenrolled under one of the conditions described in Section 5.2 and pursuant with Section 1932 (a)(4)(A) of Title XIX.

In addition, within sixty (60) days prior to the open enrollment effective date, the Department will inform the member of the opportunity to remain with the current health plan or change to another health plan without cause. Those members who do not choose a new MCO within sixty (60) days of the open enrollment period shall remain in his or her current health care selection.

The member may disenroll from any contracted health plan to another at any time, for cause, as defined by the Department. See Section 5.10 "Disenrollment and Health Plan Election Changes" for details.

5.5.B Enrollment Effective Time

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

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

5.6 OPEN ENROLLMENT

Members will be notified of their ability to change plans at the end of their enrollment period at least sixty (60) days before the end of that period. Enrollment selections will be effective no later than the first day of the second month following the month in which the member makes the request for the change in plans. MCOs that have contractual enrollment limits shall be able to retain existing members who select them and shall be able to participate in open enrollment until contractual limits are met. See Attachment VI for current open enrollment information by region and city/county.

5.7 ENROLLMENT PROCESS FOR NEWBORNS

The Contractor is responsible for the entire birth month plus two additional consecutive month period for all MCO Newborns regardless of whether the newborn receives a Medicaid ID number, unless the MCO Newborn's enrollment is changed during the "birth month plus two" period by the parent or legal guardian electing to change health plans. In such cases, the former

MCO is not responsible once the MCO Newborn is enrolled into the MCO selected by the parent or legal guardian.

Any newborn whose mother is an enrolled FAMIS MOMS member in the Contractor's plan on the newborn's date of birth shall be deemed a member of that Contractor's plan for up to three calendar months (birth month plus two (2) months) and shall hereafter be referred to as an MCO Newborn.

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

If this Contract is terminated in whole or in part by the Contractor, the Contractor shall continue coverage for the MCO Newborn until the child is enrolled with another MCO in the Department's MMIS, or until the end of the "birth month plus two" period, whichever is earlier.

Any medically necessary claims for an MCO Newborn may not be denied by the MCO for any reason during the "birth month plus two" period, including- but not limited to, lack of service authorizations for newborn services, timely filing issues as a result of delayed or incorrect enrollment of the newborn, medically necessary services received out of MCOs service area, or medically necessary services received from out-of-network providers.

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

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

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

The Contractor is responsible for advising the parent or guardian of the newborn that Medicaid eligibility rules ensure continuous eligibility for the child up to twelve (12) months following birth; however, to receive coverage, the local DSS office must be notified of the birth. The Contractor shall have written policies and procedures governing the identification of MCO Newborns by their network providers. The Contractor should also encourage contracted hospitals to submit newborns via the streamlined online enrollment process.

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

5.8 ENROLLMENT PROCESS FOR FOSTER CARE & ADOPTION ASSISTANCE CHILDREN

The Contractor shall cover services for managed care enrolled foster care & adoption assistance children (designation codes 076 and 072, respectively).

5.8.A For decisions regarding the foster care child's medical care, the MCO may work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child's medical care, the MCO may work directly with the adoptive parent.

5.8.B The social worker will be responsible for all changes to MCO enrollment for foster care children. The adoptive parent will be responsible for all changes to MCO enrollment for adoption assistance children. An enrollment change can be requested at any time that the child is placed in an area not serviced by the plan of enrollment.

5.8.C Coverage shall not be limited to emergency services and must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area.

5.8.D If the MCO has found that the foster care child has been placed in an area other than the one where the MCO participates, the MCO may contact the social worker to request a change of health plan be initiated.

5.8.E The MCO must work with DSS in all areas of care coordination.

5.8.F Foster care children are not restricted to their health plan selection following the initial 90 day enrollment period, as stated in Section 5.5.A.

5.8.G Regardless of the reasons described above, if a child moves out of the service area, the child remains the responsibility of the health plan for all contractual covered services until disenrollment occurs.

Additional information pertaining to requirements for Foster Care and Adoption Assistance individuals can be located in Section 7.1.O.III.

5.9 DELAY OF ENROLLMENT DUE TO HOSPITALIZATION

Members who are inpatients in hospitals, other than those listed in Section 5.2 of this Contract, at the scheduled time of Managed Care enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date are restricted from enrollment with the MCO until the first day of the month following discharge, as set forth in 12 VAC 30-120-370 B. This does not pertain to newborns who are enrolled as described in Section 5.7 "Enrollment Process for Newborns".

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

5.10 DISENROLLMENT AND HEALTH PLAN ELECTION CHANGES

Enrollment in Medallion 3.0 is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. DMAS reserves the right to exclude from participation in the Medallion 3.0 managed care program any member who has been consistently noncompliant, as determined by the Department, with the policies and procedures of managed care or who is threatening to providers, MCOs, or DMAS. There must be sufficient documentation from various providers, the MCO, and DMAS of these noncompliance issues and any attempts at resolution. Recipients excluded from Medallion 3.0 through this provision may appeal the decision to DMAS. Disenrollment from managed care by DMAS shall be in accordance with 42 C.F.R. § 438.56(b)(2)&(3).

Members shall have the right to disenroll from the Contractor's plan to another Plan pursuant to 42 C.F.R. § 438.56, as amended, or § 1903 (m)(2) A of the Social Security Act, as amended, unless otherwise limited by an approved CMS waiver of applicable requirements. During the first ninety (90) calendar days following the effective date of enrollment, a member may elect to change health plans for any reason. Any such change of plan shall be effective no later than the first day of the second month after the month in which the member requests disenrollment.

Consistent with § 1932(a)(4) of the Social Security Act, as amended (42 U.S.C. § 1396u-2), the Department must permit a member to disenroll at any time <u>for cause</u>. The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll such as poor quality care, lack of access to necessary providers for services covered under the State Plan, or other reasons satisfactory to the Department. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 C.F.R. § 438.56(d)(2) and 12 VAC 30-120-370. The Department will respond to "cause" requests, in writing, within 15 business days of the Department's receipt of the request. In accordance with 42 C.F.R. § 438.56(e)(2), if the Department fails to make a determination by the first day of the second month following the month in which the member files the request, the disenrollment request shall be considered approved and effective on the date of approval.

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

Provision of an enhanced service that is a service qualifying for an exclusion from Medallion 3.0 Managed Care shall not be the sole basis for disenrollment or exclusion from Medallion 3.0. In order to be excluded from Medallion 3.0, individuals must meet the Department's criteria for receiving that service.

5.11 LOSS OF ELIGIBILITY

The member will lose managed care eligibility upon occurrence of any of the following events:

5.11.A Death of the member;
5.11.B Cessation of Medicaid eligibility;
5.11.C Members that meet at least one of the exclusion criteria listed in Section 5.2 of this Contract. The Department shall determine if the member meets the criteria for exclusion;
5.11.D Transfer to a Medicaid eligibility category not included in this Contract; or
5.11.E Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

The Department will determine the need for status change disenrollment based on input and supporting documentation from the Contractor and/or other source(s).

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or loss of eligibility, except for specially manufactured DME that was prior-authorized by the Contractor. However, in cases where disenrollment is anticipated, secondary to the member's participation in the Technology Assisted home and community based care waiver, nursing facility, hospice, or other exclusionary program, the Contractor is responsible for the authorization and provision of all services covered under this Contract until notified of the disenrollment by the Department.

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

The Contractor shall be entitled to a capitation payment for the member based on the recoupment/reconciliation procedures in Section 12 and the Managed Care Technical Manual. The Contractor shall not be entitled to payment during any month subsequent to status change determination. Capitation payments already paid by the Department for months beyond the month in which the event occurred shall be repaid to the Department in accordance with the provisions of this Contract.

5.12 INFORMING DMAS OF POTENTIAL INELIGIBILITY

The Department will share with the Contractor data that its agents have regarding reasons for enrollment and disenrollment (via the *Plan Change Report*) at least on a monthly basis.
When a member for who services have been authorized but not provided as of the effective date of exclusion or disenrollment is excluded or disenrolled from the Contractor's plan and from Medallion 3.0, the Contractor shall provide to the Department or the relevant PCP the history for that member upon request. This prior authorization history shall be provided to the Department or the relevant PCP within five (5) business days of request.

5.13 RURAL EXCEPTION

A Rural Exception occurs where a single MCO operates under the Federal Rural Exception guidelines, and where qualifying members are enrolled with that contracted MCO. The Contractor shall adhere to all contract requirements as described within this Contract.

The following differences apply in any locality where there is a Rural Exception:

5.13.A **Enrollment**: Members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines shall be enrolled, and remain enrolled, with the contracted MCO unless disenrolled under one of the conditions described in Section 5.2 "Exclusions from Managed Care" and pursuant with Section 1932 (a)(4)(a) of Title XIX.

5.13.B **Member Choice of PCP**: Members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines must be permitted to choose from at least two PCP providers (see Section 3.6.A).

5.13.C **Out-of-Network Services:** In addition to the requirements found in Section 7.1.J, for members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, per 42 C.F.R. § 438.52(b)(2)(B), the Contractor shall provide out-of-network coverage in all of the following circumstances:

5.13.C.I Where a provider is not a part of the Contractor's network, but is the main source of a service to the member, provided that:

5.13.C.I.a The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type;

5.13.C.I.b If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider within 60 days (after being given the opportunity to select a provider who participates);

5.13.C.II The member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

5.13.D **Assignment**: Once members are enrolled in Medicaid, they will receive a letter indicating that they may be assigned to a contracted MCO. Members who reside in a locality where a single MCO operates under the Federal Rural Exception guidelines shall be provided an advanced notice that (s)he will be enrolled in the contracted MCO

6. MEMBER OUTREACH AND MARKETING SERVICES

6.1 MARKETING PLAN

For the purposes of this Contract, Marketing Materials and Services as defined shall apply to members who may or may not be currently enrolled with the Contractor. All Contractors may utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf.

Marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to beneficiaries. An organization may be subject to sanctions if it offers or gives something of value to a member that the organization knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.

The Contractor shall:

6.1.A Offer its plan to members and provide to those interested in enrolling adequate, written descriptions of the MCO's rules, procedures, benefits, fees and other charges, services, and other information necessary for members to make an informed decision about enrollment.

6.1.B Submit to the Department a complete marketing plan annually. This is provided to the Department for informational purposes. Any changes to the marketing plan must be submitted to the Department for approval prior to use. The Department will review individual marketing materials and services as they are submitted (prior to their planned use), and approve, deny, or ask for modifications within the timeframes outlined below.

6.1.C Submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Department will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Department. (42 C.F.R. § 438.104)

6.1.D Distribute marketing materials to the Contractor's eligible population on a city or countywide basis. The Department must approve a request for a smaller distribution area. The Contractor may distribute marketing materials to Medicaid members where the member is enrolled with the Contractor's (or the Contractor's affiliates) Medicare product, within all applicable Medicare Advantage Marketing Guidelines, as set forth in Chapter 3 of CMS's Medicare Managed Care Manual, as well as all applicable statutes and regulations including and without limitation Section 1851 (h) of the Social Security Act and 42 C.F.R. Sections 422.80, 422.111, and 423.50.

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

6.1.F Assure that all marketing and informational materials shall set forth the Flesch readability scores of 40 or better (at or below 12th grade reading level) and certify compliance therewith (See Section 6.4 "Communication Standards).

6.1.G Be subject to a fine or other sanctions if it conducts any marketing activity that is not approved in writing by the Department. (42 C.F.R. § 438.700)

6.2 PERMITTED MARKETING AND OUTREACH ACTIVITIES

The Contractor may engage in the following promotional activities:

6.2.A Notify the general public of the Medicaid Managed Care program in an appropriate manner through appropriate media, throughout its enrollment area.

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

6.2.C Pre-approved mail campaigns through the Department or its agents to regions of potential members and pre-approved informational materials for television, radio, and newspaper dissemination.

6.2.D Fulfillment of potential member requests to the MCO for general information, brochures, and/or provider directories that will be mailed to the member.

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

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

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

6.2.H Offers of free non-cash promotional items and "giveaways" that do not exceed a total combined nominal value of $25.00 to any prospective member or family for marketing purposes. Such items must be offered to all prospective members for marketing purposes whether or not the prospective member chooses to enroll in the Contractor's plan. The Contractor is encouraged to use items that promote good health behavior, e.g., toothbrushes or immunization schedules.

6.2.I The Contractor is allowed to offer non-cash incentives to their enrolled members for the purposes of retaining membership, and/or rewarding for compliance in immunizations, prenatal visits, or participating in disease management, HEDIS or HEDIS related measures/activities, etc. These incentives shall be limited to $25.00 for individual "giveaways" as stated in item "h." above unless an approved exception is made by the state within its discretion. Gifts of this type cannot exceed $50.00 in any fiscal year to any one individual. For raffles or prize drawings, only 1 special incentive drawing a year per health plan in excess of the $50.00 will be allowed. The prize has to be health related. Wii or Xbox

game consoles with exercise video will meet this requirement. Contractors are required to keep a database to ensure that giveaways (including gift cards) do not exceed $50.00 per member per contract year. This incentive shall not be extended to any member not yet enrolled in the Contractor's plan. The Contractor must submit all incentive award packages to DMAS for approval prior to implementation. Non-cash incentives may include gift cards. The Contractor must have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash.

6.3 PROHIBITED MARKETING AND OUTREACH ACTIVITIES

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

6.3.A Engaging in any informational or marketing activities which could mislead, confuse, or defraud members or misrepresent the Department. (42 C.F.R. § 438.104)

6.3.B Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites. (42 C.F.R. § 438.104)

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

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

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

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

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

6.3.H Engaging in marketing activities which target prospective members on the basis of health status or future need for health care services, or which otherwise may discriminate against members eligible for health care services.

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

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

6.3.K No educational or enrollment related activities may be conducted at Department of Social Services offices unless authorized in advance by the Department of Medical Assistance Services.

6.3.L No assertion or statement (whether written or oral) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity. (42 C.F.R. § 438.104).

6.3.M No assertion or statement that the member must enroll with the Contractor in order to keep from losing benefits (42 C.F.R. § 438.104).

6.3.N Contacting members at any time for the purpose of determining the need for, or providing assistance with, recertification/renewal of Medicaid benefits. In addition, health plan may not solicit reason for disenrollment from members leaving Contractors plan, except as authorized in Section 6.3.I.

6.4 COMMUNICATION STANDARDS

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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

The Contractor must make available member handbooks in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by Medallion 3.0 regions and will only affect handbooks distributed in the affected region.

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

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

All enrollment, disenrollment and educational documents and materials made available to members by the Contractor must be submitted to the Department for its review at start-up, upon revision, and upon request, unless specified elsewhere in this Contract.

6.5 MEMBER IDENTIFICATION (ID) CARD

The Contractor shall provide each member an identification card that is recognizable and acceptable to the Contractor's network providers. The Contractor's identification card must also serve as sufficient evidence of coverage for non-participating providers. The Contractor's identification card will include, at a minimum, the name of the member, the Medicaid identification number, member co-payment responsibility (as applicable), the name and address of the Contractor, the name of the member's primary care provider, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, a Contractor identification number, and any other information needed to process claims or provide customer service numbers, if applicable. All member identification cards issued on or after July 1, 2013 are also required to include the telephonic contact information for Smiles For Children program. The Contractor must submit and receive approval of the identification card from the Department prior to production of the cards.

Please see Section 6.7 for mailing requirements for Member ID cards and New Member Packets. The Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the member's Medicaid identification number, first/last name, incorrect address, and correct address, if available.

6.6 NEW MEMBER PACKET

The Contractor shall provide its members, as expediently as possible upon receiving the end of the month 834 file in which their enrollment starts, an identification card (if not already mailed) and an information packet indicating the member's first effective date of enrollment. (Reference Section 11 and the Managed Care Technical Manual for time frames related to enrollment report information exchange.) The Contractor may send this information in a single mailing to the household (by case number listed in the enrollment report), and is only required to send one member handbook per case. Each member must receive an individual identification (ID) card. Further, the Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the member identification cards. The Department must receive a copy of this packet for review due prior to signing original contract, upon revision, upon request, and as needed.

At a minimum, the member information packet shall include:

6.6.A An introduction letter.

6.6.B An identification card that includes the Medicaid ID number and the member's co-payment responsibility, if applicable.

6.6.C A description of the service area and how to access the Provider Directory that lists names, locations, telephone numbers, and non-English languages spoken by contracted providers in the member's service area, including identification of providers that are not accepting new patients. This includes at a minimum, information on primary care physicians, specialists, and hospitals. Additionally, this directory must identify any restrictions that could impact the member's freedom of choice among network providers. [42 C.F.R. § 438.10.f.6]

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

6.7 MAILING REQUIREMENTS FOR MEMBER ID CARDS AND NEW MEMBER PACKETS:

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

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

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

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

On or before July 15, 2014, the MCO will submit a written process, procedure, and mode of delivery, which must outline mailing deadlines for any New Members identified on the end of month 834. The Department will review each proposed process and determine if the mailing requirements are acceptable. The process should include, at a minimum:

6.7.B.I A process to compare the mid-month file to the end of month file to identify new members,

6.7.B.II The mode of delivery for mailings which must meet the requirements of 6.7.A (first class, priority or overnight, and "Return Services Requested");

6.7.B.III A clear timeline beginning with receipt of the end of the month file to the mailing of New Member Packets and Member ID Cards for those new members not on the mid-month;

6.7.B.IV The policy regarding access to point of sale pharmacy services: whether pharmacies are required to enter the Medicaid ID number and/or the unique health plan number for the member to access point of sale pharmacy services.

6.7.B.I.a If the Contractor relies solely on the use of the unique health plan number to access point of sale pharmacy services, the Contractor must also include special instructions on how to access pharmacy and point-of-service claims.

6.7.B.V The process to provide assistance for members who need to access services between the first of the month and the time the Member ID card is received by the member.

6.8 MEMBER HANDBOOK

The Contractor shall submit a copy of the Member Handbook to the Department for approval sixty (60) calendar days prior to distribution. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The Contractor must update the Member Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or a red-lined handbook showing before and

after language. The red-lined document may be submitted on paper or electronically. Such changes must be approved by the Department prior to dissemination to members and shall be submitted to the Department at least sixty (60) calendar days prior to planned use. The Department will respond to changes within thirty (30) calendar days of the date of the Department's receipt of the request. If the Department has not responded to the Contractor within thirty (30) days from receipt of the Member Handbook, the Contractor may proceed with its printing schedule. If the Contractor prints and distributes a version of the handbook that was not approved by the Department, the Contractor will be required to amend and redistribute to its entire member population within thirty (30) days. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Department. The Member Handbook must include instructions advising members about EPSDT and how to access such services.

The Contractor's Member Handbook shall reflect a copy of the member rights (as referenced in this Contract) as provided at open enrollment.

The Member Handbook must be provided to each member (and potential member if requested) after the Contractor receives notice of the member's enrollment. Once a year the Department will notify managed care members of their right to request and obtain this information from the Contractor.

The Handbook must include, at a minimum, the following information:

6.8.A Table of Contents

6.8.B Member Eligibility

- **6.8.B.I** Effective date and term of coverage.
- **6.8.B.II** Terms and conditions under which coverage may be terminated.

6.8.C Choosing or Changing an MCO

- **6.8.C.I** Procedures to be followed if the member wishes to change MCOs.

6.8.D Choosing or Changing a PCP

- **6.8.D.I** Information about choosing and changing PCPs and a description of the role of Primary Care Providers.

6.8.E Making Appointments and Accessing Care

- **6.8.E.I** Appointment-making procedures and appointment access standards.
- **6.8.E.II** A description of how to access all services including specialty care and authorization requirements.
- **6.8.E.III** The role of the PCP and the Contractor in directing care.

6.8.F Member Services

- **6.8.F.I** A description of all available covered services, as outlined in Section 7 of this Contract, including preventive services, and an explanation of any service limitations, referral and service authorization requirements. The description shall include the procedures for obtaining benefits, including family planning services from out-of-network providers.
- **6.8.F.II** A description of the enhanced services that the Contractor offers.
- **6.8.F.III** Instructions on how to contact Member or Customer Services of the Contractor and a description of the functions of Member or Customer Services.

6.8.F.IV Notification that each member is entitled to a copy of his or her medical records and instructions on how to request those records from the Contractor.

6.8.F.V Instructions on how to utilize the after-hours Medical Advice and Customer Services Departments of the Contractor.

6.8.F.VI A description of the Contractor's confidentiality policies.

6.8.F.VII Advice on how enrolled members may acquire services that are covered under Medicaid but not under this contract, including home and community based care waiver services as applicable. A description of these services, including how they may be accessed, is provided as Attachment II.

6.8.G Emergency Care

6.8.G.I The telephone number to be used by members for assistance in obtaining emergency care.

6.8.G.II The definition of an emergency using the "prudent layperson" standard, a description of what to do in an emergency, instructions for obtaining advice on getting care in an emergency, and the fact that service authorization is not required for emergency services. Members are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911.

6.8.G.III A description of how to obtain emergency transportation and other medically necessary transportation.

6.8.G.IV How to appropriately use emergency services and facilities.

6.8.G.V Information indicating that emergency services are available out-of-network without any financial penalty to the member.

6.8.G.VI Definition of and information regarding coverage of post-stabilization services in accordance with 42 C.F.R. § 422.113(c) as described in Section 7 of this Contract.

6.8.G.VII The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this Contract.

6.8.H Member Identification Cards

6.8.H.I A description of the information printed on the identification card, including the Medicaid ID number.

6.8.H.II A description of when and how to use the identification card.

6.8.I Member Responsibilities

6.8.I.I A description of procedures to follow if:

6.8.I.I.a The member's family size changes;

6.8.I.I.b The member's address changes;

6.8.I.I.c The member moves out of the Contractor's service area, (where the member must notify the DSS office regarding change of address and must notify the Contractor for assistance to receive care outside of the Contractor's service area until the member is disenrolled);

6.8.I.I.d He or she obtains or has health coverage under another policy or there are changes to that coverage.

6.8.I.II Actions the member can make towards improving his or her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor.

6.8.I.III Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. §489.100, 42 C.F.R. § 438.6 (i) (3) and (4) and 12 VAC 30-10-130.

6.8.I.IV Notification of any co-payment in accordance with Section 7.1.A, if applicable, the member will be required to pay.

6.8.I.V Information regarding the member's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid

6.8.J MCO Responsibilities

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

6.8.K Grievances and Appeals [42 C.F.R. § 438.10(f)&(g)]

6.8.K.I A description of the grievance and appeals procedures including, but not limited to, the issues that may be resolved through the grievance or appeals processes; the fact that members have the right to appeal directly to the Department for a State fair hearing and providing the Department's address for the appeals; the process for obtaining necessary forms; and procedures and applicable timeframes to register a grievance or appeal with the Contractor or the Department as described in this Contract.

6.8.K.II The availability of assistance in the filing process.

6.8.K.III The toll-free numbers that the member can use to file a grievance or an appeal by telephone.

6.8.K.IV A description of the continuation of benefits process as required by 42 C.F.R. § 438.420 and information describing how the member may request continuation of benefits, as well as information on how the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

6.8.K.V The telephone numbers to register complaints regarding providers (Health Professionals, 1-800-533-1560) and MCOs (Managed Care Helpline, 800-643-2273, Fraud 800-371-0824 and 888-323-0587).

6.8.L Interpretation and Translation Services

6.8.L.I Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42 C.F.R. § 438.10(c)(5)]

6.8.L.II A multilingual notice that describes translation services that are available and provides instructions explaining how members can access those translation services. [42 C.F.R. § 438.10(c)(5)] As the size of the Contractor's non-English speaking member population attains the threshold specified in Section F for translation of the member handbook into a language other than English, the Contractor shall be responsible for such translation as required by Section 6. Some of this information may be included as inserts in or addenda to the Member Handbook. As the

member handbook is translated into other languages, the Contractor shall provide a language appropriate copy to all such non-English speaking members.

6.8.L.III Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments. [42 C.F.R. § 438.10(d)(2)]

6.8.M Program Referral and Service Changes

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

6.8.N Additional Information that is available upon request, including the following:

6.8.N.I Information on the structure and operation of the Contractor.

6.8.N.II Physician incentive plans as set forth in 42 C.F.R. § 438.6(h).

6.9 MEMBER RIGHTS

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding member rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to member rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964 as implemented at 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality.

At a minimum such member rights include the right to:

6.9.A Receive information in accordance with 42 C.F.R. § 438.10 as described in Section 3 and Section 6 of this Contract.

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

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

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

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

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

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

6.9.H Be furnished health care services in accordance with 42 C.F.R. §§ 438.206 through 438.210 as described in this Contract.

6.10 CULTURAL COMPETENCY

The Contractor must demonstrate cultural competency in its dealing, both written and verbal, with members and must understand that cultural differences between the provider and the member 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.

6.11 MEMBER SERVICES

6.11.A The Contractor agrees to maintain and staff **a toll-free Member or Customer Services** function to be operated at least during regular business hours and to be responsible for the following:

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

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

- **6.11.B.I** **Waiting/Hold Times** - The Contractor shall have appropriate equipment and personnel in place to ensure that daily hold time for a member service Helpline inquiry (for Virginia Medicaid only) never exceeds three (3) minutes. Waiting/Hold Times reported shall include only Virginia specific program information.
- **6.11.B.II** **Abandonment Rate** - The Contractor's daily telephone abandonment rate for member service helpline (Virginia Medicaid only) access calls shall be less than ten percent (10%) for all incoming calls.

  Records of wait times and abandonment rates specific to Virginia Medicaid only shall be kept by the Contractor and available upon request.

6.12 MEMBER EDUCATION PROGRAM

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

revision, and upon request, as needed. At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Department prior to implementation.

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

7. BENEFIT SERVICE REQUIREMENTS AND LIMITS

Throughout the term of this Contract, the Contractor shall promptly provide, arrange, purchase or otherwise make available all services required under this Contract to all of its members. (A chart summarizing covered services, carved-out services, and non-covered services is provided in Attachment II to this Contract.) Contractor should adhere to all special payment terms found in §12, Financial Management.

7.1 GENERAL RULES

7.1.A Cost-Sharing

In accordance with Federal regulations at 42 C.F.R. § 438.108, the Contractor shall not impose any cost-sharing for services unless cost sharing exists under the Department's fee for service program. There are no cost sharing responsibilities for services to children under age 21, family planning services, or for services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy. Additionally, in accordance with 42 C.F.R. § 447.50 through 447.60, the Contractor shall not impose any cost sharing obligations on members for covered and non-covered services, except as set forth in 12 VAC 30-20-150 and 12 VAC 30-20-160. The Contractor may not impose co-payments on prescription drugs, as stated in Section 7.2.S.

The Contractor shall include a description of any member co-payment responsibility in the member handbook, and shall list the applicable co-payment information on the member identification card.

For the purposes of this Contract, the Contractor's decision to implement or change benefits must follow the same guidelines as listed in this Contract for enhanced benefits.

7.1.B Court-Ordered Services

The Contractor shall be liable for covering all covered, court-ordered services, in accordance with the terms set forth in this Contract. In the absence of an agreement otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.

7.1.C Coverage of Authorized Services

7.1.C.I The Contractor (the member's current MCO) shall assume responsibility for all managed care contract covered services authorized by the Department, its designee, or a previous MCO, which are rendered after the enrollment effective date, in the absence of a written agreement otherwise. The Contractor shall allow their new members who are transitioning from Medicaid fee-for-service to receive services from out-of-network providers if the member contacts the Contractor in advance of the service date and the member has an appointment(s) within the initial month of enrollment with a specialty physician(s) that was scheduled prior to the effective date of membership. For on-going services, such as home health, outpatient behavioral health, and outpatient rehabilitation therapies, etc.,

the Contractor (the member's current MCO) shall continue prior authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider.

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

7.1.C.III If the authorized service is an inpatient stay, the financial responsibility shall be allocated as follows: For per diem provider contracts, reimbursement will be shared between the Contractor and either the Department or the new MCO. In the absence of a written agreement otherwise, the Contractor and the Department or the new MCO shall each pay for the period during which the member is enrolled with the entity. This also applies to newborns hospitalized at the time of enrollment. For DRG provider contracts, in accordance with Section 12, the Contractor is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any member actively enrolled in the MCO on the date of admission, regardless of the members' disenrollment from the MCO during the course of the inpatient hospitalization.

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

7.1.D Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

7.1.D.I In accordance with 42 C.F.R. § 441 Subpart B (Sections 50 – 62), the Early and Periodic Screening Diagnosis, and Treatment (EPSDT) program is a comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislation and includes periodic screenings; and vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care services listed in Section 1905(a) of the Act be provided to an EPSDT member when the service is needed to correct or ameliorate a medical condition. Ameliorate is defined as necessary to improve or to prevent the condition from getting worse. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. The Department reports to CMS each April EPSDT screening information results.

7.1.D.II Nothing in this Contract shall require the Contractor to provide services and benefits which are specifically excluded under the program. EPSDT may provide additional benefits for children outside the basic Medicaid benefit package including, but not limited to, extended behavioral health benefits, nursing care (including private duty), pharmacy services,

treatment of obesity, neurobehavioral treatment, and other individualized treatments specific to developmental issues where it is determined that otherwise excluded services/benefits for a child is a medically necessary service that will correct, improve, or is needed to maintain (ameliorate) the child's medical condition.

7.1.D.III In addition to the traditional review for medical necessity, Medicaid children who are denied services that do not meet the plan's general coverage criteria must receive a secondary review to ensure that the EPSDTs provision has been considered. The Contractor's secondary review process for medical necessity must consider the EPSDT correct, maintain or ameliorate criteria. The Department must approve the Contractor's second review process for EPSDT prior to implementation or when requested. Denial for services to children cannot be given until this secondary review has been completed. The Contractor shall establish a process approved in advance by the Department which allows providers to contact case managers to explore alternative services, therapies, and resources for members when necessary. No service provided to a child under EPSDT can be denied as "non-covered", "out-of-network" and/or "experimental" unless specifically noted as a carved out service under this Contract. See Section 7.2.C "Clinical Trials as EPSDT" for additional information.

7.1.D.IV **Screenings -** Comprehensive, periodic health assessments, or screenings, from birth through age 20, at intervals as specified in the EPSDT medical periodicity schedule established by the Department and as required and indicated in the Screenings and Assessments provisions of this Contract. The medical screening shall include:

7.1.D.IV.a A **comprehensive health and developmental history**, including assessments of both physical and mental health development to include reimbursement for developmental screens (CPT 96110) rendered by providers other than the primary care provider.

7.1.D.IV.b A comprehensive **unclothed physical examination**, including:

7.1.D.IV.b(i) vision and hearing screening;

7.1.D.IV.b(ii) dental inspection;

7.1.D.IV.b(iii) nutritional assessment; and

7.1.D.IV.b(iv) The Contractor shall encourage pediatric primary care providers to incorporate the use of a standardized developmental screening tool for children consistent with the American Academy of Pediatrics (AAP) policy statements and clinical guidelines. AAP policy recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings should be documented in the medical record using a standardized screening tool. The Contractor shall not require any service authorization associated with the appropriate billing of these developmental screening services (e.g., CPT 96110) in accordance with AAP recommendations.

7.1.D.IV.c **Appropriate immunizations** according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination.

7.1.D.IV.d **Appropriate laboratory tests:** The following recommended sequence of screening laboratory examinations shall be provided by the Contractor; additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.

7.1.D.IV.d(i) hemoglobin/hematocrit

7.1.D.IV.d(ii) urinalysis

7.1.D.IV.d(iii) tuberculin test (for high-risk groups)

7.1.D.IV.d(iv) blood lead testing including venous and/or capillary specimen (fingerstick) in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. A blood lead test result equal to or greater that 10 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to The Virginia Department of Health, Office of Epidemiology.

7.1.D.IV.e **Health education/anticipatory guidance**

The Contractor shall work with the Department's EPSDT program and send lead notices to primary care providers whose patients who have been identified by the Department or the MCO as needing a blood lead screen.

7.1.D.IV.f Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

7.1.D.V **Vision Services**

Periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided according to the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

7.1.D.VI **Hearing Services**

All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Periodic auditory assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in the Department's EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids. Hearing screening shall mean, at a minimum, observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

7.1.D.VII Dental Screenings

An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her three-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral must be made for needed dental services.

The Contractor is not required to cover testing of fluoridation levels in well water.

7.1.D.VIII Dental Varnish

Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form shall be covered.

7.1.D.IX Tobacco Cessation Services

Medically-necessary tobacco cessation services, including both counseling and pharmacotherapy, for children and adolescents shall be covered by the Contractor. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when

medically necessary for individuals under age 21. (State Medicaid Director Letter, June 24, 2011 – page 4).

7.1.D.X Private Duty Nursing

The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department's criteria described in the DMAS EPSDT Nursing Supplement, and as required in accordance with EPSDT regulations described in 42 C.F.R. § 441.50, 42 C.F.R. § 440.80, and the Social Security Act §§1905(a) and 1905(r) I.

Members who may qualify for PDN include members who require continuous nursing that cannot be met through home health. Under EPSDT PDN, the member's condition warrants continuous nursing care including but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT PDN differs from home health nursing which provides for short-term intermittent care where the emphasis is on member or caregiver teaching. Examples of members that may qualify for PDN coverage include but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention. Another example of members who may qualify for PDN includes members waiting to be screened for the Technology Assisted Waiver.

While the Contractor may utilize its own criteria for medical necessity determination for most covered services, since there are no nationally recognized published criteria for EPSDT PDN, the Contractor shall use the Department's criteria, as described in the DMAS EPSDT Nursing Supplement when determining the medical necessity for PDN services. The Contractor may use an alternate assessment instrument, if desired, which must be approved by the Department. However, the Department's established coverage guidelines must be used as the basis for the amount, duration, and scope of the PDN benefit.

7.1.D.XI Other

7.1.D.XI.a Other medically necessary health care, diagnostic services, treatment, and measures as needed to correct or treat defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's current level of functioning or to prevent the child's medical condition from getting worse including, but not limited to private duty nursing.

7.1.D.XI.b The Contractor shall inform members about EPSDT services.

7.1.D.XI.c EPSDT services shall be subject to all the Contractor's documentation requirements for its network provider services. EPSDT

services shall also be subject to the following additional documentation requirements:

7.1.D.XI.c(i) The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule and all EPSDT related services whether provided by the PCP or another provider.

7.1.D.XI.c(ii) Documentation of a comprehensive screening shall, at a minimum, contain a description of the components described herein.

7.1.D.XI.d The Contractor shall assure that a participating child is periodically screened and treated in conformity with the periodicity schedule. To comply with this requirement, the Contractor shall design and employ policies and methods to assure that children receive prescreening and treatment when due. If the family requests assistance with transportation and scheduling to receive services, the Contractor is to provide this assistance.

7.1.D.XI.e The Contractor shall incorporate EPSDT requirements such as lead testing and developmental screenings in its quality assurance activities. The Contractor must implement interventions/strategies to meet the following criteria.

7.1.D.XI.e(i) Childhood Immunization rates must meet requirements pursuant to Section 8.

7.1.D.XI.e(ii) Well-child rates in all age groups must meet requirements pursuant to Section 8.

7.1.D.XI.e(iii) Lead testing rates must meet requirements pursuant to Section 8.

7.1.D.XI.e(iv) Increase percentage of lead testing of 1-5 year olds for prior contract year.

7.1.D.XI.e(v) Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).

7.1.D.XI.e(vi) Each MCO will follow a long-term improvement plan not to exceed five (5) years to increase EPSDT levels.

7.1.D.XI.f When a developmental delay has been identified by the provider, the Contractor shall ensure appropriate referrals are made and documented in the member's records.

7.1.D.XI.g Case management services for infants up to age two (2) are required as set forth in 12 VAC 30-50-280 through 510, to include:

7.1.D.XI.g(i) Case management services for all newborns/infants admitted to the NICU (Nursery Level 3/NICU) for neonatal intensive care

EPSDT requires that all medically necessary services for children needed to correct, ameliorate, or maintain health status shall be covered by the Contractor.

7.1.E Early Intervention Services

See Section 7.5.B.

7.1.F Medical Necessity

The Contractor shall cover all medically necessary services, as defined in this Contract, and in accordance with 42 C.F.R. § 440.230, State Plan for Medical Assistance (State Plan), as amended and as further defined by written Department policies (including agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. The actual provision of any service is subject to the professional judgment of the Contractor's providers as to the medical necessity of the service, except in situations in which the Contractor must provide services ordered by the Department pursuant to an appeal from the Contractor's grievance process or an appeal directly to the Department by a member or for emergency services as defined in this Contract. Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness and the application of EPSDT criteria (for those under age 21). Disputes between the Contractor and members about medical necessity may be appealed to the Department by the member or the member's representative.

7.1.G Modification in Scope of Covered Services During a Contract Year

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

7.1.H Moral or Religious Objections

In accordance with 42 C.F.R. § 438.102 the Contractor shall not be required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds in accordance with all of the following guidelines:

Information Requirements – The Contractor must furnish information about the services it does not cover:

7.1.H.I To the Department:

- 7.1.H.I.a With the initiation of the Contract, whenever changes are made, and upon request.
- 7.1.H.I.b Upon adoption of such policy in the event that the Contractor adopts the policy during the term of the Contract.

7.1.H.II To potential members, before and during enrollment.

7.1.H.III To members, within 30 days before the effective date of this policy.

7.1.I Notification to the Department of Sentinel Events

The Contractor shall maintain a system for identifying and recording any member's sentinel event. The Contractor shall provide the Department or its Agent with reports of sentinel events upon discovery. See the Managed Care Technical Manual for details.

7.1.J Out-of-Network Services

7.1.J.I The Contractor shall cover and pay for all care that it has pre-authorized and provided out of its established network. Out-of-network claims must

be paid in accordance with the Medicaid fee schedule in place at the time the service was rendered or at another fee negotiated between the Contractor and the provider of services.

7.1.J.II The Contractor shall cover and pay for emergency and family planning services rendered to a member by a non-participating provider or facility, as set forth elsewhere in this Contract.

7.1.J.III The Contractor shall cover, pay for, and coordinate care, rendered to members by out-of-network providers when the member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract.

7.1.J.IV The Contractor shall cover and pay for services furnished in facilities or by practitioners outside the Contractor's network if the needed medical services or necessary supplementary resources are not available in the Contractor's network.

7.1.J.V The Contractor must provide coverage out-of-network for any of the following circumstances:

7.1.J.V.a When a service or type of provider (in terms of training, experience, and specialization) is not available within the MCO's network,

7.1.J.V.b Where the MCO cannot provide the needed specialist within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas,

7.1.J.V.c For members other than those residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the Contractor must provide coverage out-of-network for up to 30 days to transition the member to an in-network provider when a provider that is not part of the MCOs network has an existing relationship with the beneficiary, is the beneficiary's main source of care, and has not accepted an offer to participate in the MCOs network,

7.1.J.V.d When the type of provider needed and available in the MCOs network does not, because of moral or religious objections, furnish the service the member seeks,

7.1.J.V.e When DMAS determines that the circumstance warrants out-of-network treatment.

7.1.J.VI In addition to a – e above, for members residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, per 42 C.F.R. § 438.52(b)(2)(B), the Contractor shall provide out-of-network coverage in all of the following circumstances:

7.1.J.VI.a Where a provider is not a part of the Contractor's network, but is the main source of a service to the member, provided that:

7.1.J.VI.a(i) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO network as other network providers of that type;

7.1.J.VI.a(ii) If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the member will be given the opportunity to transition to a participating provider

within 60 days (after being given the opportunity to select a provider who participates);

7.1.J.VI.b The member's primary care provider or other provider determines that the member needs related services that would subject the member to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.

7.1.K Out-of-State Services

The Contractor is not responsible for services obtained outside the Commonwealth <u>except under any of the following circumstances</u>:

7.1.K.I Necessary emergency or post-stabilization services,

7.1.K.II Family planning where it is a general practice for members in a particular locality to use medical resources in another State,

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

7.1.K.IV While the MCO is honoring a transition of care plan authorized by the Contractor, another MCO, or the Department until services can be safely and effectively transitioned to a provider in the MCO's network within the Commonwealth.

7.1.K.V 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).

7.1.L Pharmacy Utilization Management Program for Members

The Contractor must provide written notification to the Department at least 90 days prior to its implementation of a beneficiary pharmacy program to proactively manage misuse or abuse by members of prescription drug benefits. Such notice shall include applicable policies and procedures. The Contractor shall provide appeals rights, including the right to request a State Fair Hearing, to any member included in the program.

If the Contractor has established a pharmacy management program, the following criteria will be required:

7.1.L.I Allow choice of pharmacy by individual (if one is not selected, the health plan may select one for them);

7.1.L.II Provisions for emergency after hours prescription if their pharmacy does not have 24-hour access;

7.1.L.III Provide appeal and state fair hearing rights to allow the individual to appeal being in the pharmacy management program.

7.1.L.IV The Contractor will report a detailed summary on a Monthly basis (see Managed Care Technical Manual).

7.1.M Primary Care (Provider) Management Program

A primary care (provider) management program is a program that may be instituted by the MCO, which is designed to promote proper medical management of essential health care,

and at the same time, promote cost efficiency. If the Contractor has established a primary care management program, the following criteria are required:

7.1.M.I Allow choice of primary care by individual (if one is not selected, the health plan may select one for them);

7.1.M.II Provide appeal and state fair hearing rights to allow the provider to appeal being in the primary care management program.

7.1.M.III The Contractor will report a detailed summary on a monthly basis (seethe Managed Care Technical Manual).

7.1.N Second Opinions

The Contractor shall provide coverage for a second opinion when requested by the member for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. The Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the member to obtain one outside the network, at no cost to the member. The Contractor may require an authorization to receive specialty care for an appropriate provider; however, cannot deny a second opinion request as a non-covered service.

7.1.O At-Risk Populations

7.1.O.I Protection of Children and Aged or Incapacitated Adults

Suspected or Known Child Abuse or Neglect - The Contractor shall report immediately upon learning of any suspected or known abuse of a child to the local Department of Social Services in the county or city where the child resides or where the abuse or neglect is believed to have occurred or to the Virginia Department of Social Services' toll-free child abuse and neglect hotline:

In Virginia: (800) 552-7096
Out-of-state: (804) 786-8536
Hearing-impaired: (800) 828-1120

Suspected or Known Abuse of Aged or Incapacitated Adults – In accordance with Section 63.2-1606 of the Code of Virginia, the Contractor shall report immediately upon learning of any suspected or known abuse of aged or incapacitated adults to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline at:

(888) 832-3858.

7.1.O.II Member Assessment (Aged/Blind/Disabled - ABD)

Refer to Section 7.7 " Assessments & Annual Plan for Aged & Disabled Members."

7.1.O.III Children with Special Healthcare Needs (CSHCN), Foster Care & Adoption Assistance Individuals

The Contractor shall make every reasonable effort to assure that Children with Special Health Care Needs, Foster Care children, and Adoption Assistance children receive a visit to their assigned primary care provider within 60 calendar days of enrollment with the Contractor.

The Contractor must develop and maintain a system of policies and procedures for identifying children with special health care needs, including children with disabilities or chronic or complex medical and behavioral health conditions including obesity. These policies and procedures should be submitted to the Department upon creation and thereafter when changed or upon request by the Department.

In the event that the Contractor is not successful in having its enrolled children with Special Health Care Needs visit the child's PCP, the Contractor shall communicate to the child/family, in a format which has been approved in advance by the Department, advising that the member is due for a visit to receive an assessment or for a specific service (immunization, well-child visit, etc.).

Children with Special Health Care Needs must be assessed by the Contractor in the following manner:

7.1.O.III.a **Identification -** Children with Special Health Care Needs (CSHCN) include children under age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. CSHCN consist of at a minimum, children in the eligibility category of SSI, children identified as Early Intervention (Part C) participants, Foster care or Adoption Assistance (includes any individuals who have been enrolled in a particular health plan under a non-disabled or Foster Care/Adoption Assistance when the individual becomes enrolled in a disabled or Foster Care/Adoption Assistance) and others as identified through the Contractor's assessment or by DMAS.

7.1.O.III.b **Assessment and Referral -** In accordance with 42 C.F.R. § 438.208(c) I, the Contractor shall make a best effort to conduct an assessment of all CSHCN, as identified and reported by the Department, within 60 calendar days of enrollment and at least once every year thereafter.
Such assessment should include the application of screening procedures/instruments for all new members. Assessment should include review of physician, hospital, and pharmacy utilization, providing referral policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for members to self-refer for a needs assessment. The

Contractor shall provide a monthly report to the Department detailing and confirming by identification number the number of completed assessments. The Contractor shall provide copies of completed assessments upon request. The Contractor shall provide, prior to signing the initial contract, upon revision, or on request, to the Department a copy of the detailed policies and procedures of the Contractor's assessment mechanism. This mechanism must reflect the utilization of appropriate health care professionals and must identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.

The Contractor shall assess the quality of care of CSHCN in the following areas:

7.1.O.III.b(i) **Program Development** – Involve stakeholders, advocates, providers, and/or consumers, as applicable, in creating a program to support families of children with disabilities.

7.1.O.III.b(ii) **Enrollment Procedures** – Identify and collect data on children with special needs through surveys to assess the quality, appropriateness of, experience of, and satisfaction with care provided to children and adolescents with special health care needs. The Children with Chronic Conditions Satisfaction Survey described in Section 8 (CAHPS – Child Supplemental Questions) is sufficient in meeting this Satisfaction survey requirement.

7.1.O.III.b(iii) **Provider Networks** – Assure the availability of providers who are experienced in serving children with special needs and provide a "medical home" that is accessible, comprehensive, coordinated, and compassionate.

7.1.O.III.b(iv) **Care Coordination** – Provide care coordination for CSHCN among the multiple providers, agencies, advocates, and funding sources serving CSHCN.

7.1.O.III.b(v) **Access to Specialists** – The Contractor shall have a mechanism in place for members determined to have ongoing special conditions that require a course of treatment or regular care monitoring, that allows the member direct access to a specialist through a standing referral or an approved number of visits as appropriate for the member's condition and identified needs.

7.1.O.III.c **Assurance of Expertise for Child Abuse and Neglect and Domestic Violence**

The Contractor shall arrange for the provision of examination and treatment services by providers with expertise, capability, and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse, neglect, and domestic violence. Such expertise and capability shall include the ability to identify possible and potential victims of child abuse, neglect, and domestic violence and demonstrated knowledge of statutory reporting

requirements and local community resources for the prevention and treatment of child abuse and neglect and domestic violence. The Contractor shall include such providers in its network. The Contractor shall utilize human services agencies or appropriate providers in their community.

The Contractor shall notify all persons employed by or under contract to it who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. The Contractor assures that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

7.1.O.III.d **Case Management**

The Contractor is responsible for establishing policy and procedures which facilitate provider contact with medical management staff to explore alternative resources and services for members with special health care needs. Case managers serving children with special health care needs and children requiring special assistance shall assist these members in scheduling appointments, providing referrals to appropriate medical providers, offering assistance in identifying resources, other appropriate treatment options, referrals to resources, and shall make contact with the member or his family on a regular basis. The Contractor shall assess, and provide if necessary, members' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services."Hand to hand" service includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported "hand-to-hand."

7.1.O.IV Foster Care Workgroup

The Contractor shall work collaboratively with the Department in meeting the federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care.

7.1.P Utilization Management/Authorization Program Description

The Contractor must have a written utilization management (UM) program description which includes procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical services. In accordance with 42 C.F.R. § 438.210, the Contractor's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate. The program shall demonstrate that members have equitable access to

care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the members.

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

The Contractor shall use the Department's service authorization criteria or other medically-sound, scientifically based criteria in accordance with national standards in making medical necessity determinations. Contractor criteria shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department.

In accordance with 42 C.F.R. § 438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. Additionally the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. In accordance with 42 C.F.R. § 438.210(c), the Contractor shall notify the requesting provider, and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements outlined in Section 7.1 of this Contract.

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

7.1.P.I **Standard Authorization Decisions** – For standard authorization decisions, the Contractor shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if: the member or the provider requests extension; or the Contractor justifies to the Department upon request that the need for additional information per 42 C.F.R. 438.210. (d)(1)(ii) is in the members interest.

7.1.P.II **Expedited Authorization Decisions** - For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life 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 member's health condition requires and no later than three (3) working days after receipt of the request for service.

The Contractor may extend the three (3) working days turnaround time frame by up to fourteen (14) calendar days if the member requests an

extension or the Contractor justifies to the Department a need for additional information and how the extension is in the member's interest.

If the Contractor delegates (subcontracts) responsibilities for UM with a subcontractor, the Contract must have a mechanism in place to ensure that these standards are met by the subcontractor. The UM Plan shall be submitted to DMAS prior to signing original contract, upon revision, upon request, & as needed**.**

The Contractor must ensure that the preauthorization requirements do not apply to emergency care, family planning services, preventive services, and basic prenatal care. Reference Section 7.2.S for provisions regarding authorizations for prescription drugs.

The Contractor (the member's current MCO) shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in this Section of this Contract.

7.2 COVERED SERVICES

The Contractor shall provide, arrange for, purchase or otherwise make available the full scope of services, with the exception of the carved-out services defined in Section 7.5 and other exceptions noted herein to which persons are entitled under the State Plan for Medical Assistance (State Plan), as amended, and as further defined by written Department policies (including, but not limited to, agreements, statements, provider manuals, Medicaid memorandums, instructions, or memoranda of understanding) and all applicable State and Federal regulations, guidelines, transmittals, and procedures. Brief descriptions of covered services are provided herein.

In no case shall the Contractor establish more restrictive benefit limits for medically necessary services than those established by Medicaid as defined in the State Plan and other documents identified above. The Contractor shall manage service utilization through utilization review, service authorization, and case management, but not through the establishment of benefit limits for medically necessary services that are more restrictive than those established by Medicaid. In accordance with 42 C.F.R. § 438.210, the Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

Coverage decisions that depend upon service authorization and/or concurrent review to determine medical necessity must be rendered in accordance with the requirements described in this Contract.

The Contractor shall assume responsibility for all covered medical conditions of each member as of the effective date of coverage under the Contract, regardless of the date on which the condition arose. The Contractor shall cover all pre-existing conditions. This responsibility for

all covered medical conditions shall not apply in the case of persons temporarily excluded from enrollment due to hospitalization.

7.2.A Behavioral Health & Substance Abuse Treatment Services (BHS)

7.2.A.I Traditional & Non-Traditional Behavioral Health Service Categories

Coverage responsibility for Behavioral Health and Substance Abuse Treatment Services (BHS) is shared by the Contractor and the Department's Behavioral Health Services Administrator (BHSA), within two categories of service: 1) traditional and 2) non-traditional. The Contractor shall cover traditional BHS, including: inpatient, outpatient (individual, family, and group) therapies, and temporary detention and emergency custody order services. The Department's BHSA provides coverage for non-traditional, community mental health rehabilitation services (for MCO and fee-for-service enrolled members).

7.2.A.I.a Traditional Behavioral Health Services –

The Contractor shall cover all of the following traditional behavioral health and substance abuse treatment services within Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001; available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.):

7.2.A.I.a(i) **Inpatient Behavioral Health Services:**

Inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all eligible members regardless of the age of the member, as set forth in 12 VAC 30-50-100. The Contractor shall cover all medically necessary services rendered in freestanding psychiatric hospitals to members up to twenty-one (21) years of age and members over sixty-four (64) years of age. The Contractor shall cover inpatient substance abuse treatment services for children under age 21 when medically necessary in accordance with EPSDT criteria.

The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements. If a member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the Contractor and reimbursed by the Contractor as an enhanced service, that member will be excluded from managed care participation, effective one day prior to admission. See also Section 7.5 "Carved Out & Excluded Services."

All inpatient mental health admissions shall be approved by the Contractor using its own service authorization criteria, consistent with the guidelines described in Section 7.2.I. of this Contract.

7.2.A.I.a(ii) **Outpatient Behavioral Health and Substance Abuse Treatment Services (Traditional Individual, Family, and Group Therapies)**

The Contractor shall provide coverage for medically necessary outpatient individual, family, and group behavioral health and substance abuse treatment services for children, adolescents, and adults, except for carved out non-traditional, community based BHS.

7.2.A.I.a(iii) **Temporary Detention Order (TDO)**

Pursuant to 42 C.F.R. § 441.150, the *Code of Virginia*, § 16.1-335 et seq. and § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age 21 through 64 **and** admitted to a freestanding facility. The MCO is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the client is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services**. The duration of temporary detention shall be in accordance with the *Code of Virginia*, as follows:**

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

or private facility certified by the State Board of Behavioral Health and Developmental Services.

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

Coverage for services for members admitted to a freestanding psychiatric facility under a TDO will be handled as follows:
If the individual is under age 21 or over age 64, and the member goes into private freestanding IMD for a TDO, the MCO is responsible for the TDO. If the individual remains admitted to the IMD after the TDO expires, the MCO is responsible for the psychiatric stay. Following expiration of the TDO, the MCO can require that the individual transfer to a network facility.

If the individual is under age 21 or over age 64, and the member goes into a State freestanding IMD for a TDO, the MCO is responsible for the TDO. If the individual remains admitted to the State IMD after the TDO expires, the member is disenrolled from the MCO on the expiration of the TDO and FFS is responsible for the State facility psychiatric stay.

For individuals age 21 through 64, where the member goes into private freestanding IMD for a TDO, providers should submit the TDO claim to the state TDO program. The individual will remain enrolled with the MCO beyond the TDO timeframe. The MCO will manage the individuals treatment needs beyond the TDO timeframe and can require that the individual transfer to a network facility.

For individuals age 21 through 64, where the member goes into a State freestanding IMD for a TDO, providers should submit the TDO claim to the State TDO program. Coverage beyond the TDO timeframe in a State facility for individuals age 21 through 64 is not a covered benefit. The MCO should transition the individual to a network facility where possible. Otherwise, the individual will lose Medicaid benefits for the period in which they are institutionalized in an IMD**.**

When an out-of-network provider provides TDO services, the Contractor shall be responsible for reimbursement of these services. In the absence of an agreement 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.

Following the expiration of the TDO, if it is determined by the judge, as the result of a hearing, that the member may be transferred without medically harmful consequences, the Contractor may designate an appropriate in-network or out-of-network facility for the provision of care. Utilization review for medical necessity for meeting continued, acute care stay criteria is appropriate after the TDO for Mental Health Services has been concluded. The Contractor shall cover TDO in accordance with Medicaid timely filing requirements which are for one year from the date of the TDO.

In the event that an MCO-enrolled member between 21 and 64 is admitted to a freestanding psych facility under a TDO, the MCO will be responsible for reimbursing transportation to the facility.

7.2.A.I.a(iv) **Emergency Custody Orders (ECO)**

Pursuant to the *Code of Virginia*, § 16.1-335 et seq. (minors) and § 37.2-800 et. seq. (adults), and the 2014 Virginia Acts of Assembly, Chapter 691,, the Contractor shall provide and be responsible for coverage of medically necessary screenings, assessments, and treatment services, as covered under this Contract, for members who are under an emergency custody order.

7.2.A.I.b **Non-Traditional Behavioral Health Services (Carved-Out)**

Non-traditional BHS, including community mental health rehabilitation and substance abuse treatment services (CMHRS), are managed through the Department's Behavioral Health Services Administrator within the Department's established coverage criteria and guidelines. Reference details for non-traditional, BHS in the Carved-Out Services section of this contract. Additional information is also available on the BHSA website, http://www.MagellanofVirginia.com, and in the Department's appropriate provider service manual (manuals governing Behavioral Health include: "Children's Mental Health Program," "Community Mental Health-Rehab Services," "Mental Health Clinic," and "Psychiatric Services."), available on the DMAS web-portal (under the provider services tab) at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

7.2.A.I.b(i) **Contractor Coverage for Carved-Out Related Services**

The Contractor shall provide coverage for transportation and pharmacy services necessary for the treatment of behavioral health and substance abuse conditions, including for carved out services. The contractor shall provide coverage for opioid drugs in instances where the member obtains such drugs through a pharmacy. If the opioid medication is administered by a substance abuse treatment provider as part of an opioid treatment program, where the substance abuse treatment provider obtains the drugs for the member, such drugs shall be considered carved-out of this contract and shall be covered by the Department as part of opioid treatment, and in accordance with the Department's coverage criteria and guidelines.

7.2.A.II Virginia Independent Clinical Assessment Program (VICAP)

The Contractor shall honor the treatment recommendation for behavioral health services as determined medically necessary by the Independent Clinical Assessment (ICA) until such time that the Contractor completes its own medical necessity review. The Department's BHSA requires the ICA to be conducted by a Community Services Board (CSB) or Behavioral Health Authority (BHA) in order for children to access certain CMHRS. The ICA may be expanded to include additional programs and expanded age groups as determined by the Department or its BHSA. The services for which an ICA is currently include: Intensive In-Home (IIH), Therapeutic Day Treatment (TDT), and Mental Health Skill-building Services (MHSS). Levels A and B Group Home Services also require an assessment by an independent team through Comprehensive Services Act (CSA) or the CSB: a certification of need must be completed. Children and adolescents who are being discharged from residential treatment (DMAS Levels A, B, or C) or an inpatient psychiatric hospitalization do not need an ICA to access IIH, TDT, or MHSS, but are required to have an ICA as part of the first service reauthorization.

The Contractor must have a process in place to appropriately refer children for an ICA as necessary. Referrals for the ICA should be made to the local CSB or CSA. Members, or the MCO case manager on the member's behalf, may contact the BHSA's Member Services for assistance as needed, at 1-800-424-4046. Additionally, the Contractor shall be responsible for providing transportation for these services as needed.

The Independent Assessor will evaluate the child and will make a treatment recommendation, for the type(s) and level(s) of service(s) determined to be medically necessary and appropriate. The recommended service(s) may include inpatient or outpatient behavioral health services as covered through the Contractor. Upon completion of the ICA, the assessor will inform the member's parent or guardian of the recommended

treatment. If the recommended treatment falls within MCO coverage, the assessor will refer the member to contact their MCO member services department for assistance in accessing the recommended treatment. If the recommended treatment is carved-out of the MCO contract, the member is provided with a list of treatment providers in their area. The Department and its BHSA are in the process of evaluating the quality and effectiveness of the current VICAP program. A work group is being developed to obtain input and recommendations for program enhancements from involved stakeholders.

7.2.A.III Community Mental Health Rehabilitation Services (CMHRS) Data Sharing

The Department will provide community mental health services authorization and claims payment data to the Contractor on a monthly basis. Details on these reports are described in Section 4.1 of the Managed Care Technical Manual. Although CMHRS are carved-out from the MCO contract, this information is provided to help identify recipients who may need additional behavioral health services or referral to an MCO behavioral health case manager.

7.2.A.IV Behavioral Health Services Administrator (BHSA)

The 2011, 2012, 2013 Acts of Assembly directed the Department to implement a coordinated care model for individuals in need of behavioral health services that are not currently provided through a managed care organization. In addition, the 2013 *Acts* of *Assembly*, Chapter 806 identifies expectations that there exist "direct linkages" between medical and behavioral services that makes it easier for consumers to obtain timely access to needed care and services. Pursuant to this directive, in December 2011, the Department solicited proposals from interested Behavioral Health Services Administrators (BHSA). The Department's BHSA assumed the role effective December 1, 2013. The BHSA manages the full spectrum of behavioral health and substance abuse treatment services (traditional and non-traditional) to members who are not enrolled in managed care, and the subset of "non-traditional" BHS that are carved-out of this contract for MCO enrolled members.

7.2.A.V Coordination with the BHSA

Management of the Department's behavioral health benefits is shared by the Contractor and the Department's BHSA. Therefore, the Contractor and the BHSA shall work together closely and cooperatively to coordinate services in a manner that fully supports timely access to appropriate person-centered services through a seamless continuum of care that is based on the individual clinical needs of the member. Care coordination opportunities between the Contractor and the BHSA shall include, but are not limited to, the following circumstances:

- Facilitating the effective transition for members that move between fee-for-service and MCO enrollment with the Contractor,
- Enabling the smooth transition for members that move between levels of care as managed by the Contractor and the BHSA, and
- Facilitating efficient and effective continuity of care for members in need of or receiving services concurrently through the Contractor and the Department's BHSA.

7.2.A.V.a **In addition to the requirements above, all the following shall apply:**

7.2.A.V.a(i) The Contractor and the BHSA shall provide the names and contact information for a primary and back-up behavioral health care coordinator for use by the Department, the BHSA, and the Department's contracted MCOs as necessary for care coordination purposes.

7.2.A.V.a(ii) The Contractor and the BHSA shall assure reasonable efforts to share clinically relevant information for care coordination purposes in a manner that complies with State and Federal confidentiality regulations, including:

7.2.A.V.a(ii)(1) HIPAA regulations at 45 CFR parts 160-164, allowing for the exchange of clinically relevant information for care coordination of services (i.e., without the need of a patient release of information form), and

7.2.A.V.a(ii)(2) Federal regulations at 42 CFR §2.31(a) pertaining to substance abuse preventing and treatment services, which requires member consent, and where such consent must include the member's name, the description of the information to be disclosed, the identity of the person or class of persons who may disclose the information and to whom it may be disclosed, a description of the purpose of the disclosure, an expiration date for the authorization, and the signature of the person authorizing the disclosure. [Member consent is not required in instances related to "public interest," when required by law (court-ordered warrants, law enforcement); when appropriate to notify authorities about victims of abuse, neglect, or domestic violence; and, when necessary to prevent or lessen serious and imminent threat to a person or the public, where information shared must be limited as needed to accomplish the purpose.]

7.2.A.V.a(iii) The Contractor and the Department's BHSA shall honor service authorizations issued by one another for services, in accordance with each entity's (Contractor's and BHSA's) contract with the Department, and shall ensure continuation of the authorized services without interruption until the responsible entity (Contractor/ BHSA) completes its own medical necessity review.

7.2.A.V.a(iv) The Contractor shall assure that it has processes in place to refer members seeking services covered through the BHSA to the Department's BHSA, offering special assistance when necessary. Conversely, the Department's BHSA is required to have referral processes in place as needed, to refer members seeking services covered through the Medallion 3.0 contract to the member's MCO as appropriate. These referral processes include hands-on assistance as needed for members with special medical or behavioral health needs, high-risk cases, and other circumstances as warranted. (Examples include, but are not limited to: warm transfer of telephone calls from members to the correct entity and collaborative discussions between the member's BHSA and MCO care managers.

The Contractor shall assure that it has processes in place to receive referrals for services covered under this contract from the Department's BHSA. Conversely the BHSA is required to assure that it has appropriate procedures in place for receiving referrals from the member's MCO.

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

7.2.A.VI Behavioral Health Network

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

7.2.B Clinic Services

The Contractor shall cover clinic services which are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients, as set forth in 12 VAC 30-50-180. With the exception of certified nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.

7.2.C Clinical Trials as EPSDT

Clinical Trials are considered under EPSDT when no acceptable or effective standard treatment is available for the child's medical condition and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.

7.2.D Colorectal Cancer Screening

The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

7.2.E Dental and Related Services

7.2.E.I Services Covered Under Medical

Under the terms of this Contract, the Contractor shall not cover routine dental services, which are provided by a dental benefits administrator (DBA). The Contractor shall assure it has processes in place to refer members seeking routine dental services to the dental contractor. The Contractor shall be responsible for transportation and medication related to covered dental services. The Contractor

will be responsible for medically necessary procedures of the mouth for adults and children, including but not limited to, the following:

7.2.E.I.a CPT codes billed for dental services performed as a result of a dental accident;

7.2.E.I.b Medically necessary procedures for adults and children, including but not limited to: cleft palate repair, 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.

7.2.E.II Hospitalization and Anesthesia Related Services

In accordance with § 38.2-3418.12 of the Code of Virginia, the Contractor shall cover anesthesia and hospitalization for medically necessary dental services. The Contractor shall work with the DMAS DBA to coordinate coverage for these services as follows:

7.2.E.II.a Coverage is required for children under the age of 5, persons who are severely disabled, and persons who have a medical condition that require admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the covered person's treating physician, that such services are required to effectively and safely provide dental care.

7.2.E.II.b The Contractor shall designate a liaison (by name, phone number, and email address) and a back-up to work collaboratively with the Department's DBA and to assure that the required authorizations are handled timely and in accordance with the provisions described below.

7.2.E.II.c Authorizations for these services shall be handled as follows:

7.2.E.II.c(i) The dental service provider must submit the request for authorization directly to the DBA;

7.2.E.II.c(ii) If the DBA reviews the request for dental related hospitalization and/or anesthesia based upon medical necessity;

7.2.E.II.c(iii) If the DBA approves the request, the DBA coordinates anesthesia and hospitalization authorization for Dental Services with the Contractor and within the Contractor's provider network.

7.2.E.II.c(iv) The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA. The Contractor shall respond in writing via facsimile (262) 834-3575 to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request.

If the Contractor disagrees with the DBA's decision for medical necessity, the Contractor may appeal within two (2) business days of notification by the DBA of the authorization. The appeal must be made directly with the Department's Dental Benefit Manager. The Department's decision shall be final and shall not be subject to further appeal by the Contractor. The Department's decision,

however, does not override any decisions made as part of the member's State Fair Hearing Process as described in Section 10 of this Contract.

7.2.F Durable Medical Equipment (DME)

All medically necessary medical supplies and equipment shall be covered as set forth in 12 VAC 30-50-165. The Contractor shall provide a secondary review for children for denied services in accordance with EPSDT review requirements.

Any specialized DME authorized by the Contractor will be reimbursed by the Contractor, even if the member is no longer enrolled with the plan or with Medicaid. For a complete listing of Medicaid covered medical supplies and equipment refer to the Durable Medical Equipment (DME) and Supplies Appendix B of the Medicaid DME Provider Manual, as amended.

Retraction of the payment for specialized equipment can only be made if the member is retroactively disenrolled for any reason by the Department and the effective date of the retroactively disenrollment precedes the date the equipment was authorized by the Contractor. The Department and all Contractors must use the valid preauthorization begin date as the invoice date. Specialized equipment includes, but is not limited to, the following:

7.2.F.I Customized wheelchairs and required components;
7.2.F.II Customized prone standers; and,
7.2.F.III Customized positioning devices.

The Contractor shall cover supplies and equipment necessary to administer enteral nutrition. See Section 7.2.M "Nutritional Supplements and Supplies."

7.2.G Emergency Services

The Contractor shall cover emergency and post stabilization services rendered by qualified participating or non-participating providers after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

7.2.G.I Placing the member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
7.2.G.II Serious impairment to bodily functions; or,
7.2.G.III Serious dysfunction of any bodily organ or part.

In accordance with 42 C.F.R. § 438.114, the Contractor shall ensure that all covered emergency services are available, without requiring service authorization, twenty-four (24) hours a day and seven (7) days a week through the Contractor's network.

In accordance with 42 C.F.R. § 438.114, the Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Additionally the Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the Contractor of the member's screening and treatment within ten (10) calendar

days of presentation for emergency services. Title 42 C.F.R. § 438.114 further requires that a member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The Contractor may not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the "prudent layperson" standard, as defined herein, was in fact non-emergency in nature.

In accordance with Section 1867 of the Social Security Act, hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care, regardless of their insurance status or other personal characteristics. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize that condition. A hospital may not transfer a patient in an unstabilized emergency condition to another facility unless the medical benefits of the transfer outweigh the risks, and the transfer conforms to all applicable requirements.

When emergency services are provided to a member of the Contractor, the organization's liability for payment is determined as follows:

7.2.G.IV Presence of a Clinical Emergency - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition exists, the Contractor must pay for both the services involved in the screening examination and the services required to stabilize the patient.

7.2.G.V Post Stabilization Care - The Contractor shall pay for all emergency services which are medically necessary until the clinical emergency is stabilized and until the patient can be safely discharged or transferred. This shall include payment for post stabilization care; or services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. Coverage shall include treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.

If there is a disagreement between a hospital and the Contractor concerning whether the member is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its own physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member.

Coverage and payment for post stabilization care services must be in accordance with provisions set forth in 42 C.F.R. § 422.113(c), as described below.

7.2.G.V.a Coverage - The Contractor shall cover post-stabilization care services that are:

7.2.G.V.a(i) Pre-approved by a plan provider or the MCO;

7.2.G.V.a(ii) Not pre-approved by a plan provider or the MCO, but administered to maintain the member's stabilized condition within 1 hour of a request to the MCO for pre-approval of further post-stabilization care services;

7.2.G.V.a(iii) Not pre-approved by a plan provider or the MCO, but administered to maintain, improve, or resolve the member's stabilized condition if:

7.2.G.V.a(iii)(1) The MCO does not respond to a request for pre- approval within 1 hour;

7.2.G.V.a(iii)(2) The MCO cannot be contacted; or

7.2.G.V.a(iii)(3) The MCO and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the member until a plan physician is reached or until one of the criteria listed in number 2 below is met.

7.2.G.V.b Payment - In accordance with 42 C.F.R. § 422.113 (c), the Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

7.2.G.V.b(i) A plan physician with privileges at the treating hospital assumes responsibility for the member's care;

7.2.G.V.b(ii) A plan physician assumes responsibility for the member's care through transfer;

7.2.G.V.b(iii) The Contractor and the treating physician reach an agreement concerning the member's care; or,

7.2.G.V.b(iv) The member is discharged.

7.2.G.VI **Absence of a Clinical Emergency** - If the screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the Contractor shall pay for all services involved in the screening examination if the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the "prudent layperson" standard, as defined herein. If a member believes that a claim for emergency services has been inappropriately denied by the Contractor, the member may seek recourse through the MCO or State appeal process.

7.2.G.VII **Referrals** - When a member's primary care physician or other plan representative instructs the member to seek emergency care in-network or out-of-network, the MCO shall be responsible for payment for the medical screening

examination and for other medically necessary emergency services, without regard to whether the patient meets the "prudent layperson" standard, as defined herein.

The Contractor shall cover those medical examinations performed in emergency departments for enrolled children as part of a child protective services investigation. In the absence of an agreement otherwise, these services shall be reimbursed at the applicable Virginia Medicaid fee-for-service program rate in effect at the time the service was rendered.

The Contractor may require that continuing care, following the conclusion of an emergency, be obtained from a network provider or another health care provider specified by the Contractor. An emergency shall be deemed to have concluded at such time as the member can, without medically harmful consequences, travel or be transported to an appropriate Contractor facility or to such other facility as the Contractor may designate.

In the absence of an agreement or otherwise, all claims for emergency services shall be reimbursed at the applicable Medicaid fee-for-service program rate in effect at the time the service was rendered. Required payments for emergency services are summarized in the table below and in 12 VAC 30-50-300, 12 VAC 30-50-310, and 12 VAC 30-120-395 and in accordance with 42 C.F.R. § 438.106.

Provider	Non-Emergency Condition	Emergency Condition
In-Network	Negotiated rate or, in absence of such, Medicaid triage fee in effect at the time the service was rendered	Negotiated rate or, in absence of such, applicable Medicaid fee-for-service rate in effect at the time the service was rendered
Out-of-Network	Triage fee set at a negotiated rate but not lower than the Medicaid triage fee or, in the absence of such, the Medicaid triage fee in effect at the time the service was rendered	Applicable Medicaid fee-for-service rate in effect at the time the service was rendered

7.2.H Home Health

The Contractor shall cover home health services, including nursing services and home health aide services, as set forth in 12 VAC 30-50-160. The Contractor is not required to cover the following home health services, medical social services, services that would not be paid for by Medicaid if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, 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.

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 member's home health benefit, in accordance with the guidelines cited in Section 7.2.O.

7.2.I Hospital Services

7.2.I.I Inpatient Hospital

The Contractor shall cover inpatient hospital stays in general acute care and rehabilitation hospitals for all members. The Contractor's pre-authorization process for inpatient hospital services must be congruent with guidelines detailed in Section 7.1 of this Contract.

7.2.I.II Outpatient Hospital

The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, except in the case of certified nurse-midwife services that are furnished under the direction of a physician, and are furnished by either a rural health center (RHC), a Federally Qualified Health Center (FQHC), or an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting and meets the requirements for participation in Medicare, as set forth in 12 VAC 30-50-110. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient pre-certification and admission. Transportation and pharmacy services necessary for the treatment of mental health and substance abuse treatment, including for carved out services, shall be the responsibility of the Contractor.

7.2.I.III Inpatient Rehabilitation Hospitals

The Contractor shall cover inpatient rehabilitation services in facilities certified as rehabilitation hospitals and rehabilitation hospitals which have been certified by the Department of Health to meet the requirements to be excluded from the Medicare Prospective Payment System, as set forth in 12 VAC 30-50-200 and 12 VAC 30-50-225, and 12 VAC 30-70-10 through 12 VAC 30-70-90, excluding 12 VAC 30-70-50.

7.2.I.IV Inpatient Behavioral Health Hospitalization Services (Traditional Inpatient BHS)

See Section 7.2.A.I.a(i). See Section 7.5 "Carved Out & Excluded Services."

7.2.I.V General Obstetrical Hospital

The Contractor shall cover stays in general acute care hospitals as set forth in 12 VAC 30-50-100. The length of stay for vaginal and cesarean births shall be consistent with 12 VAC 30-50-100 including provisions for early discharge and home visits as set forth in 12 VAC 30-50-220.

7.2.J Immunizations/Vaccinations

The Contractor shall ensure that providers render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the conduct of the

EPSDT screening and that members are not inappropriately referred to other providers for immunizations. The Contractor shall, as set forth elsewhere in this Contract, work with its network providers to adhere to the ACIP recommendations.

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

The capitation rate paid to the Contractor does include the fee for the administration of the vaccines. The cost for immunization serum is paid for with federal funds. The Contractor shall not allow primary care providers to routinely refer Medicaid members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, the Contractor and its network of providers shall participate in the Statewide immunization registry database, when it becomes fully operational. Further, the Contractor is required to submit its immunization data to the Virginia Immunization Registry on a monthly basis. Coordination of Benefits is not applicable for VVFC claims submitted by VVFC providers. Payments for such claims are to be made by the Contractor.

7.2.J.I **Flu Vaccinations**: The Contractor shall be required to cover adult flu vaccinations in accordance with the Affordable Care Act (ACA) as a required preventative service.

7.2.K Laboratory and X-Ray Services

The Contractor shall cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner of the healing arts, as set forth in 12 VAC 30-50-120. All laboratory testing sites providing services under this Contract must have Clinical Laboratory Improvement Amendments (CLIA) certification and either a clinical laboratory license, a certification of waiver, or a certificate of registration and an identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of the waiver. Laboratories with certificates of registration may perform the full range of services for which they are certified.

7.2.L Nursing Facilities (Screening)

The Contractor is not required to cover nursing facility care. However, the Contractor shall make a good faith effort to refer all members in need of nursing facility care to be prescreened prior to admission. This screening must be done regardless of the member's anticipated length of stay in the nursing facility setting.

Once a member is screened, authorized, and enters a nursing facility, the nursing facility submits a Patient Intensity Rating Survey (PIRS) form to Department's Fiscal Agent. This information is used to enroll the member into the DMAS MMIS system. Once a nursing facility admission is entered into the MMIS system, any open managed care enrollment is

closed on the day prior to the nursing facility admission date. The Contractor must cover all medically necessary services until the member is disenrolled from the MCO.

Nothing in this Contract shall preclude the Contractor from providing additional health care improvement services or other services not specified in this Contract, including but not limited to step down nursing care as long as these services are available, as needed or desired, to members

7.2.M Nutritional Supplements and Supplies

Coverage of enteral nutrition (EN) and total parenteral nutrition (TPN) which do not include a legend drug is only required when the nutritional supplement is the sole-source form of nutrition (except for members under age twenty-one (21), where the supplement must be the primary source of nutrition), is administered orally or through nasogastric or gastrotomy tube, and is necessary to treat a medical condition. Sole source means that the member is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that the nutritional supplements are medically indicated for the treatment of the member's condition. Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Specialized formula for children and enteral nutrition/medical foods for members under 21 are carved out of this Contract. The Contractor shall cover supplies and equipment necessary to administer enteral nutrition.

7.2.N Obstetric and Gynecologic Services

The Contractor shall cover routine and medically necessary obstetric and gynecologic (OB/GYN) health care services covered under Medicaid for covered members. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists. The Contractor shall reimburse OB/GYN services at least the amount reimbursed under the Medicaid fee schedule.

7.2.N.I Certified Nurse-Midwife

The Contractor shall cover the services of certified nurse-midwives as allowed under licensure requirements and Federal law, as set forth in 12 VAC 30-50-260.

7.2.N.II Family Planning

The Contractor shall cover all family planning services which includes services and supplies for individuals of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. Covered services include drugs, supplies, and devices provided under the supervision of a physician, as set forth in 12 VAC 30-50-130 and 42 C.F.R. § 441.20.

In accordance with 1902 (a)(23)(B) of the Social Security Act and 42 C.F.R. § 431.51(b)(2), as amended, the Contractor may not restrict a member's choice of provider for family planning services, drugs, supplies, or devices. The Contractor must cover family planning services, including drugs, supplies and devices by network and out-of-network

providers. Federal law (42 C.F.R. § 441.20) requires that the Contractor also allow the member, free from coercion or mental pressure, the freedom to choose the method of family planning to be used. Code of Virginia § 54.1-2969 (E), as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.

7.2.N.III Sterilizations

The Contractor shall not perform sterilization for a member under age twenty-one (21). The Contractor shall comply with the requirements set forth in 42 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 Contractor shall ensure that the consent form of 42 C.F.R. § 441.258 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the member being informed, the members giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor shall comply with State and Federal (42 C.F.R. Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

7.2.N.IV Hysterectomies

The Contractor may not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor shall inform the patient that the hysterectomy will result in sterility and must have the patient acknowledge her understanding. Patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Contractor shall comply with State and Federal (42 C.F.R. Part 441 Subpart F as amended) reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or in request.

7.2.N.V Women's Health

7.2.N.V.a The Contractor shall permit any female member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the Code of Virginia, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most

current published recommendations of the American College of Obstetricians and Gynecologists.

7.2.N.V.b The Contractor shall cover mammograms for female members age thirty-five (35) and over, consistent with the guidelines published by the American Cancer Society, as set forth in 12 VAC 30-50-220.

7.2.N.V.c The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason as set forth in 12 VAC 30-50-210.

7.2.N.V.d The Contractor shall provide coverage for at least a 48-hour hospital stay following a radical or modified radical mastectomy and not less than 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 709 of 1998 Virginia Acts of Assembly, § 32.1-325 (A) (1) through §32.1-325 (A)(25) of the Code of Virginia.

7.2.N.V.e The Contractor shall cover reconstructive breast surgery in accordance with 12 VAC 30-50-140.

7.2.N.V.f The Contractor shall cover lactation consultation and breast pumps.

7.2.N.V.g The Contractor shall cover services to pregnant women, including:

7.2.N.V.g(i) Pregnancy-related and postpartum services to the end of the month in which the sixtieth (60th) calendar day after the pregnancy ends, as set forth in 12 VAC 30-50-290;

7.2.N.V.g(ii) Services to treat any other medical condition that may complicate pregnancy, as set forth in 12 VAC 30-50-290;

7.2.N.V.g(iii) Prenatal and infant programs as described in this subsection under Prenatal and Infant Programs (Section 7.2.N.V).

7.2.N.V.h In cases in which the newborn and mother or the newborn alone are discharged earlier than forty-eight (48) hours after the day of delivery, the Contractor 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 and newborns or the newborn alone, if the mother has not been discharged, who meet the Department's criteria for early discharge, as set forth in 12 VAC 30-50-220.

7.2.N.V.i 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 and a newborn assessment, as set forth in 12 VAC 30-50-220.

7.2.N.V.j The Contractor shall not be responsible for covering Medicaid covered residential or day treatment substance abuse treatment services for pregnant women. The Contractor must have in place written policies and procedures related to the coordination of substance abuse

treatment services with other providers and a mechanism whereby member's seeking or needing these services may obtain from the Contractor the Department's listing of appropriate providers. The Contractor shall submit to the Department prior to initial contract signature and on request for review its policies and procedures addressing coordination of substance abuse services for pregnant women.

7.2.N.V.k The Contractor shall ensure that, as a routine component of prenatal care, every pregnant member shall be advised of the value of testing for HIV infection as set forth in 12 VAC 30-50-510 and shall request of each such pregnant member consent to testing as set forth in § 54.1-2403.01 of the Code of Virginia. Any pregnant member shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the member's medical record.

7.2.O Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Language Pathology & Audiology Services)

The Contractor shall cover all physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP), and audiology services at least equal in amount, duration, and scope as described in 12 VAC 30-50-160, 12 VAC 30-50-200, and 12 VAC30-130-40. The scope of coverage for Medicaid specifically includes coverage for both acute and non-acute conditions. Medicaid regulations define "acute conditions" as conditions that are expected to be of brief duration (less than 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. The Contractor shall cover medically necessary PT, OT, and SLP therapies, including for both acute and non-acute conditions, regardless of whether or not the child is receiving PT, OT, and SLP therapies through the school or though Early Intervention.

The Contractor shall also cover all medically necessary, intensive outpatient physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs), as set forth in 12 VAC 30-50-225.

7.2.P Organ Transplants

The Contractor shall cover organ transplantation services for kidneys and corneas for all eligible individuals, regardless of age as set forth in 12 VAC 30-50-540 and 12 VAC 30-50-550. The contractor shall provide coverage for reasonable and necessary procurement/donor related services. The Contractor shall cover services for bone marrow transplants and high-dose chemotherapy for adult (age twenty-one (21) or over) members diagnosed with breast cancer, leukemia, lymphoma and myeloma, as set forth in 12 VAC 30-50-570. The Contractor shall cover liver, heart, and any other medically necessary transplant procedures for members up to age twenty-one (21), as set forth in 12 VAC 30-50-580 and 12 VAC 30-50-560. The Contractor shall cover liver, heart and lung transplantation procedures for

individuals over the age of 21 years when medically necessary, as set forth in 12 VAC 30-50-560. Coverage of liver transplants (for adults and children) includes coverage for partial or whole, and orthotopic or heterotopic liver transplantation, from cadaver or living donor, within the amount duration and scope, (and for individuals meeting the criteria) as outlined in 12 VAC 30-50-560, and 12 VAC 30-10-280.

The Contractor must use Department service authorization criteria or other medically sound, scientifically based criteria in accordance with national standards in making medical necessity determinations for all transplantations. Medical necessity criteria used by the Contractor shall be treated by the Department as proprietary information of the Contractor and shall not be subject to disclosure by the Department. The Contractor is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by DMAS must be honored by the Contractor, as with all authorizations, until such time that DMAS can disenroll the member from the Contractor, if applicable, if the transplant is scheduled concurrent with the member's enrollment with the Contractor. Required coverage for transplants is summarized in the following table.

Transplant	Under 21 *	Age 21 and Over	Coverage Criteria
Kidney From Cadaver or Living Donor	Yes	Yes	12 VAC 30-50-540 and 12 VAC 30-10-280
Corneas	Yes	Yes	12 VAC 30-50-550 and 12 VAC 30-10-280
Liver From Cadaver or Living Donor	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Heart	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Lung	Yes	Yes	12 VAC 30-50-560 and 12 VAC 30-10-280
Heart & Lung	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280
Bone Marrow	Yes	Yes - for limited diagnoses, specifically: myeloma, lymphoma, breast cancer or leukemia	12 VAC 30-50-560 and 12 VAC 30-50-570 and 12 VAC 30-10-280
Small Bowel	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280
Small Bowel with Liver	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280

Pancreas	Yes	No	12 VAC 30-50-580 and 12 VAC 30-10-280

*Any medically necessary transplants that are not experimental or investigational are covered for children under 21 years of age, when preauthorized.

7.2.Q Physician Services and Screenings

The Contractor shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses as set forth in 12 VAC 30-50-140. Cosmetic services are not covered unless performed for medically necessary physiological reasons. The Contractor is only required to cover routine physicals when the services are provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The Contractor is strongly encouraged to cover routine physicals for members not covered through the EPSDT program.

7.2.R Podiatric Services

The Contractor shall cover podiatric services that are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture, as set forth in 12 VAC 30-50-150.

7.2.S Prescription Drugs, Formularies, and Rebate Submissions

The Contractor shall be responsible for covering all prescription drugs for its members, as set forth in 12 VAC 30-50-210, and in compliance with § 38.2-4312.1 of the Code of Virginia. The Contractor shall document protocols for which will ensure the appropriate use of medications including psychotropic medications. The Contractor shall make such protocols available to the Department upon request.

The Contractor shall cover all Medicaid covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The Contractor is not required to cover Drug Efficacy Study Implementation (DESI) drugs.

The Contractor 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 Contactor shall not cover drug agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

The Contractor may establish a formulary. However, the Contractor shall have in place, and/or shall similarly require its pharmacy benefit manager to have in place, mechanisms to ensure the effective transition of care for members with established pharmacological treatment regimens, including for medications that are not on the Contractor's formulary, and especially in relation to the ADHD class of medications. The Contractor shall have in place authorization procedures to allow providers to access drugs outside of this formulary, if

medically necessary. If the Contractor establishes a formulary, the formulary and pre-authorization requirements must be reported and updated to the Department. This is due prior to signing the original contract, upon revision, and upon request. Any updates to the formulary must be sent to the Department prior to their effective date. If a formulary is in place, in accordance with NCQA, the Contractor is required to notify those members who are affected by any product withdrawal, as well as notify the practitioner who prescribed the product.

The Contractor shall cover atypical antipsychotics. The Contractor shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the patient. The Contractor shall monitor and report atypical utilization to the Department upon request, providing the number of requests and denials.

The Contractor shall follow its authorization procedures within its prescribed time frame and promptly notify both the physician and the pharmacy providers of its decision. Pharmacy services which are denied for children must be afforded a secondary review in accordance with the EPSDT requirements set forth in Section 7.1.D. The Contractor shall respond to the authorization request within 24 hours. The Contractor's response may be a request for additional information from the provider if this is needed to make the decision. If coverage is denied, the Contractor shall inform the member of his or her rights and the procedures for filing an appeal. If the drug is prescribed for an "emergency medical condition," the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision.

The Contractor may not impose co-payments on prescription drugs.

7.2.S.I Prescription Drug Rebates

The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010. Section 2501 of the PPACA amended section 1927 of the Social Security Act (42U.S.C. 1396r-8) and made changes to the Medicaid Drug Rebate Program. PPACA requires that Medicaid MCOs submit drug utilization to the State for each drug paid for by the MCO. The State will submit that utilization along with their fee-for-service (FFS) utilization to the appropriate manufacturers for the purpose of obtaining Medicaid Drug Rebates. In following with the above federal guidelines, submission of drug utilization data to the fiscal agent must be weekly or at a frequency approved by the Department. Section 2501 of the PPACA also requires that the drug utilization be used to establish the actuarial soundness of the State's MCO capitation rate.

Drug utilization data must include all drugs dispensed at point-of-sale (POS) and those administered in a provider's office or other outpatient setting. Pursuant to Section 2501(c)(1)(C)(III), the Department will require encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS physician administered code. The quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier (F2, ML, GR or UN) is also required. Each HCPCS physician administered code must be submitted with a valid NDC on each claim line. If the drug administered is comprised of more than

one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a claim line using the same HCPCS physician administered code. For the purpose of this contract the term "dispense" is defined to include the terms "provide" and "administer." The Contractor must develop a process and procedure to ensure the exclusions of drugs administered under Section 340b of the Public Health Service Act as codified at 42 U.S.C. § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program.
The Contractor (and/or its Pharmacy Benefits Manager) must make available two pharmacy representatives (one primary and one secondary) to work directly with the Department and its drug rebate vendor to assist in all rebate disputes and appeals. This representative must have pharmacy knowledge and/or experience in working with pharmacists and/or prescription drugs.

Any rebate dispute that involves drug utilization must be resolved within five (5) business days.

7.2.T Private Duty Nursing (PDN)

The Contractor is not required to cover PDN services for adults. See also, Section 7.1D "EPSDT."

The Contractor is not required to cover PDN services in the school setting. When the Contractor receives a request for PDN services to be rendered in the school setting, the Contractor should require the requesting provider to pursue payment for services through DMAS directly in accordance with the Department's established criteria and guidelines for school-based private duty nursing.

7.2.U Prostate Specific Antigen (PSA)

The Contractor shall cover Prostate Specific Antigen (PSA) testing and digital rectal examinations for the purpose of screening for prostate cancer as set forth in 12 VAC 30-50-220.

7.2.V Prosthetic/Orthotic

The Contractor shall cover medically necessary prosthetic and orthotic services and devices at least equal in amount duration and scope as described in 12 VAC 30-50-210 and 12 VAC 30-60-120. Coverage for prosthetics includes artificial arms, legs and their necessary supportive attachments, internal body parts (implants), breasts, and eye prostheses when eyeballs are missing and regardless of the function of the eye. The Contractor shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthoses, etc.) for members under twenty-one (21) years of age. The Contractor shall cover medically necessary prosthetics and orthotics for a member regardless of the member's age when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.

7.2.W Telemedicine

The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-

for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services. The Department recognizes the following "remote" providers for telemedicine 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. The listed provider types are also recognized for the telemedicine "originating" sites, where the Medicaid recipient is located. Originating sites also include other providers, such as staff at renal dialysis centers, health departments, and community services boards. The originating site provider bills the Q3014 service code. A description of the Department's telemedicine coverage is available as a "Medicaid Memo" issued September 29, 2009 and coverage is subject to updates. 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.

7.2.X Transportation

The Contractor shall cover emergency transportation as well as non-emergency transportation to ensure that members have necessary access to and from providers of medical 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, members' needs for special transportation requirements, which may include but not be limited to, ambulance, stretcher van, curb to curb, door to door, or hand to hand services."Hand to hand" service includes transporting the member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some members with dementia or developmental disabilities, for example, may need to be transported "hand-to-hand."The Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in § C.F.R. § 440.170(a). The Contractor shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services as defined in Section 7.5, with the exception of transportation to home and community based waiver services, which shall be paid by the Department under fee-for service. The Contractor shall cover transportation to and from Medicaid covered community mental health and rehabilitation services. The Department allows the Contractor to subcontract for all transportation services. The Contractor shall assure that provider agreements (through the Contractor or the subcontractor) include the following language:

7.2.X.I Requirements for Drivers

The Contractor shall assure that all drivers of vehicles transporting members meet the following requirements:

7.2.X.I.a Are at least 18 years of age and have had a valid driver's license for at least one year.

7.2.X.I.b All drivers shall have a current valid driver's license from the Commonwealth of Virginia.

7.2.X.I.c Drivers shall not have been convicted of any crime as defined in § 37.2-314(B) Code of Virginia.

7.2.X.I.d 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.

7.2.X.I.e All drivers and attendants shall wear or have visible, easily readable proper identification.

7.2.X.I.f Drivers shall not use mobile telephones (including texting) or headphones while the vehicle is in motion.

7.2.X.II Requirements for Vehicles

7.2.X.II.a 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.

7.2.X.II.b All vehicles shall have a functioning speedometer, odometer, heating and air-conditioning systems.

7.2.X.II.c 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.

7.2.X.II.d Smoking is prohibited in all vehicles while transporting members. All vehicles shall post "no smoking" signs in all vehicle interiors, easily visible to the passengers.

7.2.X.II.e All vehicles shall be equipped with a first aid kit.

7.2.X.II.f All vehicles must meet State, Federal, local, and manufacturer's safety and mechanical operating and maintenance standards for the vehicles.

7.2.X.II.g Vehicles shall comply with the American's with Disabilities Act (ADA) specifications for transportation, 49 C.F.R. § 38, subparts A and B.

7.2.Y Vision

The Contractor shall cover vision services which are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all members, shall be allowed at least once every two (2) years. The Contractor shall cover eyeglasses and contact lenses prescribed by a physician skilled in diseases of the eye or by an optometrist for member s up to age twenty-one (21), as medically necessary and as set forth in 12 VAC 30-50-210.

7.3 NON-COVERED SERVICES

Except where explicitly stated in the Contract, the Contractor is not responsible for covering DMAS non-covered or Home and Community Based waivered services described in 12 VAC 30-50-450, 12 VAC 30-120-211 through 30-120-249. Medicaid non-covered services are those services not covered by DMAS and, therefore, not included in the covered services as defined in

the Virginia State Plan or State regulations, except if ordered as a result of an EPSDT screen or high-risk pregnancy screen.

7.3.A List of Medicaid Non-Covered Services

Some, but not all, Medicaid non-covered services are listed below:

7.3.A.I Services rendered by chiropractors, as set forth in 12 VAC 30-50-150.

7.3.A.II Services of Christian Science nurses and care as set forth in 12 VAC 30-50-300(B).

7.3.A.III Any procedure that is experimental or investigational, as defined by the Department, as set forth in 12 VAC 30-50-140. Clinical trials are not always considered to be experimental or investigational, and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.

7.3.A.IV Coverage of drugs for the treatment of erectile dysfunction.

7.3.A.V Services provided to inmates/incarcerated members enrolled with the Contractor. Individuals on house arrest are not considered as incarcerated. The Contractor shall report to DMAS any members it identifies as incarcerated, within 48 hours of knowledge (See the Managed Care Technical Manual).

7.3.B Abortions

Under the terms of this Contract, the Contractor shall not cover services for abortion. This includes any related services performed at the immediate time of the abortion. The Commonwealth will be responsible for payment of these services. The Contractor shall provide coverage for any necessary follow-up medical care, per the requirements in this contract that may be needed in relation to the abortion services performed.

7.4 ENHANCED SERVICES

Enhanced services are those services offered by the Contractor to members in excess of covered services. Nothing in this Contract shall preclude the Contractor from providing additional health care improvement services or other services not specified in this Contract, including but not limited to chiropractic care, step down nursing care, and psychiatric care provided in a freestanding psychiatric hospital, as long as these services are available, as needed or desired, to members. No increased reimbursement will be made for additional services provided by the Contractor under this Contract. The Contractor must inform the Department at least thirty (30) calendar days prior to implementing any new enhanced services and prior to implementing revisions to existing enhanced services. The Contractor must report the enhanced services it offers at start up, upon revision or upon request. Enhanced services for step-down care or adult psychiatric care provided in a free-standing psychiatric hospital may not be used to substitute for state plan covered services.

Enhanced services offered by the Contractor are listed in the Department's Managed Care Program comparison charts. Comparison charts are revised once annually. Any changes to enhanced services occurring after the annual comparison chart publication cannot be incorporated until the next annual revision. Revisions to enhanced services should be made only at open enrollment. However, the Contractor may revise enhanced services at any date, if the Contractor accepts the cost of revising and printing comparison charts. The Contractor must be

able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to members during the contract year for rate setting purposes.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services which have been included in the response to the RFP or have since been added by the Contractor and approved by the Department.

7.5 CARVED-OUT & EXCLUDED SERVICES

7.5.A Carved-Out Services:

The following services are carved-out services:

7.5.A.I **Community Mental Health Rehabilitative Services (CMHRS)–** The subset of non-traditional behavioral health services that are covered by the Department's BHSA in accordance with the Department's established criteria and guidelines (See Section 7.2). Additional information on these services is available on the DMAS website, under the Behavioral Health Services tab, or at: http://www.dmas.virginia.gov/Content_atchs/obh/cmhrs-info.pdf , and on the DMAS Provider Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal and on the Behavioral Health Services Administrator website at: http://www.MagellanofVirginia.com

The Department's BHSA shall cover community mental health rehabilitative services, including: crisis intervention, crisis stabilization, intensive in-home, therapeutic day treatment for children under age 21, day treatment/partial hospitalization for adults, mental health skill-building services, psychosocial rehabilitation, intensive community treatment, mental health and substance abuse targeted case management and treatment, foster care case management, substance abuse residential treatment for pregnant women, substance abuse day treatment for pregnant women, substance abuse intensive outpatient, EPSDT behavioral therapy, and residential treatment for children under age 21(Levels A, B, and C) for Medicaid members. Transportation and pharmacy services necessary for the treatment of substance abuse services, including carved out services are the responsibility of the Contractor. Inpatient substance abuse treatment is not covered except through EPSDT.

7.5.A.II **School health services -** are defined as medical and/or mental health services through the child's individualized education program (IEP). These services include physical therapy, occupational therapy, speech therapy, psychological and psychiatric services, medical evaluation services, and IEP-related transportation on specifically adapted school buses. The services are rendered in a public school setting and included on the child's IEP. All school health services that are rendered in a public school setting or on school property, (including Head Start) and included

on the child's IEP (except those noted below) are carved out of this Contract and are reimbursed directly by DMAS.

The following services provided on school grounds may be covered by the Contractor:

7.5.A.II.a Services performed by a in-network clinic, FQHC, RHC, or medical facility housed on school grounds and providing covered medical and/or behavioral health services;

7.5.A.II.b Well-child screenings and/or immunizations performed by a registered nurse or nurse practitioner employed by the school system in DMAS-identified provider shortage areas.

7.5.A.II.c Services performed within a private school or day care setting except Early Intervention Services as defined in this Contract.

The MCO cannot directly reimburse a nurse practitioner for services rendered if not operating within the licensing requirements defined in 18 VAC 90-30-10 et seq.

The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school.

7.5.A.III Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with intellectual disability; individuals with intellectual disability and related conditions participating in home- and community-based care waivers; the elderly; and members of Auxiliary Grants as provided in 12 VAC § 30-50-420 through –470.

7.5.A.IV Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of eligible children who have been diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227.

7.5.A.V Abortions that are referenced in Public Law 111-8, as is written at the time of the execution of this contract.

7.5.A.VI Dental Services as set forth in 12 VAC 30-50-190.

7.5.A.VII Specialized infant formula and medical foods for members under age 21.

7.5.A.VIII Private duty nursing (PDN) services when provided through HCBS waivers covered in 12 VAC 30-50-170, 12 VAC 30-120-211 through 30-120-249, or when provided at school.

7.5.A.IX Personal care services.

7.5.A.X Services provided under the home and community-based Medicaid waivers (Individual and Family Developmental Disabilities Supports, Intellectual disability, Elderly or Disabled with Consumer Direction, Day Support, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

7.5.A.XI Early Intervention services as described in Section 7.5.B of this Contract.
7.5.A.XII Therapeutic Foster Care (TFC) as authorized by the Department.
7.5.A.XIII Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease, currently only available for Medicaid Works members.

7.5.B Early Intervention

Early Intervention (EI) services are designed to meet the treatment needs of an infant or toddler up to age 3 with developmental delay in one or more areas of development (physical, cognitive, communication, social or emotional, or adaptive). Services are performed by EI certified providers in the child's natural environment, to the maximum extent possible. Natural environments can be the child's home or a community based setting in which children without disabilities participate. EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP) which addresses the developmental needs of the child while also enhancing the capacity of families to meet those developmental needs through family centered treatment.

In October, 2009, the Department, working collaboratively with DBHDS, implemented a restructured EI program requiring providers to be trained and certified by DBHDS, and requiring providers to bill using newly established EI specific fee-based procedures codes. The restructured EI program is designed to effectively provide the necessary EI services, including developmental supports, therapies and services to EI enrolled children in natural environment settings, while ensuring compliance with Federal Part C payor of last resort requirements.

The Contractor is not required to provide coverage for Early Intervention services. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines described in 12 VAC 30-50-131. Early Intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.

The Contractor shall cover other medically necessary rehabilitative/developmental therapies within EPSDT guidelines and as described in Section 7.1.D of this Contract, including for EI enrolled children where appropriate. Refer to Section 7.1.O.III, Children with Special Health Care Needs for related assessment and case management requirements.

Below are some examples/parameters for when services could fall under Outpatient Rehab instead of under EI benefits:

- When the parent elects to have outpatient treatment versus EI therapy;
- When there is not an EI provider available but there is a facility based provider available to do the physician's ordered, medically necessary therapy. For example, the child may receive PT and OT in the natural environment under EI,

but needs speech language pathology in the facility – for example in a feeding clinic; and,

- Where the child suffers an acute injury during EI, where there is a medical need for outpatient rehab instead of or in addition to EI, including where the type of therapy/treatment provider is not available under the EI treatment model.

7.5.C Service Exclusion Criteria

Members who receive any of the following services shall meet the criteria for exclusion from the Medallion 3.0 Program. Once the Contractor determines that a member is receiving these services and notifies the Department, the Department will begin the process to exclude the member. Until the Department has excluded the member, the Contractor is responsible for covering services for that member. <u>However, in no event is the Contractor responsible for provision of the following services, which will be reimbursed by the Department</u>:

7.5.C.I Services for members with intellectual disability and related conditions, including case management, who are participants in the Home and Community Based Services are carved out as set forth in 12 VAC 30-50-450, 12 VAC 30-120-70 through 30-120-249.

7.5.C.II Services for members in the Plan First, Family Planning Program

7.5.C.III Inpatient mental health services rendered in a State psychiatric hospital, as set forth in 12 VAC 30-50-230 through 12 VAC 30-50-250.

7.5.C.IV Hospice services defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in 42 C.F.R., Part 418 and as set forth in 12 VAC 30-50-270.

7.5.C.V Nursing facility care, as set forth in 12 VAC 30-50-130.

7.5.C.VI DMAS authorized level C Residential Treatment Facility (RTF) programs as authorized by the Department.

7.6 COORDINATION AND CONTINUITY OF CARE

7.6.A Generally

In accordance with 42 C.F.R. § 438.208, the Contractor shall have systems in place that ensure coordinated patient care for all members and that provide particular attention to the needs of members with complex, serious and/or disabling conditions. The systems, policies and procedures shall be consistent with the most recent NCQA standards. Such systems shall ensure the provision of primary care services, coordinated patient care, and access when necessary to specialty care services/providers. The Contractor's coordination and continuity of care systems shall include provisions for all of the following processes:

7.6.A.I Members must have an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.

7.6.A.II The Contractor's system to coordinate patient care must include provisions to coordinate benefits and methods to prevent the duplication of services especially with transition of care activities.

7.6.A.III The Contractor shall ensure that the process utilized to coordinate the member's care complies with member privacy protections described in

HIPAA regulations and in Title 45 C.F.R. parts 160 and 164, subparts A and E, to the extent applicable.

7.6.A.IV The Contractor's pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The Contractor shall submit to the Department prior to signing the initial contract, upon revision or on request referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

7.6.A.V The Contractor shall require their contracted providers to ensure that members with disabilities have effective communication with health care system participants in making decisions with respect to treatment options.

7.6.A.VI The Contractor shall have in place a process to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety-net" providers, teaching institutions, and facilities that are needed to assure that members are able to access and receive the full continuum of treatment and rehabilitative medical and outpatient mental health services and supports needed. As part of this process, MCOs shall provide discharge planning and/or coordination with long-term care service providers for members who are being enrolled in home and community based care waivers or nursing facilities to assure continuity of care.

7.6.B Outreach and Case Management

The Contractor shall provide local outreach and case management to its membership. Case management shall be provided through licensed registered nurses (RNs) or individuals with appropriate professional clinical expertise. **The Contractor shall have a full-time, Virginia-based medical director who is a Virginia-licensed medical doctor.** Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Medicaid members' case management needs at all times. The Contractor, on a quarterly basis, shall notify the Department of all full time case managers by region, and report any staff changes.

7.7 ASSESSMENTS & ANNUAL PLAN FOR AGED AND DISABLED MEMBERS

7.7.A Assessments:

The Contractor shall take steps to assure that newly enrolled aged and disabled members are assessed within sixty (60) calendar days of initial enrollment and at least once every year thereafter. New members are those who have not been covered by the Contractor within the previous six months of enrollment. A monthly report of new aged and disabled members, noting who received a successful assessment must be submitted to the Department as specified in the Managed Care Technical Manual. A successful assessment is considered a contact by the health plan that results in a fully completed health assessment questionnaire which assesses health care needs, including mental health, interventions received, and any additional services required including referrals to other resources and programs with completion of an approved assessment tool.

The Contractor must also, each quarter, identify and report those members with physical and behavioral limitations and conditions. These must include diagnoses for hearing and vision impairment and cognitive and behavioral disorders.

7.7.B Annual Plan

The Contractor must develop and maintain a program to address and improve the care and access of services among aged and disabled members included in eligibility designation codes 049, 051, 052, 059, 060, 061, and 062. The Department will audit compliance with this requirement and will request copies of monitoring activities, utilization outcomes, and completed assessments.

The Contractor shall submit an annual plan to the Department for approval by October 1st of each year outlining its assessment plan for the contract year. The submission must include its assessment tool. In addition to requesting specific member assessment information, the Department shall request a random sampling of completed member assessments to assure the Contractor's compliance with this requirement.

The Contractor must educate and inform members identified as not complying with EPSDT periodicity and immunization schedules. The Contractor shall provide copies of any such notices to the Department and advise as to the frequency and timing of these notices.

The Contractor must develop and maintain a system of assessment procedures for identifying members with special health care needs (children and adults), including people with disabilities or chronic or complex medical and behavioral health conditions and Children with Special Health Care Needs.

The Department agrees to provide each MCO a utilization report based upon the percentage of ABD members who have been continuously enrolled in the MCO for at least twelve (12) months, upon request by the Contractor. The results may be trended and could serve as the foundation for additional monitoring.

The Contractor shall make every reasonable effort to comply with the Health Plan Assessments requirements detailed in this Contract. The Contractor shall meet the reporting requirements for assessments as detailed in the Managed Care Technical Manual.

7.7.C PCP Visits for Disabled Populations

All disabled members must receive at least one primary care or specialist visit each calendar year. Health plans must complete an annual assessment to ascertain a disabled members future case management needs.

7.8 MEDALLION CARE SYSTEM PARTNERSHIP (MCSP)

The Department established the Medallion Care System Partnership (MCSP) with the goal of improving health outcomes for Medicaid members through a system designed to integrate

primary, acute, and complex health services provided by contracted MCOs through Health Care Homes or other MCSP approved arrangements. The MCSP model allows the Contractor the flexibility to create and test innovative payment models, incentive structures and arrangements, and value-and-market-based programs within geographic areas, particular populations, or even at the physician practice level to determine how to bend the cost curve while improving quality.

The Contractor must form partnerships with providers and/or health care systems in an effort to increase participation of integrated provider health care delivery systems, improve member health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and member experience.

As part of this MCSP arrangement, the Contractor shall enter into contractual arrangements that include:

- gain and/or risk sharing,
- performance-based incentives, and/or
- other incentive reforms tied to Commonwealth-approved quality metrics and financial performance.

7.8.A Health Care Home (Formally Patient Centered Medical Home)

To qualify as an MCSP initiative, the Contractor's provider network must incorporate and be comprised of local medical groups (including individual medical providers) that meet the Health Care Home principles outlined below. The Health Care Home designation shall demonstrate adherence to the core set of Medical Home principles, such as the following:

- Demonstrated Leadership;
- Team-based approach to care;
- Population risk stratification and management;
- Practice-integrated care management;
- Enhanced access to care;
- Behavioral-physical health integration;
- Connection to community resources;
- Commitment to reducing unnecessary health care spending, reducing waste, and improving cost-effective use of health care services;
- Integration of health information technology; and,
- Inclusion of patients and families in implementation of the PCMH model; and
- Provider recognition for improved outcomes.

In addition, the Contractor (via its Health Care Homes) must address complex and chronic health conditions by:

- Identifying and monitoring members with complex or chronic health conditions who are enrolled in a designated MCSP/Health Care Home, and
- Assigning member enrollment in the MCSP/Health Care Home to the medical group site and identifying member-specific care needs.

7.8.A.I The MCO shall report all specified MCSP data, as defined by the Department, including specified Health Care Home Provider data.

7.8.B MCSP Requirements

7.8.B.I The MCO must operationalize at least two MCSPs, one of which must include pediatric care services and specifically target pediatric populations. All services provided through the MCSP must be designed to individually coordinate Medicaid primary and acute care, and/or mental health services in accordance with the Contract.

7.8.B.II The MCO's inability to establish MCSP arrangements before the Termination Date of this Contract shall not be construed as a breach if the MCO can demonstrate good faith attempts to do so.

7.8.B.III The MCO and its existing care systems may qualify as MCSPs, provided the MCO meets these criteria or will make necessary changes to meet them within six (6) months of being provided the performance measures by the Department.

7.8.B.IV The Department has developed a list of quality measures appropriate for populations assigned to the Health Care Home. The MCO will select measures from this list, found in Attachment XV, to link performance metrics to incentives. The MCO must select one measure from Menu #1, in addition to one measure from Menu #2, for each MCSP.

7.8.B.V Providers may participate in more than one MCSP and may contract with more than one MCO. MCOs are not required to modify or expand existing networks to establish an MCSP.

7.8.B.VI The MCO must audit each MSCP annually.

7.8.C MCSP Proposals and Evaluations.

7.8.C.I Annually, in accordance with the Managed Care Technical Manual or upon amendment, the MCO shall submit a written description of its MCSPs to the Department using the proposal and evaluation template created by the Department. The Department will review each description and determine whether the MCSP criteria have been met prior to proposal acceptance and review the merits of each model upon completion of MCSP evaluation. The description of the MCSP(s) shall include:

7.8.C.I.a The service delivery and care coordination model;

7.8.C.I.b Target population;

7.8.C.I.c Current or projected enrollment numbers;

7.8.C.I.d Service area, which may be fewer counties/localities than the MCO Service Area as defined in the Contract;

7.8.C.I.e Identification of each MCSP provider, in addition to identification of those providers included in the MCSP arrangements who are designated as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);

7.8.C.I.f The specified model options and incentive type to be used from the attached table); MCOs may combine options and incentive types within a single MCSP or use the same model in different service areas;

7.8.C.I.g The process for assigning or attributing members;

7.8.C.I.h Method that will be used for tracking cost of care or total costs of care as needed to implement the model chosen;

7.8.C.I.i The MCO's process for monitoring and evaluating the MCSP performance; and

7.8.C.I.j The benchmarks or standards used to determine whether the Provider entity is effectively managing performance and costs of care.

7.8.C.I.k Evaluations must provide the same information as proposals, as well as a comprehensive review of the MCSP in terms of quantitative data, financial incentive relationship with quality, and substantive policies/procedures analysis to determine the successes and/or failures of the MCSP models selected the previous year. The evaluation submitted to the Department should not exceed twenty pages in total length, with more detailed information available to the Department upon request.

7.8.D MCSP Payment Types.

7.8.D.I The MCSP subcontracts must establish incentives. Performance results must be reported annually to the Department. The MCO will provide data necessary to verify reported results upon request.

7.8.D.II Care Coordination, quality metrics, financial performance measures, Department review and acceptance, and reporting requirements are required for each payment type.

7.8.D.III All models must support consumer choice of providers and be designed to improve health outcomes.

7.8.D.IV The following table outlines MCSP model options and payment types:

MCSP Payment Types

The Contractor must implement two distinct MCSPs. Accordingly, the quality measures selected must coincide with the model MCSP selected by each plan, as indicated in this chart.

	Payment Types	**Type A**	**Type B**	**Type C**	**Type D**
Model Options		Performance rewards: performance pool or pay for performance	Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Alternative Proposals

MCSP Payment Types The Contractor must implement two distinct MCSPs. Accordingly, the quality measures selected must coincide with the model MCSP selected by each plan, as indicated in this chart.					
	Payment Types	**Type A**	**Type B**	**Type C**	**Type D**
Model 1.1	MCO contracts with Primary Care Providers	OPTION "1.1.A"	NA	NA	NA
Model 1.2	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees.	NA	OPTION "1.2.B"	NA	NA
Model 2	MCO contracts with provider Care System or a collaborative (primary care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/ performance payment models across services	NA	NA	OPTION "2.c"	NA
Model 3	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes	OPTION "3.A"	OPTION "3.B"	OPTION "3.c"	NA
Model 4	Alternative defined by proposal	NA	NA	NA	OPTION "4.D"

8. QUALITY IMPROVEMENT (QI) & OVERSIGHT

Contract Compliance: Monitoring and Reporting

The Department shall be responsible for conducting an ongoing contract monitoring process. As part of this monitoring process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract, in the proposal submitted in response to the RFP, and in the RFP. The Department may, at its sole discretion, conduct any or all of the following activities as part of the contract monitoring process:

- Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;
- Conduct MCO, network provider, and subcontractor site visits; and
- Review MCO policies and procedures and other internal documents.

8.1 QUALITY IMPROVEMENT (QI), GENERALLY

The Contractor shall cooperate with the Department's quality improvement requirements to the extent described herein and shall, upon request, demonstrate to the Department its degree of compliance with the Department's quality standards set forth below. Additionally, the Contractor shall cooperate with the Department or its designated agent (EQRO) with quality improvement activities in accordance with CMS recommended protocols. Each section below has a subheading of requirements that are for new Medicaid health plans who are not accredited in Virginia.

8.2 QUALITY COLLABORATIVE

The Contractor shall participate in the Department's quality collaborative meetings such that at least one member of the Contractor's quality improvement team shall participate in person.

New Health Plans have the same requirement.

8.2.A Quality Improvement Structure

In compliance with 42 C.F.R 438.240, the Contractor shall provide to the Department no later than July 31st of each year, a written description of its ongoing quality assessment and performance improvement program. The Contractor should clearly define its quality improvement structure. The Contractor must include, at a minimum, all of Element A (quality improvement structure) from the most recent version of NCQA's standards.

New Health Plans shall provide their Quality Improvement Plan (QIP) at least sixty (60) days before the first membership file is provided to the MCO. The new MCO shall submit a plan that adheres to NCQA's "Element A, Standards for Quality Improvement Plan Structure." The new health plan must provide the Department with an update to its QIP at least once every twelve months for possible review by both the Department and the EQRO.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide DMAS with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within 30 days. DMAS must also be notified in writing within ten (10) days of any change to an MCO's accreditation level.

8.3 HEDIS MEASURES

The Contractor is required to consent to publication via NCQA's Quality Compass of all Medicaid HEDIS measures for the Virginia Medicaid product. In addition, the Contractor shall, at a minimum, consider the following Medicaid HEDIS performance measures as a priority. The Contractor will assure annual improvement in these Medicaid HEDIS measures until such time that the Contractor is performing at least at the 50th percentile for "HMOs" as reported by Quality Compass. Thereafter, the Contractor is to at least sustain performance at the Medicaid 50th percentile. The Contractor is encouraged to set goals to support the Department's goal of attaining the seventy-fifth (75th) percentile for each of these measures.

8.3.A Childhood Immunization Status (Combo 2) and each vaccine must be reported separately as well

8.3.B Childhood Immunization Status (Combo 3) and each vaccine must be reported separately as well.

8.3.C Lead Screening in Children

8.3.D Breast Cancer Screening

8.3.E Timeliness of Prenatal Care

8.3.F Postpartum Care

8.3.G Well-Child Visits in the First 15 Months of Life each number of visits listed separately

8.3.H Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

8.3.I Adolescent Well-Care Visit

8.3.J Comprehensive Diabetes Care all age categories set forth by the HEDIS technical specifications for these diabetes measures only:

- 8.3.J.I HbA1c Testing
- 8.3.J.II HbA1c Control
- 8.3.J.III Eye Exams
- 8.3.J.IV LDL Screen
- 8.3.J.V LDL Control
- 8.3.J.VI BP Control <140/90

8.3.K Asthma – Appropriate Use of Medication (all age categories set forth by the HEDIS technical specifications)

8.3.L Cholesterol Management for Patients with Cardiovascular Conditions (Control only)

8.3.M Control of High Blood Pressure (<140/90) among members diagnosed with hypertension

8.3.N Antidepressant Medical Management (Acute and Continuation)

8.3.O Follow Up After Hospitalization for Mental Illness 7 day and 30 day

8.3.P **Other Measure**: The Department shall contract with its EQRO to apply the CHIPRA measures for Asthma Emergency Department (ED) visits for each MCO and for an average. The EQRO shall use the technical specifications for this measure as set forth in the CHIPRA technical specifications and shall use the dates of service as January 1, 2012 through December 31, 2012. The measure and results shall be in the "public domain" but shall not be subject to the corrective action plan requirements described herein.

In conducting these HEDIS calculations, the Contractor shall use the hybrid methodology unless HEDIS technical specifications only require the use of administrative data only. Failure to use hybrid methodology may result in corrective action. For those measures that are eligible for rotation (per NCQA), the MCO shall report the actual/audited scores AND the rotated scores (if applicable). The Contractor shall provide the HEDIS measures' data in Excel format.

The scores for the measure which are in effect on January 1 of the applicable contract year must be reported to the Department by July 31 of the same year. *(For example, HEDIS technical specifications used for calculating and uploading scores to NCQA in June 2013 must be reported to DMAS by July 31, 2013).* In order to facilitate the Department's reporting requirements to the CMS on national measures, the Contractor is required to provide all numerators and denominators for all measures listed above.

With respect to the HEDIS measures listed above, the Contractor's scores that are below the 50th percentile (for Medicaid HMOs) per Quality Compass or that have decreased by more than five (5) percentage points from the previous year (not as a result of a change in HEDIS specifications), shall be included in a detailed, written corrective action plan (CAP), which must be submitted to the Department within 30 days following the release of NCQA's annual Quality Compass for that year. The five (5) percentage point parameter does not apply to the Asthma Emergency Department measure, found in Section 8.3.P. The Contractor does not need to include CAHPS in the CAP.

The Contractor may use the Department's template for the CAP or may use its own template so long as the content required in the Department's template is included. DMAS will review the CAP and may require refinement by the Contractor.

The Contractor will perform the Children and the Adult CAHPS annually. The CAHPS Adult Survey and the CAHPS Child Survey reports provided to the Department shall include detailed results for all survey items. Composite scores shall also be reported. The Contractor is required to submit their CAHPS for Children and CAHPS for Adults results to the Agency for Healthcare Research and Quality (AHRQ) for inclusion in the National CAHPS Benchmarking Database if the option is available through AHRQ.

New Health Plans: Throughout the course of attaining new health plan accreditation from NCQA, new health plans are required to report certain HEDIS measures to NCQA as part of the First evaluation. The health plan must also report these scores (those that overlap with the required measures listed previously) to the Department and include evidence that the scores have

been audited by a certified HEDIS auditor. The same requirement applies to Children and Adult CAHPS surveys.

8.4 OTHER QUALITY ACTIVITIES

The Contractor shall cooperate with and ensure the cooperation of network providers and subcontractors with the EQRO, which is contracted by the Department to perform quality studies. The level of cooperation includes, but is not limited to, responding favorably and promptly to requests for members' medical records in the format and timeframe requested by the EQRO or the Department.

The Contractor shall also submit requested information from the Department or EQRO for Performance Measure Validation, Performance Improvement Projects, and Comprehensive or Modified Operational Systems Reviews as described in this section by the due date provided by the EQRO or as communicated by the Department. If an extension is required, the request must be made by the Contractor to the Department at least one week prior to the requested due date.

8.4.A Performance Improvement Project Validation

The Contractor shall conduct two annual performance improvement projects (PIPs) annually for validation by the EQRO, in accordance with CMS requirements. The Department shall select the topics. The Contractor shall assure effective interventions for improving its performance on quality measures. The Department is not responsible for developing or implementing interventions for the Contractor. It is the sole responsibility of the Contractor to develop, implement, track, and evaluate the effectiveness of its own PIPs. This will be the second year for the following topics:

- Adolescent Comprehensive Well-Child Visits
- Follow-up after hospitalization for mental illness.

New Health Plans: The timing of this requirement will be in alignment with NCQA's timeline for the 2013 Health Plan Standards and Guidelines for New Health Plans. The first PIP validation will occur on the same year as the "Interim" NCQA evaluation option. However, the PIP validation will not include the elements that require baseline and interim data measures. Additionally, the MCOs that receive a comprehensive onsite review from the EQRO this contract year should expect the EQRO to review the MCO's data validation capabilities relating to a PIP during the Information Systems (IS) capabilities assessment.

8.4.B Performance Measure Validation (PMV)

To meet a CMS EQR mandated activity for validating performance measures, the EQRO will validate a select group of each MCO's HEDIS scores on an annual basis. The measures will be communicated by the Department to the MCOs each year at a time and in a format as determined by the Department.

The EQRO will follow the current CMS recommended protocol for validating performance measures, "Validating Performance Measures, A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol."

New Health Plans: The timing of this requirement will be in alignment the with NCQA's timeline for the 2013 Health Plan Standards and Guidelines for New Health Plans. The first performance measure validation will occur the same year as the "First" NCQA evaluation option, which would occur during year three (3) of the health plan delivering care to Virginia Medicaid members. However, all MCOs that are not accredited and receive a comprehensive onsite review from the EQRO this contract year should expect the EQRO to review the MCOs data validation capabilities during the IS assessment.

8.4.C Operational Systems Review (OSR)

Once every three years, the Contractor shall cooperate with and allow the EQRO to perform an onsite review of each of the MCO's operational systems as mandated by CMS through 42 C.F.R. §438.358 (b) (3).

During the years when the comprehensive OSR is not conducted, DMAS may convene a team of internal subject matter experts or contract with the EQRO to perform a "modified-OSR" of each MCO. The modified-OSR will focus on those elements identified during the most recent OSR as needing improvement and any critical elements of the MCO contract that may need focused attention. The following schedule reflects the OSR schedule:

- Comprehensive OSR during calendar year 2014 and 2017
- Modified OSR during calendar years 2015 and 2016

For all modified and comprehensive operational system reviews, the Contractor shall adhere to the timelines and tasks set forth by the EQRO or the Department.

New Health Plans: Due to the complexities involved with new health plans, mergers, and acquisitions, the Department will determine the operational systems review (OSR) schedule and scope for each new health plan that is not NCQA accredited in Virginia for the Medicaid product. The OSR is structured such that each new MCO will be subject to a possible onsite/comprehensive operational systems review from the Department, the EQRO, or both, with at least one onsite comprehensive OSR per year until such time that the Department determines the yearly frequency of OSR is no longer necessary.

8.4.D Coordination of QI Activity with Other Management Activity

The Contractor's QI findings, conclusions, recommendations, actions taken, and results of the actions taken shall be documented and reported to appropriate individuals within the Contractor's management organization and through the established QI communication channels.

QI activities shall be coordinated with other performance monitoring activities, including the monitoring of members' grievances and appeals and shall reflect the most current requirements of NCQA.

8.4.E Monitoring and Evaluation of Member Grievances and Appeals

The Contractor shall have in place a mechanism to link its member grievances and appeals system, as set forth in Section 10, to the QIP and credentialing process.

The Contractor shall, at a minimum, track trends in grievances and appeals and incorporates this information into the QI process. The Contractor's appeals and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards. See Section 10 "Grievances and Appeals" for more information.

8.4.F Wellness and Member Incentive Programs Report

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

8.5 PERFORMANCE INCENTIVE AWARDS

.Performance Incentive Awards will be made to each MCO according to criteria established by DMAS, including the quality performance measures listed below in Section 8.5.A. The criteria will include assessment of performance in quality of care and member experience. This should include, but is not limited to, scores on a subset of HEDIS measures; composite scores on CAHPS adult and child measures; performance in EQRO-conducted activities; and other measures determined by the Department. The awards will be proportionate to the extent by which the MCO achieves benchmarks for each performance measure. Note that Quality Compass® is NCQA's comprehensive national database of health plans' HEDIS® and CAHPS® results. The scoring structure and processes will be finalized by July 1, 2015.

Please note that the structure of the performance incentive awards follows a HEDIS year timeframe. HEDIS 2015, for instance, reflects services provided in the calendar year 2014.

The implementation schedule for the performance incentive awards is as follows:

Pilot Year: HEDIS 2015, reflecting services provided in 2014, will serve as the pilot baseline year with no incentives or incentive payments. NCQA's Quality Compass, scheduled for release in October 2015, shall trigger evaluation by the Department. Performance incentive scores for the Contractor, based on HEDIS 2015, will finalized by March 2016 and a consumer decision support tool will be available in May 2016.

Performance Incentive Program Active: Beginning July 1, 2016, the Department will provide each Contractor with a monthly calculation of the performance amount at risk (PAAR) for HEDIS 2016, reflecting services provided in 2015. The Department will further adjust each MCOs Fiscal Year 2018 monthly capitation payments to reflect the calculated incentive payments for HEDIS 2016 performance. NCQA's Quality Compass, scheduled for release in October 2016, shall trigger re-evaluation of performance incentive scores by the Department. Performance incentive scores for the Contractor, based on HEDIS 2016, will finalized by March 2017 and a consumer decision support tool will be available in May 2017.

The procedure will recur in following years.

8.5.A Quality Measures for Performance Incentive Awards

The value-based purchasing measured used to determine the performance incentive awards are as follows:

- **HEDIS: Combo 3 Immunization Measure: Percent of 2 year olds who are fully immunized.**
  - This measure includes all of the following vaccines by second birthday: "at least four DTaP"-diphtheria, tetanus and acellular pertussis; "at least three IPV" - polio; "at least one MMR"- measles, mumps and rubella; "at least three Hep B- hepatitis B; "at least three HiB" – H influenza type B; "at least one VZV" – chicken pox; "at least four PCV"- pneumococcal conjugate.
- **HEDIS: Percent of Members with Hypertension Cardiovascular Condition and whose blood pressure is controlled.**
- **HEDIS: Percent of Members Who Are Pregnant and Receive Timely Prenatal Care.**
- **Claims Reporting and Processing Measure**. The technical specifications for this measure are under development and will be released as final via the Managed Care Technical Manual (MCTM) once available.
- **Timeliness and Accuracy of Reporting Deliverables.** The technical specifications for this measure are under development and will be released as final via the Managed Care Technical Manual (MCTM) once available.
- **Assessments – Children with Special Health Care Needs.** The technical specifications for this measure are under development and will be released as final via the Managed Care Technical Manual (MCTM) once available.

8.6 COMPLEX CARE MANAGEMENT PROGRAMS, & PREGNANCY/PRENATAL CARE PROGRAMS

8.6.A Complex Care Management Programs:

8.6.A.I The Contractor must have, at a minimum, complex care management programs that focus on improving the health status of members diagnosed with the following conditions:

8.6.A.I.a Respiratory Conditions such as Asthma & Chronic Obstructive Pulmonary Disease (COPD),
8.6.A.I.b Heart disease, including Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF),
8.6.A.I.c Diabetes,
8.6.A.I.d Co-occurring Mental/Behavioral Health conditions, and
8.6.A.I.e Cancer.

8.6.A.II A special focus shall be placed on pediatric asthma and pediatric diabetes programs. Nothing in this section shall limit the Contractor from implementing additional complex care management programs.

8.6.A.III The Contractor must have operational complex care management programs, as set forth in this Contract, in order for the Contractor to serve eligible populations. The Contractor must have a process in place to refer members with Kidney disease to the National Kidney Foundation.

8.6.A.IV Complex Care Management Plan Submission to the Department

8.6.A.IV.a The Contractor must submit to the Department, on September 30th of each contract year, a document outlining the approach taken to address individuals with the conditions listed above. The Complex Care Management Plan must include the following elements:

8.6.A.IV.a(i) A description of how the Contractor identifies the members with the six focus conditions,

8.6.A.IV.a(ii) A description of any predictive modeling techniques employed by the Contractor,

8.6.A.IV.a(iii) A description of how success is measured in the program (HEDIS outcomes and non-HEDIS outcomes, and other measures that may include such things as: member satisfaction, decreased utilization of avoidable, inappropriate, and/or unnecessary services such as hospital readmissions, unsuitable emergency department use, preventable hospitalizations related to the chronic disease(s) at issue, etc.,

8.6.A.IV.a(iv) A description of how and why the program has or has not been successful under that definition, and

8.6.A.IV.a(v) A description of any successful measures employed by the Contractor in another state (Commercial or Medicaid lines of business), and a brief justification as to whether these measures could be successfully utilized by the Commonwealth.

8.6.B Pregnancy/Prenatal Care Programs

8.6.B.I Prenatal care, aimed to reduce infant mortality and morbidity, is an important component of the Medallion 3.0 program. As such, the Contractor must provide prenatal care, guidance and prenatal programs to its pregnant members as soon as possible within the term of the pregnancy. The Contractor, on a continuous basis, is required to identify pregnant members through the various sources available: Department transition reports, enrollment broker plan change reports, medical assessments, provider referrals, claims data, and customer/member service. Within five (5) days of identification, proactive outreach efforts must be taken by the Contractor to assist with needed prenatal services and offer prenatal programs.

8.6.B.I.a As part of the prenatal services provided, the Contractor shall provide or arrange for the screening and referral of prenatal and postnatal depression in accordance of the American College of Obstetricians and Gynecologists (ACOG). The Contractor shall make a best faith effort to screen (or refer to the appropriate practitioner to screen) pregnant women with a history of

major depression. For pregnant women with current depression or that test positive when screened for depression, the Contractor shall have/follow a process to refer the member for appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment for pre/post-natal depression.

8.6.B.I.b Smoking cessation services, education and pharmacotherapy are covered for all pregnant individuals (12VAC30-50-60).

8.6.B.II For high-risk pregnant members, the Contractor's prenatal program must assist pregnant and postpartum women in meeting other priority medical needs that affects their well-being. The prenatal service must include:

8.6.B.II.a Assessment, performed within thirty (30) days of the member being identified as having a high-risk pregnancy, to determine clients' needs which include psychosocial, nutritional, and medical factors;

8.6.B.II.b Case management services, including coordination of services and referrals to minimize fragmentation of care, reduce barriers, and link clients with appropriate services to ensure comprehensive, continuous health care;

8.6.B.II.c Service planning to develop individualized descriptions of what services and resources are needed and how to access those resources;

8.6.B.II.d Services such as patient education, homemaker services, nutritional assessment and counseling, and provision of blood glucose meters when medically necessary and within the amount, duration, and scope provisions described in 12VAC30-50-510; and,

8.6.B.II.e Substance abuse treatment services for pregnant and postpartum women. This may include referral and coordination with the Department for individuals that require day and residential treatment services (carved out of this contract) and provided through the Department's fee-for-service program.

8.6.B.III The Contractor shall submit policies and procedures to the Department which fully describe the Contractor's prenatal programs and services, including how these services are intended to be utilized, and how the Contractor will measure and monitor the prenatal program outcomes. The policies and procedures will be submitted upon start up, upon revision thereafter, and upon request. The Contractor will report on the outcomes of measurements annually.

9. PROGRAM INTEGRITY (PI) & OVERSIGHT

9.1 GENERAL PRINCIPLES

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste and abuse.

The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct and prevent fraud, waste, and abuse.

9.2 PROGRAM INTEGRITY PLAN, POLICIES, & PROCEDURES

The Virginia Medicaid Program Integrity Plan must define how the Contractor will adequately identify and report suspected fraud, waste and abuse by members, by network providers, by subcontractors and by the Contractor.

The Virginia Medicaid Program Integrity Plan must be submitted annually (See the Managed Care Technical Manual). The Plan must include the MCO PI Lead and contact information. The PI plan must also include the following elements, described in more detail in this Section, and follow the template in the Managed Care Technical Manual:

- PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
- a listing of the health plan PI contractors (unless proprietary);
- a process to act as or sub-contract with a Contractor for Recovery Audit purposes;
- and a plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid.

All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal laws and regulations.

The Contractor shall develop a written integrity plan specific to its Virginia Medicaid program.

The Contractor will have in place a process for assessment of all claims for fraudulent activity by members and providers through utilization of computer software and through periodic audits of medical records.

- The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must follow the format specified in the Managed Care Technical Manual.

The Contractor will provide the Department, on September 30th of each contract year, an annual summary of prior year activities and results. The annual plan is separate and distinct from the Program Integrity Compliance Audit (PICA).

The Department shall share fraudulent provider activity with the Contractor on a quarterly basis.

The Contractor shall refer members and providers of suspected fraud, and abuse, to the Department within forty-eight (48) hours of discovery and before initial investigation.

The Contractor shall establish written policies for all employees of the Contractor, any Contractor or agent of the Contractor, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19.

In accordance with 42 C.F.R. § 438.608, the Contractor's Program Integrity Plan must address the following requirements:

9.2.A Written Policies and Procedures

The Contractor shall have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection and reporting of incidents of potential fraud, waste and abuse by members, by network providers, by subcontractors and by the Contractor. As required in 42 C.F.R. § 455.1, the Contractor's Program Integrity Plan must include a method to verify whether services reimbursed were actually furnished to the member. The Contractor must utilize a survey (telephonic or mail), explanation of benefits (EOB) mailing, or other method approved by the Department to accomplish this requirement. Regardless of the method utilized (EOB, member survey, etc.), the Contractor's verification method must include a statistically valid sample of members based upon a percentage of the Contractor's paid claims. The Contractor may exclude certain 'sensitive' services from these verification activities.

The Contractor should have, at a minimum, the following policies and procedures in place:

9.2.A.I A commitment to comply with applicable statutory, regulatory and contractual commitments.

9.2.A.II A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules and regulations in a timely basis (no later than 30 days after the determination that there is a potential violation of civil, criminal or administrative law may have occurred).

9.2.A.III Procedures for the identification of potential fraud, waste and abuse in a Contractor's network.

9.2.A.IV A process to ensure the Contractor, agents and brokers are marketing in accordance with applicable federal and state laws, including state licensing laws, and CMS policy.

9.2.A.V A process to identify overpayments at any level within the Contractor's network and properly recover such overpayments in accordance with federal and state policy.

9.2.A.VI Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct.

9.2.A.VII Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.

9.2.A.VIII The Contractor shall have a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as PI audit recoveries. This process must assure that appropriate decisions are made as promptly as possible.

9.2.B Compliance Officer

The Contractor shall designate a compliance officer and a compliance committee, accountable to senior management, to coordinate with the Department on any fraud, waste or abuse case. The Contractor may identify different contacts for member fraud, waste and abuse, network provider fraud, waste and abuse, subcontractor fraud, waste and abuse, and Contractor fraud, waste and abuse.

9.2.C Program Integrity Lead

The Contractor shall designate a PI Lead (as outlined in the Annual Report) who will represent and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, and pre and post claim edits, PA review, and any other fraud activities and outcomes. This individual must also be involved in the Department.

Program Integrity Collaborative. The Contractor must be aware and actively be involved with State, Federal, and CMS initiatives of Program Integrity.

9.2.D Training and Education

The Contractor shall establish effective program integrity training and education for the Compliance Officer, Program Integrity Lead, all Contractor staff and subcontractors.

9.2.E Effective Lines of Communication Between Contractor Staff

The Contractor shall establish effective lines of communication between the Compliance officer, Program Integrity Lead, other Contractor staff, members, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality. The Contractor shall also establish effective lines of communication with its members.

Contractors shall establish a process to document and track reported concerns and issues, including the status of related investigations and corrective action.

The Contractor shall submit an organizational chart annually that outlines the Medallion 3.0 operating and Program Integrity division within its plan. The organizational chart should include all divisions that handle Medallion 3.0 (claims, member services, outreach/marketing, health services, etc.).

9.2.F Enforcement of Standards through Well-Publicized Disciplinary Guidelines

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines.

9.2.G Internal Monitoring and Audit

The Contractor shall establish and implement provisions for internal monitoring and auditing.

Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable state and federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

9.2.G.I Internal Monitoring and Audit - Annual Plan and/or PICA

Contractors shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Audit Schedule and Methodology, and Types of Auditing.

The plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or "spot checks," when developing the schedule. The Internal Monitoring and Audit Plan shall consist of two components: a detailed schedule of anticipated audits for the year, as well as a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

9.2.G.I.a Audits Planned for the Upcoming Year

- **9.2.G.I.a(i)** Title/Type
- **9.2.G.I.a(ii)** Description
- **9.2.G.I.a(iii)** Priority/Risk Level
- **9.2.G.I.a(iv)** Frequency.

9.2.G.I.b Completed Audits

Additionally, the Department requires a retrospective analysis of the Internal Monitoring and Audit Plan, which would include, at a minimum, the following:

- **9.2.G.I.a(v)** All requirements from 9.2.G.I.a
- **9.2.G.I.a(vi)** # of Audits Planned for Each Type identified in 9.2.G.I.a(i)
- **9.2.G.I.a(vii)** # of Audits Completed for Each Type identified in 9.2.G.I.a(i)
- **9.2.G.I.a(viii)** Emerging Trends
- **9.2.G.I.a(ix)** Investigator Assigned (if applicable)
- **9.2.G.I.a(x)** Findings
- **9.2.G.I.a(xi)** Recommendations
- **9.2.G.I.a(xii)** Action Taken.

For the first year of operations in the Commonwealth, the components of Section 9.1.G.II will be modified or waived by the Department on a case by case basis, as appropriate.

9.2.G.II **Audit Development**:

In developing the types of audits to include in the plan Contractors shall:

9.2.A.X.a Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.

9.2.A.X.b Utilize statistical methods in:

- **9.2.A.X.b(i)** Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
- **9.2.A.X.b(ii)** Determining appropriate sample size; and
- **9.2.A.X.b(iii)** Extrapolating audit findings to the full universe.

9.2.A.X.c Assess compliance with internal processes and procedures.

9.2.A.X.d Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

Contractors 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.

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, as required in Section 9.2.B, on at least a quarterly basis.

The Contractor is required to use the most current version of the Internal Monitoring and Audit Plan tool, as found in the Managed Care Technical Manual.

Contractors shall develop as part of their work plan a strategy to monitor and audit subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.

Contractors shall include routine and random auditing as part of their contractual agreement with subcontractors. Contractors shall include in their work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and should make it a priority to conduct a certain number of on-site audits.

Contractors are 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.

Contractors shall cooperate with Department auditors' on any Recovery Audit activity/findings.

9.2.G.III Audit Report

Contractor shall produce, and make available to the Department upon request, a standard audit report for each completed audit, that includes, at a minimum, the following:

9.2.G.III.a Purpose
9.2.G.III.b Methodology
9.2.G.III.c Findings
9.2.G.III.d Determination of Action and Final Resolution
9.2.G.III.e Claims Detail List/Spreadsheet

9.2.H Development of Corrective Action Initiatives

The Contractor's Program Integrity Plan shall include provisions for corrective action initiatives. The Contractors 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.

9.2.I Reporting and Investigating Suspected Fraud, and Abuse to the Department

The Contractor is required to use the templates, formats, and methodologies specified by the Department in the Managed Care Technical Manual and on the Managed Care website, located at: http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR 455.13, 455.14, 455.31). All confirmed or suspected provider fraud and abuse shall be reported to the Department within forty-eight (48) hours of discovery and before initial investigation. This notification should be sent to DMAS via email at: ManagedCare.Reporting@dmas.virginia.gov.

The Contractor shall provide information and a procedure for members, network providers and subcontractors to report incidents of potential or actual fraud, waste and abuse to the Contractor and to the Department.

The Contractor shall report all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

The Contractor shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded on to the MFCU.

9.2.I.I Quarterly Fraud/Waste/Abuse Report

The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must include, but is not limited to, the following:

9.2.I.I.a Number of cases by providers and members investigated with resolution
9.2.I.I.b Cases referred to the Department for action must include:
9.2.I.I.c Provider/Member name
9.2.I.I.d Date case was opened
9.2.I.I.e Reason(s) for initiating case
9.2.I.I.f Date case was cleared (if applicable)
9.2.I.I.g Findings
9.2.I.I.h Corrective action taken
9.2.I.I.i Financial Summary
9.2.I.I.j Recovery action taken/completed

The Contractor shall report on the quarterly report when the Contractor denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

9.2.J Cooperation with State and Federal Investigations

The Contractor shall cooperate with all fraud, waste and abuse investigation efforts by the Department and other State and Federal offices.

9.3 PROGRAM INTEGRITY COMPLIANCE AUDIT (PICA)

The Program Integrity Compliance Audit (PICA) is a compliance and valuation measure completed by each MCO to evaluate organization-level compliance and adherence to the terms of the Managed Care contract and best practice models. Completion of the PICA requires electronic submission of any and all referenced materials (MCO Policies and Procedures manuals, etc.) and documents annually to DMAS , as specified in the Managed Care Technical Manual, no later than January 1. The Department may customize the PICA to reflect areas of particular importance or focus based on trends, previous PICA findings, or other Departmental concerns. The Contractor is required to use the most current version of the PICA tool, as found in the Managed Care Technical Manual, in submission of the PICA.

The PICA submission must address all elements required of the Program Integrity Plan, and supporting documentation.

9.4 PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES

9.4.A When the Contractor identifies potential or actual fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, the allegation must be referred to the Department.

9.4.B The Contractor shall notify the Department upon formal initiation of a recovery from a solely conducted audit by the Contractor on its own network. Likewise, the Department shall notify the Contractor of formal initiation of a recovery.

9.4.C The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

9.4.D The Department, pursuant to 42 C.F.R. Part § 455, et. seq. and Section 14.12 of this Contract, may conduct audits of the Contractor's provider network, and as a result of those audits, may recover funds as appropriate.

9.4.E The Department and the MCOs shall develop implementation processes for this subsection in its entirety, placing particular emphasis on the following matters:

9.4.E.I.a Suspension of payments to the Contractor's providers or subcontractors, pursuant to 42 C.F.R.§ 455.23.

9.4.E.I.a(i) Actions related to monitoring and/or payment suspensions of specific providers or subcontractors by the Contractor, as directed by the Department or MFCU based on a "good cause" determination.

9.4.E.I.b Recoveries, initiated by the Department, resulting from audits of the Contractor's network

9.4.E.I.c Joint Audits, where the Department and the Contractor simultaneously or concurrently institute investigations of the Contractor's network.

9.4.E.I.d Recoveries based upon joint audits by the Department and the Contractor.

10. GRIEVANCE AND APPEALS

10.1 MEMBER APPEALS

10.1.A General Requirements

The Contractor shall have a system in place to respond to grievances, appeals, and claims received from members. Additionally, the Contractor shall ensure that members are sent written notice of any adverse action (as defined below) which informs members of their right to appeal through the MCO as well as their right to access the Department's State fair hearing system. The Contractor shall provide to all network providers and subcontractors information about the grievance and appeals systems to the specifications described in 42 C.F.R. 438.10(g)(1) (described in Sections 6.6 and 6.7 of this Contract) at the initiation of all such contracts.

The Contractor shall not be responsible for handling of appeals related to non-covered, carved out, and excluded services as outlined in Sections 7.3 and 7.5, including home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time) or related transportation to waiver services via the fee-for-service program.

10.1.B Member Issues

The Contractor shall provide a timely response to all inquiries received from members or on behalf of members while ensuring HIPAA compliance. Additionally, in any instance where the Contractor receives a claim for payment filed by the member, the Contractor shall respond to the member, in writing, and at the time of any action affecting the claim. This response to the member is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the member regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

10.1.C Notice of Adverse Action

The Contractor shall notify the requesting provider and shall provide written notice to enrolled (on the date of service) members whenever rendering an adverse decision. The Contractor has the option to send the member notice as an explanation of benefits statement or as a notice of adverse action. Any statement or notice must be in accordance with the definitions, content of notice, and required timeframes listed below.

10.1.C.I Definition of Adverse Action – Consistent with 42 C.F.R. §438.400, action refers to the:

- 10.1.C.I.a Denial or limited authorization of a service authorization request; including the type or level of service; or
- 10.1.C.I.b Reduction, suspension, or termination of a previously authorized (as defined in Section 1) service;
- 10.1.C.I.c Denial in whole or in part of a payment for a covered service for an enrolled member (except where the provider's claim is denied for technical reasons including but not limited to service authorization rules, referral rules, late filing, invalid codes, etc); or

10.1.C.I.d Failure by the Contractor to render a decision within the timeframes required in Section 10 and Sections 7 and 8 of this Contract; or

10.1.C.I.e For clients residing in a locality where a single contracted MCO operates under the Federal Rural Exception guidelines, the denial of a member's request to exercise his right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside of the network.

10.1.C.II Content of Notice

The notice must be in writing and must meet the language and format requirements described in 42 C.F.R. § 438.10 (See Section 6.4 of this Contract.) The notice must explain the following:

10.1.C.II.a The action taken and the reasons for the action;

10.1.C.II.b The member's right to file an appeal with the MCO;

10.1.C.II.c The member'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 this section;

10.1.C.II.d The procedures for exercising appeal rights;

10.1.C.II.e The circumstances under which expedited resolution is available and how to request an expedited resolution; and

10.1.C.II.f The circumstances under which the member has the right to request that benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services. (Reference the "Continuation of Benefits" described Section 10.1.F.)

10.1.C.III Timing of Notice

The Contractor must mail the notice within the following timeframes:

10.1.C.III.a For termination, suspension, or reduction of previously authorized services, the notice must be issued at least ten (10) calendar days prior to the effective date of the intended adverse action, as required in 42 C.F.R. § 431, Subpart E.

10.1.C.III.b For denial of payment, the notice must be issued in accordance with Section 10 at the time of action affecting the claim.

10.1.C.III.c For standard service authorization decisions that deny services, the notice must be issued within the timeframes specified in 42 C.F.R.§ 438.210(d) as described in Section 7.1 of this Contract.

10.1.C.III.d For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) calendar days, the Contractor must mail the written notice no later than the 14th day to the member, describing the reason for the decision to extend the timeframe and informing the member of the right to file a grievance if he or she disagrees with that decision. Additionally, the Contractor must issue and carry out the review for the final determination as expeditiously as the member's health condition requires and shall not exceed the date on which the extension expires.

10.1.C.III.e For service authorization decisions not reached within the required timeframes specified in Section 7.1 of this Contract, in accordance with 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an

adverse action), the notice must be issued on the date that the established timeframes for review expire.

10.1.C.III.f For expedited service authorization decisions, the notice must be issued as expeditiously as the member's health condition requires, not to exceed three (3) working days after receipt of the request for service.

10.1.C.III.g For expedited service authorization decisions where the Contractor has extended the three (3) working days turnaround time frame in accordance with Section 7.1, as expeditiously as the member's health condition requires, not to exceed the date on which the extension expires.

10.1.D Filing Grievances and Appeals

The Contractor shall have written policies and procedures that describe the grievance and appeals process and how it operates; and the process must be in compliance with 12 VAC 30-120-420, as amended. These written directives shall describe how the Contractor intends to receive, track, review, and report all member inquiries, grievances and appeals. The Contractor shall make any changes to its member grievance and appeal procedures that are required by the Department. The procedures and any changes to the procedures must be submitted to the Department prior to signing original contract, upon revision, upon request, and as needed.

The Contractor shall provide grievance and appeal forms and/or written procedures to members who wish to register written grievances or appeals. Additionally, the Contractor shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding member notices, grievances, and appeals are contained in this Section.

The grievance and appeals processes must be integrated with the Contractor's QIP. The grievance and appeals process shall include the following:

- Procedures for registering and responding to grievances and appeals in a timely fashion;
- Documentation of the substance of the grievance or appeal and the actions taken;
- Procedures to ensure the resolution of the grievance or appeal in accordance with the requirements outlined in this Contract; and
- Aggregation and analysis of these data and use of the data for quality improvement.

The Contractor must maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish Medallion 3.0 from commercial members if the Contractor does not have a separate system for Medallion 3.0 members.

10.1.D.I Grievance Procedures

A grievance is defined as an expression of dissatisfaction about any matter other than an "action" as "action" is defined in this Contract. The Contractor's grievance process must allow the member, or the member's authorized representative (provider, family member, etc.) acting on behalf of the member, to file a grievance either orally or in writing. The Contractor shall acknowledge receipt of each grievance. (Grievances received orally can be acknowledged orally.) The Contractor shall also ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the member's condition or disease. [42 C.F.R. § 438.406]

The Contractor must respond to all grievances as expeditiously as the member's health condition requires, not to exceed 30 (thirty) calendar days from the date of initial receipt of the grievance. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the member or the member's authorized representative.

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the member under the Contractor's grievance process.

10.1.D.II Appeals Process

Members have the right to appeal most adverse "action" issued by the Contractor, the Contractor's subcontractors or providers. The Contractor must accept appeals submitted within thirty (30) calendar days from the date of notice of adverse action.

Appeals Process – The Contractor's appeals process must include the following requirements:

10.1.D.II.a Allow the member, or member's authorized representative (requires written consent from the member) acting on behalf of the member to file an appeal, either orally or in writing, and unless he or she requests an expedited resolution, must follow an oral filing with a written, signed, appeal. Per 42 C.F.R. § 438.402(b) a provider, acting on behalf of the member and with the member's written consent, may file a member appeal with the Contractor and through the State Fair Hearing Process, as described in Section 10.1.E.II below.

10.1.D.II.b Acknowledge receipt of each appeal.

10.1.D.II.c Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making.

10.1.D.II.d Ensure that the individuals who, if deciding on any of the following, are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

10.1.D.II.d(i) An appeal of a denial that is based on lack of medical necessity.

10.1.D.II.d(ii) An appeal that involves clinical issues.

10.1.D.II.e Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the member or the provider appealing on the member's behalf requests expedited resolution.

10.1.D.II.f Provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this, especially in the case of expedited resolution.

10.1.D.II.g Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including any medical records and any other documents and records considered during the appeals process.

10.1.D.II.h Include as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate.

10.1.D.II.i Continue benefits while the Contractor's appeal or the State fair hearing is pending, in accordance with 42 C.F.R. § 438.420 and Section 10.1.F below:

10.1.D.II.i(i) The member or the provider on behalf of the member files the appeal within ten (10) calendar days of the Contractor's mail date of the notice of adverse action or prior to the effective date of the Contractor's notice of adverse action; and

10.1.D.II.i(ii) The appeal involves the termination, suspension, or reduction of a previously authorized (as defined in Section 1) course of treatment; and

10.1.D.II.i(iii) The services were ordered by an authorized provider; and

10.1.D.II.i(iv) The original period covered by the initial authorization has not expired; and

10.1.D.II.i(v) The member requests extension of benefits.

10.1.D.II.j If the final resolution of the appeal is adverse to the member, that is, the Contractor's adverse action is upheld, the Contractor may pursue recovery of the cost of services furnished to the member while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above, and in accordance with the policy described in 42 C.F.R. §§ 431.230(b) and 438.420.

10.1.E Resolution and Notification

10.1.E.I Standard Resolution

The Contractor shall respond in writing to standard appeals as expeditiously as the member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to the Department, upon its request, that a delay in rendering the decision is in the member's interest. For any appeals decisions not rendered within thirty (30) calendar days where the

member has not requested an extension, the Contractor shall provide written notice to the member of the reason for the delay.

For any appeal decision that is pending the receipt of additional information, the Contractor shall issue a decision within no more than 45 calendar days from the initial date of receipt of the appeal.

10.1.E.II State Fair Hearing Process

The Contractor shall educate its members of their right to appeal directly to the Department. Any adverse action or appeal that is not resolved wholly in favor of the member by the Contractor may be appealed by the member or the member's authorized representative at any time after an adverse action, and before, during or after the Contractor's appeal process. State Fair Hearings are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 370. Adverse actions include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the member or the member's representative. The appeal may be filed at any time after an adverse action, and extending through30 days after receipt of the Contractor's appeal decision. For appeals not filed within this timeline, an acceptable reason for delay must exist.

Acceptable reasons for delay shall include, but not be limited to, situations or events where:

10.1.E.II.a The member was seriously ill and was prevented from contacting the Contractor.

10.1.E.II.b The member did not receive notice of the Contractor's decision.

10.1.E.II.c The member sent the request for appeal to another government agency in good faith within the time limit;

10.1.E.II.d Unusual or unavoidable circumstances prevented a timely filing.

Additionally, a defective notice from the Contractor (i.e., a notice that does not contain the required elements) is an acceptable reason for delay.

Upon receipt of notification that the Department has received an appeal from a member for services to the Contractor's member, the Contractor must provide sufficient information regarding the adverse action or adverse appeal decision to allow the Department to determine whether the appeal request meets the timeliness requirements (i.e., the appeal was filed within 30 days of the adverse action, that it was filed during the Contractor's appeal process, or that it was filed within 30 days of the member's receipt of the Contractor's appeal decision). The Contractor must respond to requests for information within two (2) business days of receipt of notification by the Department that a member has filed an appeal.

The Department reserves the right to sanction the Contractor $5,000 per occurrence whenever it is identified that the Contractor has failed to provide notice or provides an incorrect notice of appeal rights.

For member appeals through the Department's Appeals Division, the Contractor is responsible for providing to the Department and to the member an appeal summary describing the basis for the denial in accordance with 12 VAC 30-110-70. For standard appeals, the appeal summary must be submitted to the Department and the member at least ten (10) calendar days prior to the date of the hearing. The appeal summary must include any and all justification that the Contractor wants considered as part of the State Fair Hearing, including but not limited to the policy and applicable regulations (not a summary thereof) upon which the Contractor's decision is based. For expedited appeals, (that meet the criteria set forth in 42 C.F.R. § 438.410) the appeal summary must be faxed to the Department and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than 4 business hours after the Department informs the Contractor of the expedited appeal. The Department may require that the Contractor attend the hearing either via telephone or in person. The Contractor is responsible for absorbing any telephone/travel expenses incurred.

The Contractor shall comply with the State fair hearing process, no more or less and in the same manner as is required for all other Medicaid evidentiary hearings. The Contractor shall comply with the Department's fair hearing decision. The Department's decision in these matters shall be final and shall not be subject to appeal by the Contractor.

10.1.E.III Reversed Appeal Resolutions

In accordance with 42 C.F.R. § 438.424, if the Contractor's or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the member's health condition requires. Additionally, in the event that services were continued while the appeal was pending, the Contractor must provide reimbursement for those services in accordance with the terms of the final decision rendered by the Department's Appeals Division and with the terms of this Contract and applicable regulations.

10.1.E.IV Contractor Grievance and Appeal Reporting

The Contractor shall submit to the Department by the fifteenth (15th) day of the month after the end of each month, a mutually agreed upon summary report of all provider and member inquires, grievances and appeals as illustrated in this Contract.

10.1.E.IV.a Grievance categories identified shall be organized or grouped by following general guidelines:

10.1.E.IV.a(i) Transportation

10.1.E.IV.a(ii) Access to Services/Providers
10.1.E.IV.a(iii) Provider Care and Treatment
10.1.E.IV.a(iv) MCO Customer Service
10.1.E.IV.a(v) Payment and Reimbursement Issues
10.1.E.IV.a(vi) Administrative Issues

10.1.E.IV.b Appeal categories identified shall be organized or grouped by the following general guidelines:

10.1.E.IV.b(i) Transportation
10.1.E.IV.b(ii) MCO Administrative Issues
10.1.E.IV.b(iii) Benefit Denial or Limitation

The Contractor may use reports from its existing Member Services system if the system meets the above-stated Department criteria.

10.1.E.V Expedited Appeals

The Contractor shall establish and maintain an expedited review process for appeals where either the Contractor or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

The Contractor shall issue decisions for expedited appeals as expeditiously as the member's health condition requires, not to exceed three (3) working days from the initial receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if the Contractor provides evidence satisfactory to the Department, upon its request, that a delay in rendering the decision is in the member's interest. For any extension not requested by the member, the Contractor shall provide written notice to the member of the reason for the delay. The Contractor shall make reasonable efforts to provide the member with prompt verbal notice of any decisions that are not resolved wholly in favor of the member and shall follow-up within two calendar days with a written notice of action.

All decisions to appeal must be in writing and shall include, but not be limited to, the following information:

10.1.E.V.a The decision reached by the Contractor;
10.1.E.V.b The date of decision;
10.1.E.V.c For appeals not resolved wholly in favor of the member;
10.1.E.V.d The right to request a State fair hearing and how to do so;
10.1.E.V.e The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Contractor's decision.

10.1.F Continuation of Benefits

Contractor must continue to provide benefits while the Contractor's appeal or the State fair hearing is pending, in accordance with 42 C.F.R. § 438.420, when all of the following criteria are met:

10.1.F.I The member or the provider on behalf of the member files the appeal within ten (10) calendar days of the Contractor's mail date of the notice of adverse action or prior to the effective date of the Contractor's notice of adverse action; and

10.1.F.II The appeal involves the termination, suspension, or reduction of a previously authorized (as defined in Section 1) course of treatment; and

10.1.F.III The services were ordered by an authorized provider; and

10.1.F.IV The original period covered by the initial authorization has not expired; and

10.1.F.V The member requests extension of benefits.

10.2 PROVIDER GRIEVANCES AND APPEALS

10.2.A Provider Appeals

The Contractor shall have a reconsideration and appeals process in place available to providers who wish to challenge adverse decisions. This process must assure that appropriate decisions are made as promptly as possible.

10.2.B Provider Appeals to DMAS

If a provider has rendered services to a member enrolled with the Contractor in a Medicaid program and has either been denied reimbursement for the services or has received reduced reimbursement, that provider can request an appeal of the denied or reduced reimbursement. Before appealing to the Department, MCO providers must first exhaust all MCO appeal processes. All provider appeals to DMAS must be submitted in writing and within 30 days of the Contractor's last date of denial to the DMAS Appeals Division, 600 East Broad Street, Richmond, VA 23219. The Contractor's final denial letter must include a statement that the provider has exhausted its internal appeal rights with the Contractor and that the next level of appeal is with the Department of Medical Assistance Services. The final denial letter must include the standard appeal rights to the Department (including the time period and address to file the appeal).

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the Department after 5:00 p.m. on the deadline date shall be untimely. Upon receipt of notice that the Department has received an appeal from a provider involving services provided or to be provided to the Contractor's member, the Contractor should verify that the provider has exhausted all of the Contractor's appeal processes. Further the Contractor should verify, based upon the Contractor's records, that the appeal to DMAS meets the DMAS timeliness requirements (i.e., within 30 days of the Contractor's last date of denial). The Contractor should notify the Department within two (2) business days of the receipt of the appeal notice to the State, of any appeals where the provider has not exhausted the Contractor's appeals process and/or

where the appeal does not appear to meet the Department's timeliness requirements (based upon the Contractor's records).

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in 12 VAC 30-20-500 et. seq. There are two levels of administrative appeal: (i) the informal appeal , and (ii) the formal appeal. The informal appeal is before an informal appeals agent employed by the Department. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and an administrative hearing representative employed by the Department helps present the Department's position. The Supreme Court hearing officer writes a recommended decision for use by the Director of the Department in issuing the final agency decision.

10.2.B.I **Informal Appeal**

Providers appealing a Contractor's decision shall file a written notice of informal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the Contractor's final appeals decision. The provider's notice of informal appeal shall identify the decision being appealed. Failure to file a written notice of informal appeal within 30 days of receipt of the Contractor's final appeals decision shall result in dismissal of the appeal.

The Contractor shall file a written case summary with the DMAS Appeals Division within 30 days of the filing of the provider's notice of informal appeal. The Contractor shall mail a complete copy of the case summary to the Department's MCO Contract Monitor and 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 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. Failure to submit appeals summaries within the required timeframe and according to the applicable regulatory requirements contained within 12 VAC 30-20-540 shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees.

The DMAS informal appeals agent shall conduct the conference within 90 days from the filing of the notice of informal appeal. If the Contractor and the provider and the DMAS informal appeals agent agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the DMAS informal appeals agent shall specify the time within which the provider may file written submissions, not to exceed 90 days from the filing of the notice of informal appeal. If a provider submits written submissions after filing the notice of appeal, the Contractor is responsible for submitting a response within the time period set by the informal appeals agent. Only written submissions filed within the time specified by the informal appeals agent shall be considered.

If an informal conference is conducted, the Contractor is required to attend and defend the Contractor's decision at the informal conference with the provider before a DMAS Informal Appeals Agent. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees. The conference may be recorded for the convenience of the DMAS informal appeals agent. Since the conference is not an adversarial or evidentiary proceeding, recordings shall not be made part of the administrative record and shall not be made available to anyone other than the DMAS informal appeals agent.

Upon completion of the conference, the DMAS informal appeals agent shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 days. Only documentation or information filed within the time specified by the DMAS informal appeals agent shall be considered.

The informal appeal decision shall be issued within 180 days of receipt of the notice of informal appeal. If the Contractor's decision was based in whole or part upon a medical determination such as medical necessity or appropriateness, the Contractor shall provide sufficiently qualified medical personnel to attend the conference and defend the decision being appealed. Providers have the right to appeal the DMAS informal appeal decision in accordance with 12 VAC 30-20-560, as a formal appeal.

10.2.B.II **Formal Appeals**

Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within 30 days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify the issues being appealed. Failure to file a written notice of formal appeal within 30 days of receipt of the informal appeal decision shall result in dismissal of the appeal.

The Department and the provider shall exchange and file with the hearing officer all documentary evidence on which the Department or the provider relies within 21 days of the filing of the notice of formal appeal. Only documents filed within 21 days of the filing of the notice of formal appeal shall be considered. The Department and the provider shall file any objections to the admissibility of documentary evidence within seven days of the filing of the documentary evidence. Only objections filed within seven days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven days of the filing of the objections.

The hearing officer shall conduct the hearing within 45 days from the filing of the notice of formal appeal.

Hearings shall be transcribed by a court reporter retained by the Contractor.
Upon completion of the hearing, the Department and the provider shall have 30 days to exchange and file with the hearing officer an opening brief. Only opening briefs filed within 30 days after the hearing shall be considered. The Department and the provider

shall have 10 days to exchange and file with the hearing officer a reply brief after the opening brief has been filed. Only reply briefs filed within 10 days after the opening brief has been filed shall be considered.

The hearing officer shall submit a recommended decision to the Director of DMAS with a copy to the provider within 120 days of receipt of the formal appeal request. If the hearing officer does not submit a recommended decision within 120 days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

Upon receipt of the hearing officer's recommended decision, the DMAS Director shall notify the Department and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed within 15 days of receipt of the DMAS Director's letter. Only exceptions filed within 15 days of receipt of the DMAS Director's letter shall be considered. The DMAS Director shall issue the final agency case decision within 60 days of receipt of the hearing officer's recommended decision.

At the formal level, the Contractor assists the Department's staff counsel in preparing the case summary and acts as a witness at a hearing before a hearing officer as appointed by the Virginia Supreme Court.

The Contractor shall comply with all state and federal laws, regulations, and policies regarding content and timeframes for appeal summaries. Failure to submit appeals summaries within the required timeframe and according to the applicable regulatory requirements shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearing or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. Contractor travel or telephone expenses in relation to appeal activities shall be borne by the Contractor. Failure to attend or defend the Contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's non compliance, including but not limited to the amount in dispute together with costs and legal fees. The Contractor shall supply the necessary expertise to defend its actions and shall assist the formal appeals representative in the preparation of post-hearing matters leading to the Final Agency Decision.

The final agency decision can be appealed to court for judicial review of the record. Therefore, part of the formal administrative appeal function is to maintain an accurate and complete copy of the record of the administrative proceeding, including the decision, documentary evidence, motions, briefs, exceptions, as well as the transcript of the hearing. The first level of court review is Circuit Court, then the Virginia Court of Appeals, and then by petition to the Virginia Supreme Court.

Contract negotiations, terms, or other Contractor actions are not subject to the Department's review.

11. INFORMATION SYSTEMS MANAGEMENT

11.1 SYSTEMS MANAGEMENT

The Contractor must have in place management information systems capable of furnishing the Department with timely, accurate, and complete information. Such information systems shall:

11.1.A Accept and process enrollment reports and reconcile them with the MCO enrollment/eligibility file;
11.1.B Accept and process provider claims as set forth in this Contract;
11.1.C Generate and submit encounter data as set forth in this Contract;
11.1.D Track provider network composition and access as set forth in this Contract;
11.1.E Track grievances and appeals as set forth in this Contract;
11.1.F Perform quality improvement activities, as set forth in this Contract;
11.1.G Furnish the Department with timely, accurate and complete clinical and administrative information, as set forth in this Contract;
11.1.H Ensure that data received from providers is accurate, and complete by:
- **11.1.H.I** Verifying the accuracy and timeliness of reported data;
- **11.1.H.II** Screening the data for completeness, logic, and consistency; and
- **11.1.H.III** Collecting service information in standardized formats as set forth in this Contract.

Any reference to "systems" in this Section shall mean the Contractor's MIS unless otherwise specified. If the Contractor subcontracts any MIS functions, then these requirements apply to the subcontractor's systems.

The Contractor shall accommodate and modify future system changes/enhancements to claims processing or other, related systems as soon as possible after being notified by the State of the change or enhancement. The Contractor shall advise the Department in writing of the anticipated implementation date of the system changes/enhancements. In addition, the system shall be able to accommodate all future requirements based upon Federal and State statutes, policies and regulations. Unless otherwise agreed by the State, the Contractor shall be responsible for the cost of these changes**.** The Contractor shall make available to the Department and CMS, upon request, all data collected by the Contractor in relation to and in support of the program.

11.2 ELECTRONIC DATA SUBMISSION

The Contractor may not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent that those described in 45 C.F.R. § 142.308(d). If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

11.2.A Electronic Data Interchange (EDI)

Each party will transmit electronic files directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) days written notice.

Each party will be solely responsible for the costs of any VAN with which it contracts. Each party will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling electronic files. Each party is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

11.2.B Test Data Transmission

The Contractor shall be required to pass a testing phase for each of the encounter claim types identified by the Department before production encounter data will be accepted. The Contractor shall pass the testing phase for all encounter claim type submissions within twelve (12) calendar weeks from the effective date of the change or start-up of a newly contracted MCO.

The Contractor shall submit the test encounters to the Department's Fiscal Agent electronically according to the specifications of the HIPAA Implementation Guide, DMAS Companion Guide, and the Managed Care Technical Manual.

An MCO (or Vendor) can lose production privileges due to high volume of compliance and/or critical errors (as determined by the Department). Both the Department and its Fiscal Agent can remove production privileges. When an MCO (or Vendor) loses its production privileges, then the MCO (or Vendor) it must actively test with DMAS the Department and its Fiscal Agent. Production privileges are expected to be regained within thirty (30) days.

11.2.C Garbled Transmissions

If a party receives an unintelligible transmission, that party will promptly notify the sending party (if identifiable from the received transmission).

11.2.D Enforceability and Admissibility

Any document/file properly transmitted pursuant to this Agreement will be deemed for all purposes (1) to be "a writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document/file which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents/files introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

11.3 ENROLLMENT PROCESSING

The Department, or its duly authorized representative, shall provide the Contractor on a monthly basis a listing of all members who have selected or been assigned automatically to the Contractor's plan. The listing, or "enrollment roster," shall be provided to the Contractor sufficiently in advance of the member's enrollment effective date to permit the Contractor to fulfill its identification card issuance and PCP notification responsibilities, as described in this Contract. Should the enrollment report be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and PCP notification shall be extended by one (1) business day for each day the enrollment report is delayed. The MMIS eligibility cut-off schedule is documented in the Managed Care Technical Manual. The MCO Enrollment reports

shall provide the Contractor with ongoing information about its members and disenrollees and shall be used as the basis for the monthly capitation payments.

11.3.A Enrollment Roster

The enrollment roster (834) will list all of the Contractor's members for the enrollment month who are known on the report generation date. The Enrollment Roster will be provided to the Contractor twice a month per the schedule documented in the Managed Care Technical Manual. The Contractor shall reconcile each enrollment report as expeditiously as is feasible.

11.3.B Capitation Payment File

The 820 payment file will list all of the Contractor's members for the enrollment month who are known on the report generation date. The 820 payment file will be provided to the Contractor the month after the member is enrolled as detailed in the Managed Care Technical Manual.

11.3.C Reconciliation of Enrollment

The Contractor shall work with the Department to ensure that the enrollment databases of the Department and the Contractor are reconciled. The Department may audit the Contractor's Medicaid enrollment database.

11.3.D Retroactive Adjustments

Retroactive adjustments to enrollment and payments shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to enrollment without regard to timeliness of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment update/correction. The Department shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

11.3.E Provider Enrollment Verification

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

11.4 PROVIDER IDENTIFICATION NUMBERS (NPIS, APIS)

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

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

11.5 ENCOUNTER DATA

For the purposes of this Contract, an encounter is any service received by the member and processed by the Contractor and/or its subcontractors. The Contractor shall submit encounters for all services it processes with the exception of claims the Contractor or subcontractor has determined to be a duplicate of a previously processed encounter and other exceptions as noted in the Managed Care Technical Manual. The Contractor is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the Contractor by the Department for encounters.

The Contractor must ensure that all electronic encounter data submitted to the Department are timely, accurate and complete. The Contractor shall fully cooperate with all DMAS efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the DMAS Fiscal Agent. The Contractor shall comply with all requests related to encounter data monitoring efforts in a timely manner.

11.5.A Submission Standards

Approved and denied encounters shall be submitted following the guidelines established by the Managed Care Technical Manual, including the format, data elements, and data values specified. All encounters must be submitted via Virginia's EDI FTP Server as described in that guide.

The encounter submission calendar is documented in the Managed Care Technical Manual. This calendar defines the schedule for submission of encounters by type for each contractor. The Contractor shall adhere to the Department's submission schedule.

Submitted encounter files should only include the normal submission, no backlog, no large sized compliance errors, ST-SE errors or error corrections, unless agreed to in advance by the Department. Files should be submitted to the FTP site before noon on the designated date. Any changes or delays to the submission dates require prior approval by the Department. The Department can, at its discretion, pass through the full cost to the Contractor for encounter processing costs incurred when the Contractor submits a duplicate file to Virginia's EDI FTP server. This pass-through cost will not exceed the amount DMAS is charged by its fiscal agent.

11.5.B Data Certifications

All accepted encounter submissions are required to be certified. The Contractor must keep track of every encounter submission made through the State's Fiscal Agent during the month and the MCN assigned to each. At the end of each calendar month, this data must be reported to DMAS and certified as specified in the Managed Care Technical Manual. The Encounter Certification form requires the signature of the Contractor's Chief Financial Officer, Chief Executive Officer or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. Refer to the Managed Care Technical Manual for additional details about encounter submissions and certification.

The use of the certification form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

11.5.C Timeliness of Encounter Data

The Contractor shall submit to the Department ALL electronic encounter claims within sixty (60) calendar days of the claim payment date in the contractor or subcontractor MIS. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require more frequent submissions, based on file size/volume.

Each month, for each encounter record DMAS will calculate the lag days between the MCO's submitted payment date and the date that the encounter was received by Virginia's EDI FTP server.. DMAS will assess a monetary sanction for each service type where more than 5 percent (5%) of the encounters have a lag of more than thirty (30) days. For purposes of the lag calculation, any encounter record that has a missing or invalid MCO date of payment will be considered as more than 30 days.

Sanction amount may vary by service type. Financial penalty amounts are documented in section 11.5.F below for each service type.

11.5.D Completeness of Encounter Data

The Contractor must evaluate the completeness of data from their providers and subcontractors on a periodic basis, in particular providers and subcontractors who are capitated or paid under a global fee arrangement. The Contractor must report the plan used by the Contractor, including frequency of review, to ensure encounter data completeness at start up, when revised, and upon request. Any deficiencies found through the review process must be reported to the Department within 60 calendar days. A corrective action plan to address any deficiencies found must be provided to the Department within 30 calendar days after notification of any deficiencies.

On an annual basis, DMAS will reconcile the encounter data submitted to the MMIS by the Contractor against the data submitted to DMAS by the Contractor for rate setting purposes. DMAS will assess a monetary sanction for each service type where there is more than a five percent (5%) variance between the services reported in the rate data and the encounters submitted to the MMIS.

Sanction amount may vary by service type. Sanction amounts are documented in Section 11.5.F below for each service type.

11.5.E Accuracy of Encounter Data

If it is determined that an error occurred at no fault of the State or its Fiscal Agent, the Contractor is required to submit corrected encounter data. At its discretion, the Department can pass through the full cost to the Contractor for voiding and/or adjusting and replacing the encounter data in the Virginia MMIS. This pass-through cost will not exceed the amount DMAS is charged by its Fiscal Agent.

11.5.F Encounter Service Types & Associated Financial Penalties

For purposes of this contract, the following encounter 'service types' will be used for the purpose of evaluation and assessment of penalties for timeliness and completeness of encounter data:

Service Type	Timeliness (11.5.C) Penalty Amount Maximum	Completeness (11.5.D) Penalty Amount Maximum
837P Medical	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837P Mental Health	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837P Transportation	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837P Laboratory	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837P Vision	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837P Chiropractor	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837I Medical	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
837I Mental Health	TBD/ month, beginning 2015	TBD/ year, beginning in 2015
NCPDP Pharmacy	$10,000/month, effective upon Contract Signing	$10,000/year, effective upon Contract Signing

11.6 REPORTING

The Contractor shall submit all required report deliverables as specified in this Contract and in the current the Managed Care Technical Manual. In the event that report deliverables are returned to the Contractor due to errors, the Contractor agrees to correct the incorrect data and resubmit within ten (10) business days.

Unless otherwise specified, the Contractor shall submit all reports to the Managed Care secure FTP server at: https://vammis-filetransfer.com. All submissions must comply with the Code of Virginia §32.1-325, 12 VAC 30-20-90, §1902(a)(7) of the Social Security Act, and 42 C.F.R. § 431.30012.

12. FINANCIAL MANAGEMENT

The Contractor shall establish and maintain a financial management capability sufficient to ensure that the requirements of Section 2 "Requirements for Operations," are met.

12.1 FINANCIAL STATEMENTS

12.1.A The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance.

Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

12.1.A.I **Annual Audit by Independent Contractor**
The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The Contractor shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

12.1.B The Contractor shall agree to work with the Provider Reimbursement Division of the Department to develop a financial report that details medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Medallion 3.0 Program. The Department reserves the right to approve the final format of the report. The report shall be submitted on a quarterly basis to the Department. The first quarterly reporting period shall begin on July 1 and end on September 30th. This report is subject to audit and verification by the Department.

12.2 FINANCIAL RECORDS

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Department prior to making any changes to its basis of accounting.

12.3 FINANCIAL SOLVENCY

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards**.**

12.4 CHANGES IN RESERVES

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in reserve requirements imposed by the Bureau of Insurance or any other entity.

12.5 PAYMENT TO MCOS

The Department shall issue capitation payments on behalf of members at the rates established in this Contract and modified during the contract renewal process. The Contractor shall accept the established capitation rate paid monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for June enrollment will occur in July, July payment will be made in August, etc.). If an individual is enrolled with the Contractor the first day of any given month, that MCO has the responsibility of providing services to that member no matter if they move to another locality. If the member moves to a locality outside of the MCOs service area, the member will be dropped from the plan's enrollment at the end of the month of change. The capitation payment is based on several factors (e.g., sex, age, aid category and FIPS) and is automatically generated by the system using the information in the system at the time of payment. Individuals who have their FIPS changed even towards the end of the month of enrollment will be disenrolled at the end of the month from the MCO if that individual's FIPS is outside of the MCOs service area/region. Any and all costs incurred by the Plan in excess of the capitation payment will be borne in full by the Plan. The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments.

12.5.A Schedule of MCO Monthly Payments

Monthly capitation payments to the MCOs shall be paid retrospectively by the Department for the previous monthly MCO enrollment (Payment August enrollment will occur in September. The capitation payment schedule for the current contract year is documented in the Managed Care Technical Manual.

12.5.B Health Insurer Fee

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some Medallion 3.0 health plans that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid line of business. DMAS will make an adjustment for the impact of non-deductibility of the health insurer fee on federal and State corporate income taxes but the adjustment shall not exceed the federal or State corporate income taxes reported on the plan's 2014 annual financial statement and allocated to the Virginia Medicaid line of business.

Each plan shall furnish a copy of its Letter 5067C Final Fee Calculation from the IRS to DMAS by September 15. Along with a copy of the letter 5067C, each plan shall show the methodology for allocating the health insurer fee to Virginia Medicaid line of business and certify the results. The Department will utilize this information to determine plan specific PMPM adjustments to the FY 2015 capitation rates. There will be separate components for the fee itself and the impact of non-deductibility of the health insurer fee on federal and State corporate income taxes. The Department will make a lump sum payment by October 15 based on the PMPM adjustment multiplied by estimated annual enrollment.

Each plan shall compare its final CY2014 state and corporate income tax liability for the Medicaid line of business reported to the Bureau of Insurance and the capitation adjustment for the impact of non-deductibility of the health insurer fee and refund the difference, if any, between the capitation adjustment and the actual tax liability to the Department by April 30.

12.6 RECOUPMENT/RECONCILIATION

The Department shall recoup a member's capitation payment for a given month in cases in which a member's exclusion or disenrollment was effective retroactively. The Department shall not recoup a member's capitation payment for a given month in cases in which a member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to: death of a member, cessation of Medicaid eligibility, inpatient admission to a nursing facility or State mental hospital, approval for the Technology Assisted home and community based waiver service, hospice services or transfer to a non-managed care eligible Medicaid category. This provision does not apply in cases where the Department is responsible for the total cost of medical care in a given month, e.g., hospitalization at the time of enrollment, ninth month and third trimester pregnancy exclusions, etc. In these cases the total capitation payment for the month will be rescinded.
The Department shall recoup capitation payments made in error by the Department.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a member after the effective date of the member's exclusion or disenrollment.

If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after Contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile newborn payments on a monthly basis; all other payments are reconciled on a quarterly basis. The quarterly reconciliation shall be based on adjustments

known to be needed through the end of the quarter. See the Managed Care Technical Manual for detailed information.

12.7 PAYMENT USING DRG METHODOLOGY

If the MCO has a contract with a facility to reimburse the facility for services rendered to its members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, the MCO is responsible for the full inpatient medical hospitalization from time of admission to discharge. This will be effective for any member who is actively enrolled in the MCO on the date of admission regardless if the member is disenrolled from the MCO during the course of the inpatient hospitalization.

The Contractor shall provide coverage for payment of practitioner services rendered during the hospitalization for any dates in which the member was enrolled with the contractor on the related date of service.

12.8 PAYMENT FOR NEWBORNS

Until such time that a newborn is assigned a Medicaid identification number, the charges for newborns to mothers enrolled with the Contractor are the responsibility of the Contractor for the birth month plus 2 months. Where enrollment errors occur that are later corrected, regardless of the time frame to correct such error, the Contractor is required to cover the newborn member and related charges. The Department will reimburse the Contractor the appropriate capitation payment.

12.9 BILLING MEMBERS FOR COVERED SERVICES

The Contractor, including its network providers and subcontractors, shall not bill a member for any services provided under this Contract. The Contractor shall assure that all in-network provider agreements (Reference Attachment III. Section A. number 2) include requirements whereby the member shall be held harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. However, if a member agrees in advance of receiving the service and in writing to pay for a service that is not a State Plan covered service, then the Contractor, directly or through its network provider or subcontractor can bill the member for the service.

12.9.A Billing Members for Medically Necessary Services

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a member under the State Plan or under this Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 U.S.C. § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as members are withdrawn from assignment to the Contractor.

Pursuant to Section 1932(b)(6), (42 U.S.C. § 1396u-2 (b)(6)), the Contractor and all of its subcontractors shall not hold a member liable for:

12.9.A.I Debts of the Contractor in the event of the Contractor's insolvency;

12.9.A.II Payment for services provided by the Contractor if the Contractor has not received payment from the Department for the services or if the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor.

12.9.A.III Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the member if the service had been received directly from the Contractor.

12.10 THIRD-PARTY LIABILITY

12.10.A Comprehensive Health Coverage

Members enrolled in Medicaid, determined by the Department as having comprehensive health coverage including Medicare, 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. Members will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the MCO is responsible for coordinating all benefits and following Medicaid "payer of last resort" rules. This means that deductibles and coinsurance are covered by the contracted MCO up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage.

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 member was not identified for exclusion prior to enrollment in the MCO, the Contractor shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the Contractor and identified monthly to the Department. The Contractor shall notify DMAS on a monthly basis of any members identified during that past month who were discovered to have comprehensive health coverage.

When the other payor is a commercial MCO/HMO organization, the Contractor is responsible for the full copayment amount. The member may not be billed by provider.

12.10.B Workers' Compensation

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

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

12.10.C Estate Recoveries

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

12.10.D Other Coverage

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

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

12.11 LIMIT ON UNDERWRITING GAIN & ADMINISTRATIVE COSTS

The Contractor shall be subject to a maximum underwriting gain expressed as a percentage of Medicaid premium income equal to 8.00%. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year as reported in the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance. If the ratio for calendar year in which the contract was signed exceeds 8.00% then the Contractor shall make payment to the Department equal to the excess percentage applied to the amount of Medicaid premium income attributable to the Medallion 3.0 contract, as a refund of an overpayment.

Medicaid underwriting gain shall be the amount reported on the Analysis of Operation by Lines of Business (Gain and Loss Exhibit) line 24 under the column entitled Title XIX Medicaid. Medicaid premium income shall be the amount reported on the Analysis of Operation by Lines of Business (Gain and Loss Exhibit) line 1 under the column entitled Title XIX Medicaid.

All of the variables used in the determination of this limit and the amount of any resulting payment shall be determined as if the limit did not exist. Contractors are required to notify the Department and provide supplemental information in the event that this limit impacted the financial results reported for the quarter. This supplemental financial information should include revised values for Medicaid underwriting gain and Medicaid premium income determined without application of the limit.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 member months during the calendar year. The number of member months for a given calendar year shall be the amount reported on the Exhibit of Premiums, Enrollment and Utilization line 6 under the column entitled Title XIX Medicaid. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than 12 months of experience in the program at the beginning of the calendar year.

If the Contractor is required to make a payment to the Department under this Contract provision, the payment shall be due to the Department no later than June 1 of the following calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based upon the applicability of this contract provision.

12.12 REINSURANCE

Reinsurance is a stop-loss program provided by Virginia DMAS to the Contractor. Reinsurance is available to cover 90% of a member's annual prescription drug costs above a $150,000 attachment point. The cost to the Department of providing reinsurance coverage will be offset by a reduction to the capitation rate otherwise payable during the contract year. The amount of the reduction shall be determined prospectively and shall be applied to all capitation payments.

The amount to be used in the computation of reinsurance will be the lesser of the Department's fee-for service (FFS) reimbursement amount or the Contractor paid amount. The Contractor must notify the Department quarterly of all members whose prescription drug costs have exceeded the $150,000 attachment point during the contract year. Cases identified for reinsurance coverage will be paid for a maximum 30-day retroactive period from the date of notification to the Department. All reinsurance claims are subject to medical review by the Department.

The Department will reimburse a Contractor for 90% of the annual costs of prescription drug coverage in excess of the $150,000 attachment point for any member whose total costs of prescription drug claims incurred during the contract year, less any Medicare/TPL payment, amount exceed the attachment point. Such reinsurance reimbursements shall be made quarterly for the preceding 3 month period during the contract year. Contractors are required to submit documentation for reimbursable claims along with an invoice within thirty (30) days of each quarter end during the contract year. The quarterly periods end on September 30, December 31, March 31 and June 30 of the contract year. The Department will make reinsurance reimbursements within sixty (60) days of receipt of such list/invoice or provide notice to the Contractor if additional information is required. The Department shall base reimbursement of reinsurance encounters on the lesser of the Department's FFS reimbursement amount or the reported health plan paid amount.

The Department may, at a later date, perform audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

12.13 "NEVER EVENTS" AND HEALTH CARE ACQUIRED CONDITIONS

Reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 C.F.R. 447.26.

12.13.A Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor (Thomas Reuters) used by DMAS. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

12.13.B No payment shall be made for services for inpatients for the following Never Events: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or otherwise invasive procedure performed on the wrong patient.

12.13.C No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

12.13.D Reductions in provider payment may be limited to the extent that the following apply:

- **12.13.D.I** The identified provider-preventable conditions would otherwise result in an increase in payment.
- **12.13.D.II** The Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

12.13.E Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

12.13.F In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

12.14 PRIMARY CARE PHYSICIAN PAYMENTS

12.14.A The Patient Protection and Affordable Care Act (ACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, requires that effective January 1, 2013 for Calendar Years 2013 and 2014, the Contractor must make increased payments for primary care services furnished by a physician, or under the personal supervision of a physician with a specialty designation of family medicine, general internal medicine or pediatric medicine or a related subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA). Following is a list of specialties and subspecialties recognized by the various boards:

12.14.A.I American Board of Medical Specialties (ABMS)

12.14.A.I.a Family Medicine – Adolescent Medicine; Geriatric Medicine; Hospice and Palliative Medicine; Sleep Medicine; Sports Medicine

12.14.A.I.b Internal Medicine – Adolescent Medicine; Advanced Heart Failure and Transplant Cardiology; Cardiovascular Disease; Clinical Cardiac Electrophysiology; Critical Care Medicine; Endocrinology, Diabetes and Metabolism; Gastroenterology; Geriatric Medicine; Hematology; Hospice and Palliative Medicine; Infectious Disease; Interventional Cardiology; Medical Oncology; Nephrology; Pulmonary Disease; Rheumatology; Sleep Medicine; Sports Medicine: Transplant Hepatology.

12.14.A.I.c Pediatrics – Adolescent Medicine; Child Abuse Pediatrics; Developmental-Behavioral Pediatrics; Hospice and Palliative Medicine; Medical Toxicology; Neonatal-Perinatal Medicine; Neurodevelopmental Disabilities, Pediatric Cardiology; Pediatric Critical Care Medicine; Pediatric Emergency Medicine; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology-Oncology; Pediatric Infectious Diseases; Pediatric Nephrology; Pediatric Pulmonology; Pediatric Rheumatology, Pediatric Transplant Hepatology; Sleep Medicine; Sports Medicine.

12.14.A.II American Osteopathic Association (AOA)

12.14.A.II.a Family Physicians – No subspecialties

12.14.A.II.b Internal Medicine – Allergy/Immunology; Cardiology; Endocrinology; Gastroenterology; Hematology; Hematology/Oncology; Infectious Disease; Pulmonary Diseases; Nephrology; Oncology; Rheumatology.

12.14.A.II.c Pediatrics – Adolescent and Young Adult Medicine, Neonatology, Pediatric Allergy/immunology, Pediatric Endocrinology, Pediatric Pulmonology.

12.14.A.III American Board of Physician Specialties (ABPS)

The ABPS does not certify subspecialists. Therefore, eligible certifications are:

12.14.A.III.a American Board of Family Medicine Obstetrics; Board of Certification in Family Practice; and Board of Certification in Internal Medicine. There is no Board certification specific to Pediatrics.

12.14.B If a provider is enrolled in Medicaid, the Department will determine through the attestation process if the provider is eligible for the increase payment. The Department will post a weekly file that will enable the Contractor to reimburse these providers accordingly. For providers that are contracted with an MCO but are not enrolled in Medicaid, the Contractor must administer a self-attestation process consistent with the process described in the Medicaid Memo dated December 28, 2012. Processing of the attestation form may not take more than ten business days from the date of receipt, and a process must be established to notify the provider of the status of the attestation. The Contractor must maintain each provider's attestation form and supply to the Department upon request.

All physicians who attest on or before March 31, 2013 will be eligible for higher payments for dates of service on or after January 1, 2013. Physicians submitting forms after March 31, 2013 will be eligible for higher payments for dates of service on or after the beginning of the

month of self-attestation. The date of attestation will be based on the date received by DMAS or the health plan.

If a Medicaid member receives eligible services out of network from an eligible provider, the reimbursement rate must also align with the requirements of the Affordable Care Act. Out of state providers who have attested (without benefit of a contract otherwise) will be reimbursed using the same reimbursement rate established by the Department.

The MCO will report monthly to the Department the providers not participating in Medicaid that have attested. The report will be in a specific format as described by the Department and will reflect the provider's NPI, date of attestation, and whether the individual attested to be Board Certified or to meet the 60% payment rule.

12.14.C Payments to qualified providers will be made for the Evaluation & Management (E&M) codes 99201 through 99499 and adjusted to the Medicare rate established by the Department; MCOs need not pay for codes within the specific range that are not otherwise reimbursable under the Medicaid program.. Eligible services also include vaccine and toxoid administration procedures. DMAS will post the applicable rates for these codes on the DMAS portal.

DMAS only pays for vaccine administration for children who receive vaccines through the Vaccines for Children (VFC) program. All providers must be enrolled in the program in order to receive reimbursement. Fee-for-Service providers are instructed to bill the administration fee on vaccine product codes to receive the VFC vaccine administration fee rate. Most MCOs have similar billing arrangements for VFC providers. Based on the DMAS coverage policies for vaccine administration, the only procedure code eligible for the primary care rate increase is the VFC administration code, 90460, or the product codes used in place of 90460.

However, health plans have providers who are NOT enrolled in the VFC program, but provide vaccine administration to its members. These providers may bill vaccine administration procedure codes in the range of codes eligible for the rate increase in the final rule, other than the VFC vaccine administration code (90460). These codes are not eligible for the increased payment amount in Virginia, however, because DMAS does not cover these codes. For non-VFC providers, the MCO would continue to reimburse vaccine administration using the MCO's existing reimbursement policies. Only administration fees billed with procedure code 90460 or VFC-eligible vaccine product codes are eligible for the increased payment amount. To be eligible for the increased reimbursement amount, VFC providers must bill using procedure code 90460 and/or the VFC-eligible vaccine product codes.

12.14.D Increased payments must be passed to the provider of service if billed by a group entity. The Act requires that eligible physicians receive direct benefit of the payment increase for each of the primary care services specified in this rule. This requirement must be met regardless of whether a physician is salaried, or receives a fee for service or capitated payment. The Contractor must provide assurances that the higher payment will actually be

passed on for services furnished by eligible primary care physicians. The structure of the Contractor's provider network does not mitigate this responsibility.

12.14.D.I The higher payment may be made as part of the claim payment or as lump sum payments. Lump sum payments must be made at least quarterly and the Contractor must be able to link the additional payment to a specific claim. The Contractor must submit its payment methodology to the Department prior to implementation for approval. The report must outline the following:

12.14.D.II How it will identify eligible providers

12.14.D.III What methodology will be used to reimburse eligible providers

- **12.14.D.III.a** Claim or lump sum
- **12.14.D.III.b** Frequency of payment
- **12.14.D.III.c** How it will administer "catch-up" payment

12.14.D.IV How it will assure group practices or sub capitated contractors pass increased payments to providers of service

12.14.D.V How it will recoup any identified overpayments

12.14.E Whether reimbursing providers by claim or using a file adjustment, the Contractor must report the affected additional payment to the Department on a quarterly basis. The Contractor must use the specific file format provided by the Department and the data must include all data elements required by the Department.

Based on the quarterly data received and the list of attesting providers from the Department and all MCOs, the Department will conduct a random sample of claims from those reported to ensure that the provider(s) received the correct payment. If a percentage of the random sample is found to have a high incidence of error, a full review will be required as well as a Corrective Action Plan from the Contractor. If the Department identifies a provider that was paid in error, the Contractor will be notified and expected to retract only the increased PCP adjusted payment.

At the end of CY 2013 and 2014, the Department will review a statistically valid sample of physicians who received higher payments to verify that audited physicians meet the requirements for higher payments (attested correctly). When requested, the MCO will need to provide the attestation form of those received from non-Medicaid enrolled providers and used to qualify the provider for the increased payment.

The Contractor must have sufficiently trained staff to handle calls and/or inquiries from providers regarding the attestation and reimbursement process of this regulation.

12.15 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) & RURAL HEALTH CLINICS (RHCS)

Prior to FQHC or RHC contract signature, the Contractor must notify the Department of the type of financial arrangements negotiated with FQHCs or RHCs. The Contractor must establish the following type of contractual arrangement:

If the FQHC or RHC accepts partial capitation or another method of payment at less than full risk for patient care (i.e., primary care capitation, fee-for-service), the Department will provide a cost settlement to the FQHC or RHC so that the FQHC or RHC is paid the maximum allowable of reasonable costs. In this instance, the Department shall cover the difference between the amount of direct reimbursement paid to the FQHC or RHC by the Contractor and the FQHC's or RHC's reasonable costs for services provided to Contractor patients. This arrangement applies only to patient care costs of Medallion 3.0 members.

The Contractor must provide assurances that it is paying the FQHC or RHC at a rate that is comparable to the rate it is paying other providers of similar services, and the Contractor shall provide supporting documentation at the Department's request.

Within ten (10) business days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of arrangement it has established.

12.16 CERTIFICATION (NON-ENCOUNTERS)

Any payment information from the Contractor that is used for rate setting purposes or any payment related data required by the state must be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor must use Attachment XIII, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

12.17 DISPROPORTIONATE SHARE HOSPITAL REPORT

The Contractor shall submit the Disproportionate Share Hospital Report (See the Managed Care Technical Manual) within thirty (30) days from the end of each quarter.

13. ENFORCEMENT & REMEDIES

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations including, but not limited to, the requirements of or pursuant to Section F of 12 VAC 30-120-380, as amended, the following remedies may be imposed.

The Department reserves the right to employ, at the Department's sole discretion, any of the remedies and sanctions set forth below and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department's right to any other remedy available in law or regulation.

Remedial Actions
The Department may pursue all remedial actions with the Contractor that are taken with Medicaid fee-for-service providers. The Department will work with the Contractor and the Contractor's network providers to change and correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner, as determined by the Department.

Remedies not Exclusive
The remedies available to the Department as set forth above are in addition to all other remedies available to the Department in law or in equity, are joint and severable, and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any other remedies.

13.1 REMEDIES

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall pay damages to the Department for such breach at the sole discretion of the Department, at a minimum, according to the following subsections.

If, in a particular instance, the Department elects not to exercise a damage clause or other remedy contained herein, this decision shall not be construed as a waiver of the Department's right to pursue future assessment of that performance requirement and associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

13.1.A Federally-Prescribed Sanctions For Noncompliance

13.1.A.I Section 1932(e)(1)(A) of the Social Security Act (the Act) describes the use of intermediate sanctions for States. Such sanctions may include any of the ones described in subparagraph C.1.a.ii through C.1.a.vii below, and may be imposed if the managed care organization:

13.1.A.I.a Fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to a member covered under the Contract;

13.1.A.I.b Imposes premiums or charges members in excess of the premiums or charges permitted under Title XIX of the Act;

13.1.A.I.c Acts to discriminate among members on the basis of their health status or requirements for health care services, including expulsion or refusal to re-enroll a member, except as permitted by Title XIX of the Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible members whose medical condition or history indicates a need for substantial future medical services.

13.1.A.I.d Fails to comply with the physician incentive requirements under section 1903(m)(2)(A)(x) of the Act.

In addition, the State may impose sanctions against a Managed care organization if the State determines that the entity distributed directly, or through any agent or independent Contractor marketing materials that contain false or misleading information.

13.1.A.II Section 1932(e)(2)(A) of the Act allows the State to impose the following civil money penalties:

13.1.A.II.a For each determination that the managed care organization (MCO) fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of $25,000.

13.1.A.II.b For each determination that the MCO discriminates among members on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible members based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, member, potential member, or health care provider, a maximum of $100,000.

13.1.A.II.c For each determination that the MCO has discriminated among members or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as $15,000 for each member not enrolled as a result of the practice, up to a maximum of $100,000.

13.1.A.II.d With respect to a determination that the MCO has imposed premiums or charges on members in excess of the premiums or charges permitted, the money penalty may be a maximum of $25,000 or double the amount of the excess charges, whichever is greater. The excess amount charged must be deducted from the penalty and returned to the member concerned.

13.1.A.III Section 1932(e)(2)(B) of the Act specifies the conditions for appointment of temporary management:

13.1.A.III.a Temporary management is imposed if the State finds that there is continued egregious behavior by the MCO or there is substantial risk to the health of the members. Temporary management may also be imposed if there is a need to assure the health of the organization's

members during an orderly termination or reorganization of the MCO or while improvements are made to correct violations.

13.1.A.III.b Once temporary management is appointed, it may not be removed until it is determined that the organization has the capability to ensure that the violations will not recur.

13.1.A.IV Sections 1932(e)(2)(C), (D), and (E) of the Act describe other sanctions that may be imposed:

13.1.A.IV.a The State may permit members enrolled in a Managed care organization to disenroll without cause.

13.1.A.IV.b The State may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary of Health and Human Services or the State notifies the entity of a violation determination under Section 1903(m) or Section 1932(e) of the Act.

13.1.A.IV.c The State may suspend payment to the entity under Title XIX for individual members after the date the Secretary of Health and Human Services or the State notifies the entity of the determination and until the entity has satisfied the Secretary or the State that the basis for such determination has been corrected and will not likely recur.

13.1.A.V Section 1932(e)(3) of the Act specifies that if an MCO has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and allow members to disenroll without cause.

13.1.A.VI Section 1932(e)(4) of the Act allows the State to terminate contracts of any Managed care organization that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity's members with other managed care entities or allow members to receive medical assistance under the State Plan other than through a Managed care organization.

13.1.A.VII Title 42 C.F.R. § 438.730 allows the State to recommend that CMS impose the denial of payment sanction for new members of the managed care organization when, and for so long as, payment for those members is denied by CMS in accordance with the requirements set forth in 42 C.F.R. § 438.730, as described in this Contract.

13.1.A.VIII The State must give the Managed care organization a hearing before termination occurs, and the State must notify the members enrolled with the Managed care organization of the hearing and allow the members to disenroll if they choose without cause.

13.1.B Other Specified Sanctions

If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the Contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

13.1.B.I Suspensions of New Enrollment

The Department may suspend the Contractor's right to enroll new Medicaid members (voluntary, automatically assigned, or both) under this Contract. The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option, must notify the Contractor in writing of its intent to suspend new Medicaid enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid enrollment or disenroll Medicaid members in anticipation of the Contractor not being able to comply with any requirement of this Contract or with federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify members of Contractor non-compliance and provide such members an opportunity to enroll with another MCO.

13.1.B.II Department-Initiated Disenrollment

The Department may reduce the number of current members by disenrolling the Contractor's Medicaid members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

13.1.B.III Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

13.1.B.IV Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities which are geared toward potential members. The Contractor shall be given at least ten (10) calendar days notice prior to the Department taking any action set forth in this paragraph.

13.2 PENALTIES & ENFORCEMENT MECHANISMS

13.2.A Corrective Action Plans

13.2.A.I For Contractor Non-Compliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this Contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established pursuant to Section 13.2.B.II.d, below. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

These administrative procedures shall not supersede the administrative procedures set forth in herein and those required by the Federal government.

13.2.B Financial Sanctions

The Department may impose financial sanctions/penalties upon the Contractor of at least the amount of payment required in the Contractor's contract with the disputing party.

13.2.B.I Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department must submit to the Contractor a list of the members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the Contractor in the following situations.

13.2.B.I.a Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary covered contract services, the Department may direct the Contractor to provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days written notice prior to the withholding of any capitation payment.

13.2.B.I.b Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

13.2.B.II Procedure

In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

13.2.B.II.a The Department shall notify the Contractor of the Contractor's failure to perform required administrative functions under the Contract.

13.2.B.II.b The Department shall give the Contractor thirty (30) calendar days notice to develop an acceptable plan for correcting this failure.

13.2.B.II.c If the Contractor has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage

costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.

13.2.B.II.d The Department shall notify the Contractor when it is determined that the Contractor is not in compliance with a provision in this Contract. Notice shall be sent requesting a corrective action plan to resolve the error. If the Contractor fails to respond to the Department's request in three (3) business days, the Department shall notify the Contractor in writing of its failure to respond to the Department is a violation of this Contract. If the Contractor continues to withhold corrective action within one (1) week of the date of the letter, the Department's Director shall notify the Contractor that its continued failure to act will result in one or a combination of the following remedies to the Department:

13.2.B.II.d(i) withhold of capitation;

13.2.B.II.d(ii) withhold/suspension of future enrollment;

13.2.B.II.d(iii) fines for violation not to exceed $10,000 per occurrence; and/or termination of the Contract.

13.2.B.III Suspension of Medicaid Payments in Cases of Fraud

In accordance with 42 C.F.R. § 455.23, Managed Care Organizations are subject to payment suspensions. States should suspend payments to managed care entities based upon a pending investigation of a credible allegation of fraud. Credible allegation of fraud is defined as any allegation, which has been verified by the State, from any source, including: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. DMAS does not have to notify the Contractor first of suspension of payments. The Contractor must be granted an administrative review where state law requires this.

13.2.B.IV Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid members and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor Medicaid activities.

13.2.C Imposing Sanctions for Failure to Perform Specific Contract Requirements

The Department shall assess sanctions, where noted within the body of the Contract, for the Contractor's failure to perform specific contractual obligations. Particularly, see Section 11.5.F "Encounter Service Types & Associated Financial Penalties."

13.3 PROHIBITED ACTIONS

13.3.A Prohibited Affiliations with Entities Debarred by Federal Agencies

In accordance with requirements described in 42 C.F.R. § 438.610, 42 C.F.R. § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at http://www.cms.gov/smdl/downloads/SMD061208.pdf), the Contractor shall comply with all of the following Federal requirements. Failure to comply with accuracy, timeliness, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

13.3.A.I Contractor Owner, Director, Officer(s) and/or Managing Employees

13.3.A.I.a The Contractor and or its subcontractors may not knowingly have a relationship of the type described in paragraph (b) of this section with:

13.3.A.I.a(i) An individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

13.3.A.I.a(ii) **An individual who is an affiliate,** as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

13.3.A.I.b The relationships described in this paragraph are as follows:

13.3.A.I.b(i) A director, officer, or partner of the Contractor

13.3.A.I.b(ii) A person with beneficial ownership of five percent or more of the Contractor's equity.

13.3.A.I.b(iii) A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

13.3.A.I.c Consistent with **Federal disclosure requirements** described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)* included as

part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing.

13.3.A.II Provider & Contractor Disclosure of Ownership and Control, Business Transaction, and Criminal Conviction Information

In accordance with Federal regulations contained in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 the Contractor shall disclose all of the following:

- Information on ownership and control (42 C.F.R. § 455.104),
- Information related to business transactions (42 C.F.R. § 455.105), and
- Information on persons convicted of crimes against Federally related health care programs (42 C.F.R. § 455.106)

The Contractor shall provide the required information using the Disclosure of Ownership and Control Interest Statement (CMS 1513), included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing. Additionally, the Contractor shall submit this completed form upon request to the Department within 35 calendar days of the Department's request.

The Contractor shall conduct monthly checks for all of the Contractor's owners and managing employees against the Federal listing of excluded individuals and entities (LEIE) database. Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, sanction as described in Section 13 of the Contract and/or termination of this Contract by the Department.

The Contractor shall comply with § 1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, et seq.), as amended, which requires the disclosure and justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. § 300e, et seq., as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness.

13.3.A.II.a <u>The information provided for transactions between the Contractor and a Party in Interest will include the following</u>:

13.3.A.II.a(i) The name of the Party in Interest in each transaction;

13.3.A.II.a(ii) A description of each transaction and, if applicable, the quantity of units involved;

13.3.A.II.a(iii) The accrued dollar value of each transaction during the calendar year; and

13.3.A.II.a(iv) A justification of the reasonableness of each transaction.

13.3.A.II.b The Contractor shall notify the Department within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's

ownership. Business transactions to be disclosed include, but are not limited to:

13.3.A.II.a(i) Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;

13.3.A.II.a(ii) Any lending of money or other extension of credit between the Contractor and a Party in Interest; and

13.3.A.II.a(iii) 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.

13.3.A.I.c At least five (5) calendar days prior to any change in ownership, the Contractor must provide to the Department information concerning each Person with Ownership or Control Interest as defined in this Contract. <u>This information includes but is not limited to the following</u>:

13.3.A.I.c(i) Name, address, and official position;

13.3.A.I.c(ii) A biographical summary;

13.3.A.I.c(iii) A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling.

13.3.A.I.c(iv) The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request; and

13.3.A.I.c(v) The identity of any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason. This disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 U.S.C. § 1320a-7, as amended, and 42 C.F.R. § 455.106, as amended, and must be submitted on behalf of the Contractor and any subcontractor as well as any provider of health care services or supplies.

The Contractor shall advise the Department, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid managed care 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 managed care market in another state or jurisdiction.

The Contractor shall require its non-Medicaid enrolled providers and all subcontractors, at the time of application, credentialing,

and/or recredentialing, to disclose the required information in accordance with 42 C.F.R. 455 Subpart B as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any program under Medicare, Medicaid, or CHIP.

13.3.A.I.c(vi) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

13.3.A.I.c(vii) The Contractor must report to the Department within five business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.

13.3.A.I.c(viii) Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

13.3.B Other Categorical Prohibited Affiliations with Entities:

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities which could be included in any of the following categories (references to the Act in this Section refer to the Social Security Act):

13.3.B.I **Entities which could be excluded under § 1128(b)(8),** as amended, of the Social Security Act are entities in which a person who is an officer, director, or agent or managing employee of the entity, or a person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity has:

13.3.B.I.a Been convicted of any of the following crimes:

13.3.B.I.a(i) Program related crimes, i.e., any criminal offense related to the delivery of an item or service under any Medicare, Medicaid, or other State health care program (as provided in § 1128(a)(1) of the Act, as amended);

13.3.B.I.a(ii) Patient abuse, i.e., a criminal offense relating to abuse or neglect of a patient in connection with the delivery of a health care item or service (as provided in § 1128(a)(2) of the Act, as amended);

13.3.B.I.a(iii) Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial

misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (as provided in § 1128(b)(1) of the Act, as amended);

13.3.B.I.a(iv) Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described in subsections of a. b. or c (as provided in § 1128(b)(2) of the Act, as amended);or

13.3.B.I.a(v) Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (as provided in §1128(b)(3) of the Act, as amended.

13.3.B.I.b Been excluded from participation in Medicare or a State health care program;

13.3.B.I.c Been assessed a civil monetary penalty under Section1128A of the Social Security Act [42 U.S.C. § 1320a-7(a)-(f)]; or (Civil monetary penalties can be imposed on an individual provider, as well as on provider organizations, agencies, or other entities, by the HHS Office of Inspector General and may be imposed in the event of false or fraudulent submittal of claims for payment and certain other violations of payment practice standards.)

13.3.B.I.d Been debarred, suspended, or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 and 45 C.F.R. Part 76 or under guidelines implementing such an order or is an affiliate (as defined in such Act) of a person described in clause (a).

The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

13.3.B.II **Entities which have a direct or indirect substantial contractual relationship** with an individual or entity described in Paragraph 1, above. <u>A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services</u>:

13.3.B.II.a The administration, management, or provision of medical services;

13.3.B.II.b The establishment of policies pertaining to the administration, management, or provision of medical services; or

13.3.B.II.c The provision of operational support for the administration, management, or provision of medical services.

The Contractor attests by signing this Contract that it excludes from participation in the Contract activities all entities which could be included in the categories listed in b. i. through iii. above..

13.3.B.III **Entities who are to be excluded per Code of Virginia § 32.1- 325.**

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

13.3.C Prohibited Affiliations with Contractor and Subcontractor Service Providers

13.3.C.I In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, 42 C.F.R. § 438-610, 42 C.F.R. § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled Excluded Individuals/Entities from State/Federal Healthcare Programs.

13.3.C.II The Contractor must inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at http://exclusions.oig.hhs.gov/. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s), have written policies and procedures outlining provider enrollment and/or credentialing process.

13.4 APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in both 42 C.F.R. § 438.700 (a) and 12 VAC 30-120-400, the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 12 VAC 30-120-410- and 42 C.F.R. § 438.700 through 708 allowing them to impose the sanctions provided therein.
The Contractor shall have all the appeal rights provided for in 42 C.F.R. § 438.710 and 12 VAC 30-120-410.

13.4.A Right to Appeals

The Contractor shall have the right to appeal any adverse action taken by the Department. All appeals arising out of a sanction or remedy levied pursuant to Section 13 of this Contract shall be handled in accordance with Section 13.

The Contractor may not submit to the Department for resolution under this section disputes relating to Medicaid eligibility requirements or covered services.

13.4.B Disputes Arising Out of the Contract

As provided for in Code of Virginia § 22.4363, as amended, disputes arising out of the Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

13.4.C Informal Resolution of Contract Disputes

For any dispute arising out of the Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally. Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

13.4.D Presentation of Documented Evidence

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

13.5 HIPAA COMPLIANCE: SECURITY AND CONFIDENTIALITY OF RECORDS

13.5.A HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the Contractor with this agreement or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the Contractor

from the Department or from any other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

To the extent that the Contractor uses one or more providers and/or subcontractors to render services under this Contract, and such providers/subcontractors receive or have access to protected health information (PHI), each such provider/subcontractor shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers/subcontractors to whom it provides PHI received from the Department (or created or received by The Contractor on behalf of the Department) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract.

13.5.B Use of Disclosure of Information

The use or disclosure of information concerning Contract services or members obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, and provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

The Contractor may use or disclose PHI received from DMAS, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Contractor may disclose PHI for such purposes if the disclosure is required by law, or if Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law of for the purpose for which it was disclosed to the person, and that person will notify the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

For purposes of this Contract, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this Contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member.

Except as otherwise limited in this Contract, Contractor may use or disclose protected health information (PHI) to perform functions, activities, or services for, or on behalf of, the Department as specified in this Contract. In performance of Contract services, Contractor agrees to:

Not use or further disclose protected health information (PHI) other than as permitted or required by the terms of this Contract or as required by law;

Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Contract;

Report to DMAS any use or disclosure of PHI not provided for by this Contract of which it becomes aware;

Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of DMAS as required by the HIPAA Security Rule, 45 C.F.R. Parts 160, 162, and 164 and the American Recovery and Reinvestment Act (P.L. 111-5) when effective;

Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it;

Report to the Department any security incident of which it becomes aware;

Contractor shall notify DMAS of a breach of unsecured PHI on the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide DMAS with any other available information at the time Contractor makes notification to DMAS or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to members, and protect against any future breaches.

In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

For purposes of this paragraph, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the member.

Impose the same requirements and restrictions contained in this Contract on its subcontractors and agents to whom Contractor provides PHI received from, or created or received by a Contractor on behalf of the Department;

Provide access to PHI contained in a designated record set to the Department, in the time and manner designated by the Department, or at the request of the Department, to a member in order to meet the requirements of 45 C.F.R. § 164.524.

Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the Department;

Document and provide to the Department information relating to disclosures of PHI as required for the Department to respond to a request by a member for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528;

Make its internal practices, books, and records relating to use and disclosure of PHI received from, or created or received by a Contractor on behalf of the Department, available to the Secretary of the U.S. Department of Health and Human Services Secretary for the purposes of determining compliance with 45 C.F.R. Parts 160 and 164, subparts A and E;

At termination of the Contract, if feasible, return or destroy all PHI received from, or created or received by a Contractor on behalf of the Department that the Contractor still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the Contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Contractor may use or disclose PHI received from DMAS, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. Contractor may disclose PHI for such purposes if the disclosure is required by law, or if Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and that person will notify the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

Written notices regarding any impermissible use or disclosure by the Business Associate shall be sent to DMAS through general mail to:

Contact: Theresa Fleming, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

13.5.B.I Disclosure and Confidentiality

The Contractor must have a confidentiality agreement in place with individuals of its workforce who have access to PHI. A sample Authorized Workforce Confidentiality Agreement is included as Attachment I of this Contract. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

13.5.B.II Disclosure to Workforce

The Contractor shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contractor, therefore, must ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

13.5.B.III Safeguards

The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI), other than as provided in this Contract. A description of such safeguards must be in the form of a contractor Data Security Plan (DSP). A sample DSP is included as Attachment V to this Contract. Upon reasonable request, the Contractor shall give the Department access for inspection and copying to the Contractor's facilities used for the maintenance or processing of PHI, and to books, records, practices, policies and procedures concerning the use and disclosure of PHI, including DSPs, for the purpose of determining the Contractor's compliance with this agreement.

13.5.B.IV Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the member's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 C.F.R., Section 164.528. The Contractor shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

13.5.B.V Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant

thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this Contract.

13.5.B.VI Reporting

The Contractor shall report to DMAS any use or disclosure of PHI not provided for by this Contract of which it becomes aware. Moreover, the Contractor shall notify the Department of a breach of unsecured PHI on the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include, to the extent possible, the identification of each member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to members, and protect against any future breaches.

In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Business Associate shall be responsible for all costs associated with such notification.

13.5.B.VII Access to PHI

The Contractor shall provide access to PHI contained in a designated record set to the Department, in the time, manner, and format designated by the Department, or at the request of DMAS, to an individual in order to meet the requirements of 45 C.F.R. Part 164.

13.5.B.VII.a Amendment to PHI

The Contractor shall make PHI available for amendment and incorporate any amendments to PHI in its records at the request of the Department in a time and manner as designated by the Department.

Further, the Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement, Attachment IV.

13.5.C Access to Confidential Information

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 C.F.R. Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance, and 42 C.F.R. Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The Contractor must have written policies and procedures for maintaining the confidentiality of data, including medical records and member information and appointment records for treatment of sexually transmitted diseases and submit prior to signing the initial contract, upon revision or on request to the Department.

The Contractor shall comply with the Department's Security Requirements for vendors.

13.5.D Audits, Inspections, and Enforcement

With reasonable notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA. The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any member who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any

rights such individual may have under this HIPAA, the Agreement, or any other law relating to or arising out of the Contractor's violation any provision of HIPAA.

14 Terms and Conditions

Through submittal of the response of the Department's request for Proposals and by signing this Contract, the Contractor shall accept and agree to all of the terms, conditions, criteria, and requirements set forth in these documents and their attachments. Acceptance of the terms and conditions shall serve as a waiver of any and all objections by the Contractor as to the contents of the Department's RFP and this Contract.

The Contractor may request to be exempted from any contract requirement; however, such request for exemption must be requested in writing and in advance of the Contract effective date. Any release by the Department of any contractual requirement must be approved by the Department's management. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

14.1 ACCESS TO PREMISES

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to the Contractor's premises, subcontractor's premises, or the premises of the Contractor's network providers to inspect, audit, monitor or otherwise evaluate the performance of the Contractor, subcontractor, or network provider's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event "right of access" is requested under this section, the Contractor, subcontractor, or network provider shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor's or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

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.

14.2 ALL PAYERS CLAIM DATABASE

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contactor shall be

responsible for the submission of claims data related to services provided under this contact. Such data submission, pursuant to §32.1-276.7:1, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the *Social Security Act*.

14.3 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS

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

- Federal Statutes
- Federal Regulations
- State Statutes
- Virginia State Plan
- Managed Care Waiver
- State Regulations
- Managed Care Contract, including all amendments and attachments including Medicaid memos and manuals, as well as the Managed Care Technical Manual, as updated.

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

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

14.3.A Additional Sources of Law

14.3.A.I Governing Law (Virginia)

The Contract shall be governed and construed in accordance with the laws and regulations of the Commonwealth of Virginia.

14.3.A.I.a Specific State Laws and Regulations Governing the Provision of Medical Services

The MCO shall be required to comply with all State laws and regulations, including, but not limited to: (1) the Code of Virginia Title 38.2, Chapter 43, as amended; (2) Rules Governing Health Maintenance Organizations, Virginia Administrative Code, Title 14, as amended, Chapter 211; (3) Virginia Administrative Code, 12 VAC 30-120-360 through 12 VAC 30-120-420; and (4) Code of Virginia, Title 32.1, Chapter 10.

14.3.A.II Governing Law (Federal)

14.3.A.II.a Uniform Administrative Requirements

In accordance with 45 C.F.R. § 74, the Contractor shall comply with all of the following Federal regulations.

14.3.A.II.b **Environmental Protection Rules**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under § 306 of the Clean Air Act (42 U.S.C. § 7606, § 508 of the Clean Water Act [33 U.S.C. § 1368]), which prohibits the use, under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor will report violations to the applicable Federal agency and the U.S. EPA Assistant Administrator for Enforcement.

14.3.A.II.c **Copeland "Anti-Kickback" Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 18 U.S.C. § 874 and 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 3. See also 48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

14.3.A.II.d **Davis-Bacon Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C. § 3145, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 5. See also 48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency

14.3.A.II.e **Contract Work Hours and Safety Standards Act**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 40 U.S.C §§ 327-333, and as supplemented by Department of Labor regulations, 29 C.F.R. Part 5. See also48 C.F.R. Part 22. The Contractor shall report all suspected or reported violations to the applicable Federal agency.

14.3.A.II.f **Rights to Inventions Made Under a Contract or Agreement**

Contracts or agreements for the performance of experimental, developmental, or research work shall provide for the rights of the Federal Government and State of Virginia in any resulting invention in accordance with 37 C.F.R. Part 401 "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements, and any further implementing regulations issued by U.S. Department of Health and Human Services.

14.3.A.II.g **Byrd Anti-Lobbying Amendment**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under 31 U.S.C. § 1352 and 45 C.F.R. Part 93. No appropriated funds may be expended by the member of a Federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered Federal actions: the

awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

14.3.A.II.h **Debarment and Suspension**

Each Contractor shall comply with all applicable standards, orders, or requirements issued under Executive Orders 12549 and 12689 and 45 C.F.R. part 76. Executive Order (E.O.) 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government wide system for non-procurement debarment and suspension. A person who is debarred or suspended shall be excluded from Federal financial and non-financial assistance and benefits under Federal programs and activities. Debarment or suspension of a participant in a program by one agency shall have government wide effect.

14.3.A.II.i **Energy Policy and Conservation Act**

The Contractor shall comply with any mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation plan issued in compliance with the Energy Policy and Conservation Act, Public Law 94-163.

14.4 ATTORNEY FEES

In the event the Department shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Contractor shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

14.5 AUDIT FINDINGS

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. Any such request for clarification shall be in writing from the Contractor to the Department. If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department as provided for in Section 13.4.

14.6 CHANGES IN KEY STAFF POSITIONS & ORGANIZATION

To promote continual effective communications, the Contractor must notify in writing the Department of changes in key staff positions, particularly the Chief Executive Officer (CEO), President (corporate or Commonwealth business),Contract Administrator, Chief Financial Officer (CFO), Medical Director, Medical Management Director, Member Services/Operations

Manager, Information Technology staff, Quality Improvement Manager, Project Manager, Compliance Manager/Director, Compliance Officer, and anyone key to the Contractor's operations within five (5) calendar days of any change. The notification requirement also applies to specific program or project leads assigned to participate in or serve on the Department's Meetings and/or Board, as referenced in Section 14.20.

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

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

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

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

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

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

14.7 CONFLICT OF INTEREST

Nothing in this Contract shall be construed to prevent the Contractor from engaging in activities unrelated to this Contract, including the provision of health services to persons other than those covered under this Contract, provided, however, that the Contractor furnishes the Department with full prior disclosure of such other activities. The Contractor shall comply with Federal conflict of interest provisions and requirements described in 42 C.F.R. § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

In accordance with 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Department having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. section 27) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

14.7.A Use of Third Party Administrator (TPA)

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

14.7.B Firewalled Staff & Facilities

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a Third Party Administrator (TPA) for additional services beyond those referenced in Section 14.7.A, or when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. Contractors and TPAs must provide assurances that all service level agreements with the Department will be met or exceeded.

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

14.8 CONTRACT TERM AND RENEWAL

The effective date of this Contract is July 1, 2014. This Contract will be effective until June 30, 2015.

The service areas and capitation rates for this Contract are referenced the Attachments.

The Contract shall automatically renew for six additional months if, on the ending date of this Contract, the Contractor and the Department are actively involved in good faith renegotiations of this Contract or negotiation of another risk based Contract. The capitation rates for this automatic renewal period will be set at the discretion of the Department.

The Contractor may opt out of the above automatic renewal clause. In order to do so, the Contractor must notify the Department in writing at least six (6) full calendar months prior to the renewal. If the Contractor fails to notify the Department of non-renewal on or before this date, the Contract will be automatically renewed.

14.9 CONTRACTOR LIABILITY

The Contractor assumes full financial liability for developing and managing a health care delivery system that will arrange for or administer all covered services outlined in this Contract.

14.10 COVENANT AGAINST CONTINGENT FEES

The Contractor shall warrant that no person or selling agency has been employed or retained to solicit and secure the Contract upon an agreement or understanding for commission, percentage,

brokerage, or contingency, excepting bona fide employees or selling agents maintained by the Contractor for the purpose of securing the business. For breach or violation of this warranty, the Commonwealth of Virginia shall have the right to cancel the Contract without liability or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

14.11 DELIVERY DATES FOR INFORMATION REQUIRED BY THE DEPARTMENT

When the last day for submission of any contractually required information or reports to the Department by the Contractor falls on a Saturday, Sunday or legal holiday, the information may be delivered on the next day that is not a Saturday, Sunday or legal holiday.

14.12 DEPARTMENT OVERSIGHT

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

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

The Department shall be responsible for the administration of this Contract. Administration of the Contract shall be conducted in good faith within the resources of the State, but in the best interest of the members. The Department shall retain full authority for the administration of the Medicaid Program in accordance with the requirements of Federal and State laws and regulations.

14.13 DRUG-FREE WORKPLACE

The Contractor shall acknowledge and certify that it understands that the following acts by the Contractor, its employees, and/or agents performing services on State property are prohibited from:

- The unlawful manufacture, distribution, dispensing, possession or use of alcohol or other drugs; and
- Any impairment or incapacitation from the use of alcohol or other drugs (except the use of drugs for legitimate medical purposes).

The Contractor shall further acknowledge and certify that it understands that a violation of these prohibitions constitutes a breach of contract and may result in default action being taken by the Commonwealth in addition to any criminal penalties that may result from such conduct.

14.14 INDEMNIFICATION

The Contractor hereby agrees to defend, hold harmless and indemnify the Department, its officers, agents and employees from any and all claims by third parties, regardless of their nature or validity, arising out of the performance of this Contract by the Contractor or its agents, employees, or subcontractors including, but not limited to, any liability for costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this Contract or based on any libelous or other unlawful matter contained in such data.
The Contractor is not required to defend, hold harmless or indemnify the Department, its officers, agents, and employees from claims resulting from services provided by an Agency of the Commonwealth of Virginia or its officers, agents, and employees when and if the Agency is expressly serving as a subcontractor under the provisions of this Contract.

14.15 INDEPENDENT CAPACITY

The Contractor and the agents and employees of the Contractor, in the performance of this Contract, shall act as independent Contractors and shall not act or represent themselves as officers, employees or agents of the Department or of the Commonwealth.

14.16 INSURANCE

The Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using the Department or to failure of the using the Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

Before delivering services under this Contract, the Contractor shall obtain the proper insurance coverage during the term of the Contract and ensure that all insurance coverage shall be provided by insurance companies authorized by the Virginia State Corporation Commission to sell insurance in the Commonwealth of Virginia. The Contractor shall have the following insurance coverage at the time the Contract is awarded and during the Contract period and submit documentation verifying coverage to the Department prior to initial contract signature, upon revision by the Contractor, or at the Department's request:

14.16.A Professional Liability Insurance for the Contractor's Medical Director
Insurance in the amount of at least one million dollars ($1,000,000) for each occurrence shall be maintained by the Contractor for the Medical Director.

14.16.B Workers' Compensation
The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees working in the Commonwealth of Virginia. In the event any work is subcontracted, the Contractor shall require its subcontractor(s) similarly to provide workers' compensation insurance for all the latter's employees working

in the Commonwealth. Any subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the Commonwealth of Virginia.

14.16.C Employer's Liability

The Contractor shall maintain at least one hundred thousand dollars ($100,000) in liability coverage.

14.16.D Commercial General Liability

The Contractor shall maintain one million dollars ($1,000,000) in combined single-limit liability coverage. The Commonwealth of Virginia is to be named as an additional insured with respect to the services to be procured. This coverage is to include Premises/Operations Liability, Products and Completed Operations Coverage, Independent Contractor's Liability, and Personal Injury Liability.

14.16.E Automobile Liability

The Contractor shall maintain five hundred thousand dollars ($500,000) per occurrence in automobile liability insurance for its corporate employees who use an automobile for business purposes.

14.17 LIABILITY NOTIFICATION

The Contractor shall notify the Department immediately in writing when it or one of its subcontracts is involved in a situation where the Contractor or its subcontractor maybe held liable for damages or claims against the Contractor. Such situations include automobile accidents caused by an employee of the Contractor or subcontractor where a third party is injured or dies.

14.18 MANAGED CARE TECHNICAL MANUAL – USE OF MOST CURRENT VERSION

DMAS will post the current version of the Managed Care Technical Manual on the Virginia Medicaid Managed Care web site, and also in the report directory of the DMAS secure FTP server. The version number of the Managed Care Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

The Managed Care Technical Manual will be updated no more frequently than monthly. The revised Managed Care Technical Manual will be posted to the Managed Care web site and to the FTP server no later than the last calendar day of each month. The MCOs must check the web site or server at the beginning of each month to ensure use of the most current version of the program specs for the next submission to DMAS.

14.19 MEDICAL RECORDS: ACCESS TO AND RETENTION OF RECORDS

The Contractor shall have a requirement of all network providers that medical records will be maintained in paper or electronic form for all enrolled members. The Contractor shall require compliance of all providers and subcontractors with HIPAA security and confidentiality of records standards, as detailed in Section 13.5 of this Contract. Each report must contain the valid

member Medicaid identification number. If the ID number is not valid, the report will be returned to the Contractor for correction. Additionally, the Contractor shall maintain standards for medical records that are congruent with current NCQA guidelines.

14.19.A The requirements shall:

14.19.A.I Include written policies to ensure that medical records are safeguarded against loss, destruction, or unauthorized use. The Contractor shall have written procedures for release of information and obtaining consent for treatment.

14.19.A.II Include procedures maintained by the Contractor or maintained by network provider(s) so that individual medical records for each member are made readily available to the Department, the contracted External Quality Review Organization (EQRO), and to appropriate health professionals. Procedures shall also exist to provide for prompt transfer of records to other in- or out-of-network providers for the medical management of the member. The Contractor shall use its best efforts to assist members and their authorized representatives in obtaining records within ten (10) business days of the record request. The Contractor will identify an individual who can assist members and their authorized representatives in obtaining records. The Contractor shall use its best efforts, when a member changes PCPs, to assure that his or her medical records or copies of medical records are made available to the new PCP within ten (10) business days from receipt of request from the member.

14.19.A.III Include procedures to assure that medical records are readily available for the Department, its contracted quality assurance oversight provider; Contractor-wide quality assurance and utilization review activities and provide adequate medical and other clinical data required for quality improvement, utilization management, encounter data validation, and payment activities. Specifically, the Contractor shall use its best efforts to ensure that all medical records are provided within the greater of the amount of time, if specified in the request or twenty (20) business days. The Department shall be afforded access within twenty (20) calendar days to all members' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records. The Contractor may be given only a partial list of records required for on-site audits with no advance list of records to be reviewed or one (1) week's notice, with the remaining list of records presented at the time of audit.

14.19.A.IV Provide for adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

14.19.B In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors and providers, with HIPAA security and confidentiality of records standards, detailed in this Contract. See also Section 13.5 "HIPAA Compliance: Security and Confidentiality of Records."

14.19.B.I Access to Records

The Department and its duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors or network providers.
The Department, or its duly authorized representatives, shall be allowed to inspect, copy, and audit any medical and/or financial records of the Contractor, its subcontractors and its network providers.

14.19.B.II Retention of Records

All records and reports relating to this Contract shall be retained by the Contractor for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed, six (6) years after the renewal date. When an audit, litigation or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

14.20 MEETINGS

The Contractor shall participate in meetings with the Department of Medical Assistance Services, including the Case Manager's meetings, DMAS Managed Care Advisory Committee meetings, MCO Work-Group meetings, Quality Collaborative meetings, Financial Workgroup meetings, Program Integrity meetings, or any other groups as necessary when requested to do so by the Department. Each meeting is comprised of MCO staff members in regular attendance. Any substitutions of regularly attending staff at a specific meeting require informal notification twenty-four (24) hours in advance to the Department.

14.20.A Meetings with State Government Agencies

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

14.21 MISREPRESENTATION OF INFORMATION

Misrepresentation of a Contractor's status, experience, or capability in the performance of this Contract may result in termination. Existence of known litigation or investigations in similar areas of endeavor may, at the discretion of the Department, result in immediate Contract termination and/or replacement.

14.22 NON-DISCRIMINATION

The Contractor shall comply with all applicable Federal and State laws relating to non-discrimination and equal employment opportunity and assure physical and program accessibility of all services to individuals with disabilities pursuant to persons § 504 of the Federal

Rehabilitation Act of 1973, as amended (29 U.S.C. 794), and with all requirements imposed by applicable regulations in 45 C.F.R. Part 84, Title VI of the Civil Rights Act, the Americans with Disabilities Act, the Age Discrimination and Employment Act of 1967, and the Age Discrimination Act of 1975. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability or national origin. The Contractor shall comply with the provisions of Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and supplemented in the United States Department of Labor regulations (41 C.F.R. 60).

The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the Contractor setting forth the provisions of the non-discrimination clause

14.23 OMISSIONS

Professional Liability/Errors and Omission insurance in the amount of at least $1,000,000 per occurrence, $3,000,000 aggregate shall be maintained by the Contractor.

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.24 PRACTICE GUIDELINES

The Contractor shall establish practice guidelines as described in this section, and that are congruent with current NCQA Standards for establishing guidelines.

14.24.A Adoption of Practice Guidelines

In accordance with 42 C.F.R. § 438.236, the Contractor shall adopt practice guidelines that meet the following requirements:

- **14.24.A.I** Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- **14.24.A.II** Consider the needs of the members;
- **14.24.A.III** Are adopted in consultation with contracting health care professionals; and
- **14.24.A.IV** Are reviewed and updated periodically, as appropriate.

14.24.B Dissemination of Guidelines

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. Additionally, the Contractor shall provide a copy of its practice guidelines prior to signing the initial contract, upon revision or on request to the Department.

14.24.C Application of Guidelines

Contractor decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.

14.25 RESPONSIVENESS TO THE DEPARTMENT

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

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

14.25.A Records & Litigation holds Requested by the Commonwealth

Pursuant to a request from the Department, the Medicaid Fraud Control Unit, or other relevant Commonwealth entity, or when the Department is served a Request for Discovery, the Contractor must make any and all records and documents available. The Contractor must also have the ability to implement a litigation hold to preserve such records, if so directed by the Commonwealth.

14.26 RIGHT TO PUBLISH

The Department agrees to allow the Contractor to write on subjects associated with the work under this Contract and have such writing published, provided the Contractor receives prior written approval from the Department before publishing such writings.

14.26.A Presentations & Publications Involving Virginia Data and Information

The Contractor shall submit for review any presentation or publication that will be given to outside parties and contains Virginia data and information at least thirty (30) days in advance.

14.27 SEVERABILITY, ASSIGNABILITY, AND INTERPRETATION

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such

provision does not relate to payments or services to members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

Except as allowed under subcontracting, the Contract is not assignable by the Contractor, either in whole or in part, without the prior written consent of the Department.

Any article, section, or subsection headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.28 TERMINATION OF CONTRACT

14.28.A Suspension of Contractor Operations

The Department may suspend a Contractor's operations, in whole or in part, if the Department determines that it is in the best interest of Medallion 3.0 members to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

14.28.B Terms of Contract Termination

This Contract may be terminated in whole or in part:

14.29.B.I By the Department or the Contractor, for convenience, with 180 days advance written notice;

14.29.B.II By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of Medallion 3.0 services and continued performance of the Contractor's responsibilities; or

14.29.B.III By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

14.29.B.IV Each of these conditions for Contract termination is described in the following paragraphs.

14.29.B.V **Termination for Convenience**

The Contractor or DMAS or the Department may terminate this Contract with or without cause, upon 180 days advance written notice. In addition, the Contractor may terminate the Contract, as provided in Section 14.8 of this Contract, by opting out of the renewal clause.

14.29.B.VI **Termination for Unavailable Funds**

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time

prior to the completion of this Contract if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are withdrawn, restricted, limited, or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. Determinations by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

14.29.B.VII Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

14.29.B.VIII Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract,

the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract has been terminated, in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, and liability for medical claims.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling Contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

14.28.C Termination Procedures

14.29.C.I Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for members hospitalized at the time of termination.

14.29.C.II Refunds of Advanced Payments

If the Contract is terminated under this Section, the Contractor shall be entitled to be paid a pro-rated capitation amount for the month in which notice of

termination was effective to cover the services rendered to members prior to the termination. The Contractor shall not be entitled to be paid for any services performed after the effective date of the termination. The Contractor shall, within thirty (30) calendar days of receipt, return any funds advanced for coverage of members for periods after the date of termination of the Contract.

14.29.C.III Notification of Members

In all cases of termination, the Contractor shall be responsible for notifying members about the termination, and the Department shall be responsible for reassigning members to new MCOs, as appropriate. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

14.29.C.IV Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the Contract and about the reassigning of its members to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

14.29.C.V Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

14.29.C.V.a Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;

14.29.C.V.b Place no further orders or subcontracts for materials, services, or facilities;

14.29.C.V.c Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

14.29.C.V.d Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;

14.29.C.V.e Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;

14.29.C.V.f Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;

14.29.C.V.g Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and,

14.29.C.V.h Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.

The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

14.29 TRANSITION

The Contractor shall provide for continuity of services, which is vital to the Department's overall effort to provide managed care services to its Medicaid population. Continuity of service, therefore, must be maintained at a consistently high level without interruption. Upon expiration or termination of this Contract, a successor (i.e., another contractor) must continue these services and may need transitional assistance, such as training, transferring records and encounter data, etc. The Contractor shall, therefore, be required to prepare a transition plan to provide phase-in, phase-out services and cooperate in an effort to positively affect an orderly and efficient transition to a successor.

14.30 WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the items of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

ATTACHMENTS

ATTACHMENT I - AUTHORIZED WORKFORCE CONFIDENTIALITY AGREEMENT

This Agreement between _____ [Business Associate name] and _____ (please print), an employee of _____ hereby acknowledges that [the Entity's] records and documents are subject to strict confidentiality requirements imposed by state and federal law including 42 C.F.R. § 431 Subpart F, *Code of Virginia* §2.1-377, 12 VAC 30-20-90, et. seq.

I (initial) _____ acknowledge that my supervisor, or whoever administers the data, has reviewed with me the appropriate provisions of both state and federal laws including the penalties for breaches of confidentiality.

I (initial) _____acknowledge that my supervisor or, whoever administers the data, has reviewed with me the confidentiality and security policies of our organization.

I (initial) _____acknowledge that unauthorized use, dissemination or distribution of Virginia Department of Medical Assistance Services (DMAS) confidential information is a crime.

I (initial)_____hereby agree that I will not use, disseminate or otherwise distribute confidential records or said documents or information either on paper or by electronic means other than in performance of the specific job roles I am authorized to perform.

I (initial) _____also agree that unauthorized use, dissemination or distribution of confidential information is grounds for immediate termination of my employment or contract with [the entity] and may subject me to penalties both civil and criminal.

Signed _____ Date _____

ATTACHMENT II - SUMMARY OF COVERED MEDALLION 3.0 AND MEDICAID SERVICES

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the appropriate DMAS Provider Manual.

* Indicates Carved-Out Services – contact DMAS for information on how to obtain services

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Abortions, induced*	12 VAC 30-50-100 and 12 VAC 30-50-40	No, except in those cases where there would be substantial danger to health or life of mother	No	The Contractor shall not cover services for abortion. Requests for abortions that are referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and federal law. The Commonwealth will be responsible for payment of abortion services meeting state and federal requirements under the fee-for-service program.
Case Management Services for members of Auxiliary Grants*	12 VAC 30-50-470	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.
Christian Science Nurses and Christian Science Sanatoria	12 VAC 30-50-300	No	No	This service is not a Medicaid covered service. The Contractor is not required to cover this service.
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor is required to cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor is required to cover all medically necessary court ordered Medallion 3.0 services.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Dental Services*	12 VAC 30-50-190	No except for certain circumstances.	No except for certain circumstances.	The Contractor is required to cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover CPT and other "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain members when determined such services are required to provide dental care.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover EPSDT screenings **(including lead screenings)** and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions. (Some services may require service authorization) The Contractor shall screen and assess all children. The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Early Intervention Services*	20U.S.C. § 1471 34 C.F.R.§ 303.12 Code of Virginia § 2.2-5300	Yes	No	***The Contractor is not required to provide coverage for Early Intervention services as defined by 12 VAC 30-50-131. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines. Early Intervention billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at*** http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx. The Contractor shall cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395	Yes	Yes	The Contractor is required to cover all emergency services without service authorization. The Contractor is also required to cover the services needed to ascertain whether an emergency exists. The Contractor may not restrict a member's choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. § 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.
Experimental and Investigational Procedures*	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service.
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor may not restrict a member's choice of provider or method for family planning services or supplies, and the Contractor is required to cover all family planning services and supplies provided to its members by network providers and by out-of-network providers.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01	Yes	Yes	The Contractor is required to comply with the State requirements governing HIV testing and treatment counseling for pregnant women.
Home Health Services	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity. The MCO must continue to manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term. This includes those instances where the member 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 MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. B-12 shots Insulin injections Central line and porta cath flushes Blood draws, for example where the member is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance Changing of indwelling catheter
Hospice Services	12 VAC 30-50-270	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor is required to cover inpatient stays in general acute care and rehabilitation hospitals for all members. The Contractor is required to comply with maternity length of stay requirements. Contractor is required to comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The Contractor is required to cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor is required to cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.
Lead Investigations	12 VAC 30-50-227	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover low-dose screening mammograms for determining presence of occult breast cancer.
Medical Supplies and Equipment	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover all medical supplies and equipment at least to the extent they are covered by DMAS. The Contractor is required to cover related supplies for children and nutritional supplements for adults over 21. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Mental Health Services (See last page of this table)				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor is required to cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation (Reference Table of Coverage shown in Section 7.)	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Contractor shall cover necessary procurement/donor related services. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-580.
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor is required to cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor is required to cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover annual pap smears.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225	Yes	Yes	The Contractor is required to cover physical therapy, occupational therapy, and speech pathology and Audiology services that are provided as an inpatient or outpatient hospital service or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.
Physician Services	12 VAC 30-50-140	Yes	Yes	The Contractor is required to cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Podiatry	12 VAC 30-50-150	Yes	Yes	The Contractor is required to cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410	Yes	Yes	The Contractor is required to cover case management services for high risk pregnant women and children (up to age two). The Contractor is required to provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor is required to cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends.
Prescription Drugs	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.
Private Duty Nursing	http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf; 42 C.F.R. § 441.50 and 1905(a) of Social Security Act	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	The Contractor is required to cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor is required to cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male members for prostate cancer.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor is required to cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	Contractor is required to cover reconstructive breast surgery.
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480	No (auxiliary grant administered by DSS.)	No	The Contractor is not required to cover this service. When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment. Reference the DMAS Assisted Living Facility Provider Manual for details.
School-health Services*	12 VAC 30-50-229.1	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the Medicaid fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Medicaid school provider manual. The Contractor is responsible for covering EPSDT screenings for the general Medicaid student population. Reference Section 1 "Definitions" for more details. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school.
Skilled Nursing Facility Care	12 VAC 30-50-130 -	Yes	No	The Contractor is not required to cover skilled nursing facility care. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from Medallion 3.0 upon entry into the DMAS nursing facility authorization database. The Contractor may provide step down nursing care as an enhanced benefit to Medicaid members.

Mental Health Services Are Listed At the End of this Summary Table				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor is required to provide medical transportation to all Medicaid covered services, including those Medicaid services covered by a third party payer, and transportation to carved out services such as abortions and to services provided by subcontractors such as dental. The Contractor shall not be responsible for medical transportation for managed care members who subsequently become members in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor is also required to cover eyeglasses under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based)		Yes	No	The Contractor is not required to cover home and community based waiver services or transportation to related waiver services, however, members enrolled with a MCO that subsequently meet one or more of the criteria listed in Section 5 during MCO enrollment shall be disenrolled as appropriate by DMAS, with the exception of those who subsequently become members in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (IFDDS, IID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Inpatient Mental Health Services Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001; available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor is required to cover medically necessary inpatient psychiatric hospital stays for covered members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	No	**The Contractor is not required to cover this service**. For members aged 21 through 64, the Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid members in accordance with the Contractor's overall mental health protocols, policies, and network requirements. If a member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the MCO and reimbursed by the health plan as an enhanced service, that member will be excluded from managed care participation. The MCO will notify DMAS of all member admissions to state mental hospitals.
Intensive Behavioral Dietary Counseling Services for Adults with Hyperlipidemia and Other Known Risk Factors for Cardiovascular and Diet-Related Chronic Disease, for Members Enrolled in the Medicaid Works Program *	Pending	Yes	No	**The Contractor is not required to cover this service.** This service will be covered through the DMAS fee-for-service system.

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
Temporary Detention Orders (TDOs)	42 C.F.R. § 441.150 and Code of Virginia § 16.1-335 et seq.	Yes	Yes	Pursuant to 42 C.F.R. § 441.150 and the Code of Virginia, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age 21 through 64 and admitted to a freestanding facility. The MCO is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the member is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. The duration of temporary detention shall be in accordance with the Code of Virginia, as follows: For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the Code of Virginia, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of ninety-six (96) hours. If the 96-hour period terminates on a Saturday, Sunday, or legal holiday, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, or legal holiday. A psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will

MENTAL HEALTH SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered (see notes section)	Medallion 3.0 Covered	Notes
				make a determination. A TDO shall be provided in a State or private facility certified by the State Board of Behavioral Health and Developmental Services. For Adults age 18 and over – Pursuant to § 37.2-809.H of the Code of Virginia, the duration of temporary detention shall be a minimum of twenty-four (24) hours with a maximum of seventy-two (72) hours. If the 72-hour period terminates on a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed, the TDO duration shall continue until the close of business on the next day that is not a Saturday, Sunday, legal holiday, or day on which the court is lawfully closed.
TREATMENT FOSTER CARE AND RESIDENTAL TREATMENT SERVICES FOR CHILDREN				
Treatment Foster Care (TFC) for children under age 21 years.*	12VAC 30-60-170 12VAC 30-50-480 12VAC 30-130-900 to 950	Yes	No	**. The TFC provider must contact prior-authorization agent for authorization. TFC (CM) services are carved-out.
Residential Treatment Facility Services (RTF) for children under age 21 years – Level A, B & C*	12 VAC 30-130-850 to 890	Yes	No	**DMAS authorization into a RTF program will result in disenrollment of the member from Medallion 3.0. The RTF provider must contact prior-authorization agent for authorization. Level A & B placements are group homes and Level C refers to RTF. Level A & B settings remain enrolled with the MCO, and members enrolled in Level C are exempted.

OUTPATIENT MENTAL HEALTH SERVICES The Contractor is responsible for covering medically necessary outpatient individual, family, and group mental health and substance abuse treatment services. Coverage must comply with Federal Mental Health Parity law.				
Psychiatric Diagnostic Exam	12 VAC 30-50-180 12 VAC 30-50-140	Yes	Yes	See the highlighted section above.
Individual Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Group Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Family Medical Psychotherapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Electroconvulsive Therapy	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Psychological/ Neuropsychological Testing	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
Pharmacological Management	12 VAC 30-50-140, 12 VAC 30-50-150 and 12 VAC 30-50-180	Yes	Yes	See the highlighted section above.
COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES				
Community Mental Health Services*	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-50-420 through 12 VAC 30-50-430	Yes	No	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider and coordinate with the BHSA.
Community Intellectual Disability Services*	12 VAC 30-50-440	Yes	No	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

SUBSTANCE ABUSE TREATMENT SERVICES Coverage must comply with Federal Mental Health Parity law.				
Out-patient substance abuse treatment*		Yes	Yes	The Contractor is required to cover substance assessment and evaluation and outpatient services for substance abuse treatment for Medicaid members. The Department shall cover emergency services (crisis), intensive outpatient, day treatment and SA case management. Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the Contractor.
Out-patient substance abuse opiod treatment*		Yes	Yes	If a member has been prescribed drugs for opioid treatment and the member obtains such drugs through an independent pharmacy, the drugs are the responsibility of the Contractor. If the opioid treatment is administered by the Substance Abuse provider and the Substance Abuse provider obtains the drugs for the member, such drugs shall be considered a carved-out of this contract and shall be covered by the Department Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the Contractor.
Residential Treatment for Pregnant Women	12 VAC 30-50-510	Yes	No	The MCO must provide information and referral as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
Day Treatment for Pregnant Women	12 VAC 30-50-510	Yes	No	See comment directly above.

ATTACHMENT III - NETWORK PROVIDER AGREEMENT REQUIREMENTS

A. RIGHT OF DEPARTMENT TO APPROVE, MODIFY OR DISAPPROVE NETWORK PROVIDER AGREEMENTS

The Department may approve, modify and approve, or deny network provider agreements under this Contract at its sole discretion. The Department may, at its sole discretion, impose such conditions or limitations on its approval of an agreement as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the Commonwealth and members, including but not limited to the proposed provider's past performance. The Contractor shall submit any new network provider agreement at least thirty (30) days prior to the effective date for review, and upon request thereafter. Revisions to any agreements must be submitted at least thirty (30) days prior to the effective date of use. The Contractor shall have no greater than one hundred and twenty (120) days to implement a change that requires the Contractor to find a new network provider, and sixty (60) days to implement any other change required by the Department, except that this requirement may be shortened by the Department if the health and safety of members is endangered by continuation of an existing agreement. The Department will approve or disapprove an agreement within thirty (30) days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if in the Department's sole opinion additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) days.

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

> 1. (Contractor's name) (Hereafter referred to as "Contractor") and its intended Network Provider, (Insert Network Provider's Name) (hereafter referred to as "Provider"), agree to abide by all applicable provisions of the Contract (hereafter referred to as Medicaid contract) with the Department of Medical Assistance Services. Provider compliance with the Medicaid Contract specifically includes but is not limited to the following requirements:
> 2. No terms of this agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract.

At a minimum, MCO Contracts with Providers must include the following:

- Provider agrees to participate in and contribute required data to Contractor's quality improvement and other assurance programs as required in the Medicaid contract.
- Provider agrees to abide by the terms of the Medicaid contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by the Contractor in accordance with the Medicaid Contract.

- The Provider agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet the Department specifications required by Medicaid Contract.
- The Provider agrees to comply with all non-discrimination requirements in Medicaid Contract.
- The Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in Medicaid Contract.
- The Provider agrees to provide representatives of Contractor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit access to its premises and its Contract and/or medical records in accordance with Medicaid Contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with Medicaid Contract.
- Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.
- The Provider agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid Contract. Provider agrees to make medical records available to members and their authorized representatives within ten (10) working days of the record request.
- The Provider agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.
- The Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid services.
- The Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally the Provider agrees to hold the member harmless for charges for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.
- The Provider agrees not to bill a Medicaid member for medically necessary services covered under the Medicaid contract and provided during the member's period of Contractor enrollment. This provision shall continue to be in effect even if the Contractor becomes insolvent. However, if a member agrees in advance of receiving the service and in writing to pay for a non-Medicaid covered service, then the Contractor, Contractor provider, or Contractor subcontractor can bill.
- The Provider must forward to the Contractor medical records, within ten (10) working days of the Contractor's request.

- The Providers shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the members are withdrawn from assignment to the provider.
- Except in the case of death or illness, the Provider agrees to notify the Contractor at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel members for up to thirty (30) day after such notification, until another PCP is chosen or assigned.
- The Provider agrees to act as a PCP for a predetermined number of members, not to exceed the panel size limits set forth in Section 3of this Contract, to be stated in the network provider agreement.
- The Contractor agrees to pay the Provider within thirty (30) days of the receipt of a claim for covered services rendered to a covered member unless there is a signed agreement with the Provider that states another timeframe for payment that is acceptable to that Provider.

Notwithstanding any other provision to the contrary, the obligations of Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.

B. NETWORK PROVIDER AGREEMENT SUPPLEMENT

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Provider Agreement. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Provider Agreement. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Provider Agreement.
If the Contractor uses the Provider Manual as a supplement to the Provider Agreement, all sections pertaining to Medicaid must be submitted to the Department for approval prior to signing original contract, upon revision (changes only or with changes highlighted), upon request, and as needed.

C. REVIEW AND APPROVAL OF NEW PROVIDER AGREEMENTS AND IN APPROVED SUBCONTRACTS DURING THE CONTRACT PERIOD

- New agreements and changes in approved agreements shall be reviewed and approved by the Department before taking effect. Agreements will be considered approved if the Department has not responded within thirty (30) consecutive days of the date of Departmental receipt of request.
- This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.
- Changes in rates paid to subcontractors do not have to be approved. However, changes in method of payment (e.g., fee-for-service, capitation) must be approved by the Department.
- The Contractor shall submit its current provider network to the Department monthly.

Subcontracts with State Agencies or political subdivisions shall be excluded from the requirements of this addendum to the extent excluded elsewhere in the Contract.

ATTACHMENT IV - CONFIDENTIALITY AGREEMENT FORM

This Agreement between the Virginia Department of Medical Assistance Services (DMAS) and _____ (Contractor) sets forth the terms and conditions for the disclosure of information concerning Medicare/Medicaid applicants, members or providers (Data). For purposes of this Agreement, the Contractor includes any individual, entity, corporation, partnership, or otherwise, with or without a contractual agreement with DMAS, who has been granted permission by DMAS to use or to access Data in DMAS' possession.
The uses of DMAS Data detailed in the Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. The Contractor's Security Plan shall be eventually incorporated as an Attachment to this Agreement. No other uses of DMAS Data outside of the purposes stated in Attachment V will be allowed. The Contractor agrees to restrict the release of information to the minimum information necessary to serve the stated purpose described in the Security Plan. The Contractor agrees that there will be no commercial use of the DMAS data which it receives or creates in fulfillment of its contractual obligations.

The Contractor agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Access to information concerning applicants or members must be restricted to persons who are subject to standards of confidentiality comparable to those DMAS imposes on its own employees and agents. The Contractor attests that the data will be safeguarded according to the provisions of the written, DMAS approved, Security Plan meeting the general requirements outlined in Attachment V. In no event shall the Contractor provide, grant, allow, or otherwise give, access to the Data in contravention of the requirements of its approved Security Plan. The Contractor assumes all liabilities under both state and federal law in the event that Data is disclosed in violation of 42 C.F.R. 431, or in violation of any other applicable state and federal laws and regulations.

The Contractor shall dispose of all DMAS Data upon termination of the contract according to provisions for such disposal contained in its Security Plan. Contractor certifies that all Data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the Data shall be retained by the Contractor following completion of the contract. The Contractor acknowledges that ownership of the Data remains with DMAS at all times.

A copy of all oral, written or electronic reports, presentations or other materials, in any form, whatsoever based, in whole or in part, on the Data must be reviewed and approved by DMAS prior to its release to any third party.

The Contractor will include, on the first page of all materials released to third parties, the following statement: "The following material may contain and may be based, in whole or in part, upon data provided by the Department of Medical Assistance Services, which retains all rights of ownership thereto. No copies or reproductions, electronic or otherwise, in whole or in part, of the following material may be made without the express written permission of the Department of Medical Assistance Services."

The Contractor acknowledges that DMAS reserves the right to audit for compliance with the terms of this agreement and for compliance with federal and state laws and regulations and for implementation of the terms of the approved Security Plan.

The Contractor shall notify DMAS of a breach of unsecured PHI on the first day on which such breach is known by the Contractor or an employee, officer, or agent of the Contractor other than the person committing the breach, or as soon as possible following the first day on which the contractor or an employee, officer or agent of the Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach. Notification shall include to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide DMAS with any other available information at the time Contractor makes notification to DMAS or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach: (iii) any steps the Contractor believes individuals should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches.

In the event of impermissible use or disclosure by the Contractor of unsecured protected health information, the Contractor shall notify in writing all affected individuals as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Contractor shall be responsible for all costs associated with such notification.

The Contractor hereby agrees to comply with all of the requirements set forth herein.

ATTACHMENT V - DATA SECURITY PLAN ATTACHMENT

THIS ATTACHMENT supplements and is made a part of the Business Associate Agreement (herein referred to as "Agreement") by and between the Department of Medical Assistance Services (herein referred to as "Covered Entity") and [name Business Associate] (herein referred to as "Business Associate").

I. General Requirements

The purpose of these requirements is to provide a framework for maintaining confidentiality and security of data compiled for the Business Associate or its subcontractors. This data is the property of the Covered Entity.

The Business Associate shall submit a written Business Associate Data Security Plan within thirty (30) days of the execution of this Agreement by general mail to the Covered Entity upon request. The Business Associates Data Security Plan shall describe the manner in which the Business Associate will use the Covered Entity data and the procedures the Business Associate will employ to secure the data. The uses of Covered Entity data detailed in the Business Associate Data Security Plan shall not be in violation of purposes directly related to State Plan administration included in 42 C.F.R. § 431.302. No other uses of the Covered Entity data outside of the purposes stated in the Business Associate Data Security Plan will be allowed. The Business Associate agrees to restrict the release of information necessary to serve the stated purpose described in the Business Associate Data Security Plan. The Business Associate agrees that there will be no commercial use or marketing use of the Covered Entity's data, which he or she receives or creates in fulfillment of his or her contractual obligations. Upon reasonable request, Business Associate shall give Covered Entity access for inspection and copying to the Business Associate's facilities used for the maintenance or processing of Protected Health Information (PHI), and to its books, records, practices, policies and procedures concerning the use and disclosure of PHI, for the purpose of determining the Business Associate's compliance with this Agreement.

The Business Associate agrees to fully comply with all federal and state laws and regulations, especially 42 C.F.R. § 431, Subpart F, and *Code of Virginia*, § 2.1-377, et seq. Access to information concerning applicants or members must be restricted to individuals who are subject to standards of confidentiality comparable to those the Covered Entity imposes on its own workforce and vendors. The Business Associate attests that the data will be safeguarded according to the provisions of the written, Covered Entity approved; Business Associate Data Security Plan meeting the general requirements outlined in Part II of this document. The exact content of the Business Associate Data Security Plan will be negotiated between the Business Associate and the Covered Entity's Office of Compliance and Security since the general data processing environment of each Business Associate will be different. In no event shall the Business Associate provide, grant, allow, or otherwise give access to the data in contravention of the requirements of its approved Business Associate Data Security Plan. The Business Associate assumes all liabilities under both state and federal law in the event that data is disclosed in violation of 42 C.F.R. § 431, or in violation of any other applicable state and federal laws and regulations.

The Business Associate shall dispose of all Covered Entity data upon termination of the contract according to provisions for such disposal contained in its Business Associate Data Security Plan. The Business Associate certifies that all data, whether electronic or printed, in any form: original, reproduced, or duplicated, has been disposed of in accordance with the provisions of the Business Associate Data Security Plan within thirty (30) days of completion of the project or termination of the contract. No copies, reproductions or otherwise, in whole or in part, in whatever form, of the data shall be retained by the Business Associate following completion of the contract. The Business Associate acknowledges that ownership of the data remains with the Covered Entity at all times.

II. Format for a Basic Business Associate Data Security Plan

State the nature of the requesting organization's relationship with the Covered Entity. In the absence of a Business Associate Agreement or some other formal contractual relationship with Covered Entity, please provide an explanation of how the proposed use of the Covered Entity data is directly related to State Plan Administration [see 42 C.F.R. § 431.302].

Provide the name of the Business Associate's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

Provide the names and position designations of all individuals who will have access to the data at or for the Business Associate.

State the exact purpose(s) for which the data will be used.

Describe the format (e.g., tape, paper, disk or electronic transfer) in which the Business Associate envisions receiving the required data from the Covered Entity.

Describe the medium within the Business Associate's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Business Associate's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Business Associate's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

Describe the provisions the Business Associate is taking to physically safeguard Covered Entity data in whatever form it has been provided or created. As part of the Business Associate Data Security Plan for the Covered Entity, the Business Associate must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

Describe through what mechanisms and in what format the Business Associate proposes to make final work products available to the Covered Entity.

Summarize, within the Business Associate Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with Covered Entity. If the Business Associate is subject to any other retention requirements, those requirements should be included in the Business Associate Data Security Plan.

Provide a statement of acknowledgement in the Business Associate Data Security Plan that all Covered Entity data, no matter how manipulated or summarized remains the property of Covered Entity.

Describe the provisions the Business Associate is taking to ensure continuity of service to the Covered Entity in the event of an emergency or other catastrophic event causing Business Associate business interruption (where applicable).

Note the existence of any insurance or bonds carried by the Business Associate, which would protect the Business Associate and the Covered Entity from contingent liability in the use of the data. Otherwise, provide a statement in the Business Associate Data Security Plan if no such insurance coverage exists.

DATA SECURITY PLAN EXAMPLE

XYZ Organization Business Associate Data Security Plan

1. State the nature of the requesting organization's relationship with DMAS. In the absence of a Business Associate Agreement or some other formal contractual relationship with DMAS, please provide an explanation of how the proposed use of DMAS data is directly related to State Plan Administration (see 42 C.F.R., Section 431.302).

XYZ is the contractor for DMAS contract # XXXX_XX for Preauthorization and Utilization Management Services.

2. Provide the name of the Business Associate's designated Information Security Officer, including full name, address, phone number and fax number. State the individual's relation to the business function.

Name
Title
Organization
Address
Phone
Fax

Ms. Doe oversees all IT operations at XYZ including connectivity to and data transfer between the DMAS Medicaid Management Information System (MMIS) and XYZ.

3. Provide the names and position designations of all individuals who will have access to the data at or for the Business Associate.

Associates' name, title, department

4. State the exact purpose(s) for which data will be used.

(1) Medical Review
(2) Report Generation

5. Describe the format (e.g., tape, paper, disk) in which the Business Associate envisions receiving the required data from DMAS.

Data is submitted from providers by telephone, fax, or mail for medical review purposes and is entered into the internal XYZ databases. Information for all review cases is stored on a XYZ Windows 2000 based server with Oracle 8i as the database management system. Data are backed up to magnetic tape at the end of each business day and stored offsite at X location.

6. Describe the medium within the Business Associate's organization upon which the data will be stored (e.g., will the data be on a disk pack accessible by the Business Associate's mainframe; will the data reside on a floppy disk stored in a box of similar disks beside the Business Associate's PC; will the data be accessible to many users through a network on the Internet or on an Intranet?)

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ maintains file storage facilities for on-site review of the previous six months of documentation. XYZ maintains offsite storage for files older than 6 months at X storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

Information pertaining to all requests is entered at the Windows 2000 desktop using Visual Basic developed screens and is stored on our Windows 2000 based server with Oracle 8i as the database management system. Data is backed up to magnetic tape at the end of each business day and stored offsite at X location. Access to the server for administrative purposes is limited to the Systems Manager, John Doe, and the Database Administrator, Jane Doe. User access to the system and the case review data is controlled by Windows 2000 security provisions with additional access limitation imposed on the database side via Oracle. Both user ID's and passwords are required for access. Passwords are automatically aged by the system and must be changed by each user every thirty (30) days.

The Virginia Medicaid system is housed on a Hewlett Packard Pentium III 600 MHz server with 384k memory. Hard disk storage includes a RAID-5 disk array with four – 9.1 KB disk drives, a redundant power supply and tape backup. This system will have the same connectivity to DMAS MMIS as described above.

Data are never sent over the Internet. XYZ uses a secure 'internal' email system. Connectivity to our network is through a LAN in our Richmond office that then accesses our corporate email server via a dedicated frame delay connection line. We do not use Internet email facilities to send any DMAS information. Please refer to the response to question 7 for further information.

XYZ currently connects to the MMIS at X location via a frame-relay connection from our Richmond office to DMAS.

Future Operating Environment

As required by our new contract with DMAS we will eventually connect to MMIS at X location directly, rather than connecting at DMAS. We will use a serial connection between the XYZ provided CSU/DSU and the X router. Based on the expected volume, we will provide a 64 KBPS frame relay dedicated data line to the current DMAS Fiscal Agent's data center. In the event that traffic increases significantly, additional bandwidth can be added. At both ends of the frame relay data line, XYZ will provide an ADTRAN TSU LT T1/Fractional T1 CSU/DSU. A public address subnet will be provided if requested by Fiscal Agent for router-to-router connection. There will be a serial router port connection to the CSU/DSU on the Fiscal Agent side of the connection. As required, only public IP addresses will be presented across the data line. No connections across the Internet will be used.

XYZ will employ terminal emulation software – Eicon Access for Windows 3270 – to access the system from our desktop personal computers. Our existing employees and the DMAS contract monitors currently use this software to provide 3270 emulation for access to the DMAS computer system.

While our existing computer system easily and effectively handles all the processing required to support the DMAS requirements, every automated system can be improved. To reduce our maintenance costs, improve system access to DMAS authorized users and improve reliability, we are enhancing our existing Visual Basic/Oracle 8i Based computer system to a configuration that can also employ a browser-based client under Windows 95/98/2000. This browser-based access will use a secure Virtual Private Network (VPN) connection to XYZ's Windows 2000 server supporting the Oracle 8i-database management system. This new environment will make it possible to extend access to the system to any DMAS approved user with access to the Internet, subject to encryption in the manner prescribed in the HCFA Internet Security Policy dated 11/24/1998.

Based on provider interest and approval of DMAS, we will develop ASP based forms to allow providers using their Internet connection to enter data about the pre-authorization request directly from their location – reducing or eliminating the need to fax this information

to XYZ. Entry of information by the providers at the source of data to the XYZ maintained database means that errors and processing time associated with printing the fax, routing the fax to the appropriate reviewer and subsequent entry of the information to our computer system are eliminated.

7. Describe the provisions the Business Associate is taking to physically safeguard DMAS data in whatever form it has been provided or created. As part of the Business Associate Data Security Plan for DMAS, the Business Associate must include a copy of any security plan, security policies, or security procedures currently in effect within the organization.

Our data security and confidentiality plans are summarized and described below.

To ensure XYZ compliance with all of the confidentiality and security requirements associated with use and storage of health care information, all XYZ employees must adhere to the confidentiality rules and security procedures outlined in the XYZ Employee Notebook.

The notebook is updated as needed but at least every year to reflect current XYZ policies that its employees must adhere to. Every new employee is provided with a copy of the manual, and our Human Resources Department reviews the key section dealing with our confidentiality policy. This section includes information about:

- Access and disclosure of confidential information
- Responsibility for confidentiality vested in a single individual
- Research and statistical reporting
- Legal requests for information
- Disclosure, monitoring, review and evaluation
- Disclosure of privileged data and information to third parties
- Patient access to XYZ data and information
- Prospective employee background investigations
- Trustee and employee access and training
- Document accountability
- Building security
- Communications security, ADP security
- Subcontract requirements
- Responsibilities of medical review coordinators
- Requests for the generation of non-privileged information
- Penalties for disclosure of confidential information

HIPAA mandates new security standards to protect an individual's health information, while permitting the appropriate access and use of that information by health care providers, clearinghouses, and health plans. The standard mandates safeguards for physical storage and maintenance, transmission and access to individual health information regardless of the medium used. In addition to our institutionalization of confidentiality and security policies discussed above, XYZ will comply with all HIPAA data security requirements as needed.
These are some examples of steps we already have in place in:

We have in place appropriate physical safeguards to protect data integrity, confidentiality and availability. Our offices are secure and require a key or swipe card for entry. Only XYZ employees and four DMAS contract monitors are granted these keys/cards. Visitors to XYZ facilities are required to register and wear visitor's passes. In addition a XYZ employee must escort them. Our computer servers and databases are housed in a locked room within our secure facility. Access to the computer room is limited to information technology personnel. XYZ employees escort maintenance personnel at all times. Smoke detectors and automated sprinkler systems are installed to protect from fire.

We have developed and implemented administrative procedures to guard data integrity, confidentiality and availability. All employees are required to read and sign a non-disclosure agreement as a condition of employment. An employee handbook has been developed that details all employee responsibilities and acceptable conduct and the actions that may be taken in the event of improper conduct. Security awareness training is conducted periodically. All data is backed up on a daily basis and secured in a fireproof safe. Virus detection and correction software is installed on all PCs and corporate servers. Updates to this software are made on a bi-weekly basis.

We have implemented technical security services to guard data integrity, confidentiality and availability. Access to our local area network and the services available on that network are limited to authorized users. The program manager for each program grants authorization and a unique user id and password are used to gain access. Passwords are automatically retired every thirty (30) days. Access to the automated applications and underlying databases requires a separate logon and password. Access is further controlled on a "need" basis, providing either no access, read only or write access to data. Users are automatically denied access following 3 failed logon attempts. System logs record user logon attempts, and applications capture information about who has added, modified or deleted records.

Finally we have implemented appropriate technical security mechanisms that include the processes to prevent unauthorized access to data that is transmitted over a communications network. Our Systems Administrator, who grants access to users only upon program manager approval, controls access to our network. Currently, remote access to our local area network (and thence to the applications and databases) is highly restricted, and is used only from system administration. As we migrate our applications to a "web" ready environment, we will only support dial-in access (to users approved by DMAS) via a limited number of dial up circuits or via the Internet using Virtual Private Network (VPN) technology VPN supports user authentication via public-private key exchange and provides a secure connection from the remote user to our systems over an encrypted "virtual tunnel" through the Internet.

To ensure that our security policies and practices remain current, we will periodically assess our security risks and vulnerabilities and the mechanisms currently in place to mitigate those risks and vulnerabilities. Measures in addition to those described above will be added as needed.

8. Identify all individuals (or entities) to whom the data will be distributed as a result of the business function.

Data that identify individual members, providers or facilities will never be distributed to any entity outside DMAS except with the express prior consent of DMAS. Aggregated data may be used for provider training, legislative presentations etc., but also only with the prior consent of DMAS. Data may occasionally be requested by HCFA or to other federal oversight authorities for inclusion in multi-state studies, analyses or for other purposes, but again, will not be released without the consent of DMAS.

9. Describe through what mechanisms and in what format the Business Associate proposes to make final work products available to DMAS.

XYZ will use the mechanisms and formats preferred by DMAS to make final work products available. This may include electronic transmission, tape, diskette, hard copy, or any other medium requested by DMAS.

Currently the weekly, monthly, quarterly annual and ad hoc reports are sent to DMAS electronically and/or in hard copy format. XYZ does not electronically send any reports to DMAS that contain patient identifiable information.

10. Summarize, within the Business Associate Data Security Plan, the data retention and disposal requirements that exist in the Contract or Agreements with DMAS. If the Business Associate is subject to any other retention requirements, those requirements should be included in the Business Associate Data Security Plan.

To ensure confidentiality and security, XYZ maintains a filing process that includes staff assigned for file maintenance, file retrieval, file purging and file preparation for offsite storage. XYZ provides DMAS with access to all files during normal hours of operation.

XYZ currently maintains file storage facilities onsite and available for review for the previous 6 months of documentation. XYZ maintains offsite storage for files older than 6 months at x storage facility. Files stored at this facility are returned to our location within 24 hours of the retrieval request. Emergency same-day retrieval service is also available.

XYZ shreds all hard copy data that is not stored for retrieval. Any removable magnetic media that has been used for storage is degausses before disposal.

11. Provide a statement of acknowledgement in the Business Associate Data Security Plan that all DMAS data, no matter how manipulated or summarized remains the property of DMAS.

XYZ is well aware of the confidential nature of the information that we will receive and process, both in paper and electronic format. We also understand that all data provided by DMAS to XYZ remains the property of DMAS. We will use this data only for the activities needed to fully support all the requirements of this scope of work. In the event a need arises for use of the DMAS provided data for some other purpose, XYZ will obtain written permission from DMAS in advance of any use of this data. XYZ also agrees to follow federal and state confidentiality requirements as set forth in the then current Code of Federal Regulations and the then current Code of Virginia.

12. Describe the provisions the Business Associate is taking to ensure continuity of service to DMAS in the event of an emergency or other catastrophic event causing Business Associate business interruption (where applicable).

XYZ has instituted a policy detailing our procedures for preauthorization during loss of connectivity. The following policies may be found in our XYZ -- Virginia Operations Policy and Procedures Manual and are also attached to this document.

Utilization Review (Inpatient) Procedure for Loss of Connectivity.
Utilization Management (Inpatient) Procedure for Loss of XYZ Database
Prior-Authorization (Outpatient) Procedure for Loss of Connectivity
Prior-Authorization (Outpatient) Procedure for Loss of XYZ Database
Behavioral Health Review Procedure for Loss of Connectivity
Behavioral Health Review Procedure for Loss of XYZ Database
Community Based Care Review Procedure for Loss of Connectivity
Community Based Care Review Procedure for Loss or XYZ Database

13. Note the existence of any insurance or bonds carried by the Business Associate, which would protect the Business Associate and DMAS from contingent liability in the use of the data. Otherwise, provide a statement in the Business Associate Data Security Plan if no such insurance coverage exists.

Our current Managed Care E&O Policy does cover "Medical Information Protection for claims arising out of the inadvertent release of medical information/records." Our underwriter is:

Name
Title
Organization
Address
License #
Phone
Fax
Attachments:

Enclosed are additional documents including Policies and Procedures that XYZ has issued in order to meet the guidelines of the Data Security Plan.

ATTACHMENT VI - OPEN ENROLLMENT EFFECTIVE DATES BY REGION

Medallion 3.0 Open Enrollment Effective Dates

NOTE: THESE OPEN ENROLLMENT PERIODS DO NOT APPLY TO FAMIS

CENTRAL VIRGINIA REGION					
LETTERS MAIL LATE JANUARY. MEMBERS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1.					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION					
LETTERS MAIL LATE APRIL. MEMBERS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN AND WINCHESTER REGION					
LETTERS MAIL LATE JUNE. RECPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1.					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
WESTERN REGION					
LETTERS MAIL LATE AUGUST. MEMBERS CALL SEPTEMBER AND OCTOBER. CHANGES EFFECTIVE NOVEMBER 1.					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		
ROANOKE/ALLEGHANY REGION					
LETTERS MAIL LATE NOVEMBER. MEMBERS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1.					
005	ALLEGHANY	063	FLOYD	141	PATRICK
017	BATH	067	FRANKLIN CO.	155	PULASKI

515	BEDFORD CITY	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
FAR SOUTHWEST REGION **LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.**					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

ATTACHMENT VII – ANNUAL NOTICE OF HEALTH CARE RIGHTS

(English Translation)

ANNUAL NOTICE OF HEALTH CARE RIGHTS

Español ? ? हिन्दी
Tiếng Việt 1-800-643-2273 اللغة العربية
فارسی 한국말

You have the RIGHT to ask your Managed Care Organization (MCO):
What medical services your MCO offers.
How to get covered services that your MCO does not offer.
How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
How to get approval from your MCO to see doctors who are not in your MCO.
What to do if you have a medical emergency or need medical advice after office hours.
How to make an official complaint about your MCO or appeal a medical decision by your MCO directly to the Department of Medical Assistance Services (DMAS).
How to get information about your MCO's doctors, other providers, translation services or transportation.

You have the RIGHT to:
Have access to health care services
Receive information about your health care and see your medical records
Be involved in decisions about your health care
Receive information about treatment options or other types of care
Be treated with respect, consideration and dignity
Expect all information about your health to be confidential
Tell DMAS about any problems you are having with your MCO
Change your MCO once a year for any reason during open enrollment
Change your MCO after open enrollment for an approved reason
Make an official complaint with your MCO or appeal directly to DMAS

You also MUST:
Present your MCO Membership Card whenever you seek medical care
Provide complete and accurate information on your health and medical history
Follow your MCO's rules for getting services and follow your doctor's instructions
Schedule appointments, be on time, and notify your doctor if you are late or must cancel
Call the Department of Social Services (DSS) to report any changes such as address, phone number and other personal information (birth, marriage, death, other health insurance, or income changes)
A monthly premium is paid by the Virginia Medicaid program to your MCO for your coverage. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your worker, you may have to repay these monthly premiums, even if you received no medical services during those months.
If you have any questions on managed care or your health care rights, call your MANAGED CARE HELPLINE at 1-800-643-2273

ATTACHMENT VIII – ANNUAL NOTICE OF HEALTH CARE RIGHTS

(Back - Spanish Translation)

Español ? ? हिन्दी
Tiếng Việt 1-800-643-2273 اللغة العربية
فارسی 한국말

ANUAL DE DERECHOS DE ATENCIÓN MÉDICA

Usted tiene el DERECHO de preguntar a su Organización de Cuidados Administrados (MCO – Managed Care Organization):
What medial services your MCO offers.Qué servicios médicos ofrece su MCO.
How to get covered services that you MCO does not offer.Cómo obtener servicios cubiertos que su MCO no ofrezca.How to get a referral for specialty care and other services not provided by your primary care doctor (PCP).
Cómo obtener un referimiento para atención especializada y otros servicios no provistos por su proveedor de cuidados primarios (PCP).
Cómo obtener la aprobación de su MCO para que lo(a) atiendan médicos que no pertenezcan a su MCO.
Qué hacer cuando tenga una emergencia médica o necesite consejo médico fuera de horario de atención.
Cómo presentar una queja oficial de su MCO o apelar a una decisión médica realizada por su MCO directamente al Departamento de Servicios de Asistencia Médica (DMAS – Department of Medical Assistance Services).
Cómo obtener información sobre los médicos, otros proveedores, servicios de traducción o transporte de su MCO.

Usted tiene el DERECHO de:
Have access to health care servicesObtener acceso a servicios de cuidado de la salud
Recibir información sobre su atención médica y ver sus registros médicos
Participar en las decisiones sobre su atención médica
Recibir información sobre opciones de tratamiento u otros tipos de cuidado
Ser tratado(a) con respeto, consideración y dignidadExpect all information about your health to be confidential
Esperar que toda la información relacionada con su salud sea confidencial
Informar al DMAS sobre cualquier problema que pudiera tener con su MCOChange your MCO once a year for any reason during open enrollment
Cambiar de MCO una vez al año, por cualquier motivo, durante la inscripción abierta
Cambiar de MCO después de la inscripción abierta por un motivo aprobado
Presentar una queja oficial a su MCO o apelar directamente al DMAS

Usted también DEBE:
Present your MCO Membership Card whenever you seek medical carePresentar su Tarjeta de Miembro del MCO siempre que reciba atención médica
Proveer informaciones completas y precisas sobre su historia de salud y médicaFollow your MCO’s rules for getting services and follow your doctor’s instructions
Respetar las reglas del MCO para la obtención de servicios y seguir las instrucciones de su médico

Marcar citas, llegar en horario y notificar a su médico si se atrasará o necesita cancelar la cita
Llamar al Departamento de Servicios Sociales (DSS – Department of Social Services) para informar sobre cualquier cambio, tal como de dirección, número de teléfono y otras informaciones personales (nacimiento, casamiento, fallecimiento, otro seguro de salud o cambios en sus ingresos)
Virginia Department of Medical Assistance Services paga una cuota mensual (prima) por su cobertura médica a su MCO. Si usted no reunió los requisitos por los meses anteriores de su cobertura, debido a que usted no envió la información correcta o cambios en su situación a su empleador (partrón), usted puede tener que reembolsar (pagar) las cuotas mensuales, si usted recibió servicios médicos durante esos meses.

Si tiene dudas sobre cuidados administrados o sobre sus derechos de atención médica, llame a nuestra LÍNEA DE AYUDA DE CUIDADOS ADMINISTRADOS al 1-800-643-2273

ATTACHMENT IX – HEALTH STATUS SURVEY QUESTIONNAIRE

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?
Some of these questions are personal, and your answers will be confidential and private— only the MCO will get this information.
Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head		Case Head SSN		Case Head Language:
Last Name		First Name		Medicaid ID#
Address		City	State/Zip	Ph#
1	Gender			☐ Male ☐ Female
2	Date of Birth			
3	What MCO are you choosing?		Name:	
4	Do you have a doctor you want to be your Primary Care Provider?		Name:	
5	If you have a regular doctor now, what is the doctor's name?			Names:
6	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? (If yes) What are the names?			☐ Yes ☐ No List:
7	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]			☐ Yes ☐ No List:
8	Are you using any durable medical equipment, such as a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?			☐ Yes ☐ No What: ☐ Yes ☐ No
9	Are you pregnant? [If yes], When is the baby due? Does the doctor have any special concerns about this pregnancy?			☐ Yes ☐ No Date:
	Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.			
10	Do you have surgery planned for the future? If yes, what is the date of surgery?			☐ Yes ☐ No Date:
11	Are you getting home care or home hospice care? If yes, please explain.			☐ Yes ☐ No Explanation:
12	Are you on an organ transplant list? If yes, please explain.			☐ Yes ☐ No Explanation:
15	Are you getting physical therapy, or occupational therapy, or speech therapy?	☐ Yes ☐ No		
16	Do you have a heart condition--such as congestive heart failure?			☐ Yes ☐ No

17	Do you have a lung disorder--such as asthma or COPD?	☐ Yes ☐ No
18	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐ No
19	Do you have diabetes?	☐ Yes ☐ No
20	High blood pressure?	☐ Yes ☐ No
21	Do you have kidney disease or are you on dialysis?	☐ Yes ☐ No
22	Do you have cancer?	☐ Yes ☐ No
23	Do you smoke?	☐ Yes ☐ No
24	Are you living with HIV or AIDS?	☐ Yes ☐ No
25	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐ No
26	Do you have tuberculosis (TB)?	☐ Yes ☐ No
27	Are any children in the house in Part C services, care coordination for children Any health department program, or Do any children receive Case Manager or Care Coordination services?	☐ Yes ☐ No List program and/or care coordinator:
28	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐ No List:
29	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐ No Reason:
30	What is your height?	Feet_____inches_____
31	And your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273.

ATTACHMENT X - MANAGED CARE EXPANSION REQUIREMENTS

The following are DMAS requirements outside the managed care contracts that must be satisfied by the managed care organization (MCO) prior to any expansion being approved.

A letter of intent at least 6 months in advance of the requested expansion date, from the MCO to DMAS requesting to expand. The letter must include the localities where the expansion is proposed, a proposed effective date, copies of BOI and VDH approval (if already obtained), a network development plan and a marketing plan. The Department shall direct its focus on MCO network development to assure access is better than what is currently available in the area the MCO seeks to expand into.

Upon approval by DMAS of the expansion request, the MCO must provide the following within 30 days of the Department's approval of request to introduce one or more manage care plans into a new area:

- A plan of action to secure advocate and community support in the planned expansion area.
- A project plan for the expansion including completion of network development, information technology requirements, and communication deadlines.
- A list of the expansion team at the MCO with their title and role on the team.
- A designee who will manage the expansion project and will work with DMAS as the primary contact.
- An assessment of political ramifications, if any, for the expansion area. DMAS will review and respond to this.
- Profit and enrollment projections for the two year period following the planned expansion.
- An outreach and education plan (both long and short term) including the names of the team when available.
- A plan detailing how the expansion will be incorporated in to the MCOs current processes.
- A list of subcontractors impacted and a communication plan for notifying the subcontractor of changes.
- A detailed care transition plan.
- Assurances that all ancillary programs (i.e. prenatal, disease state management) will be operational and in place prior to implementation.
- A detailed request from DMAS for information which will assist the MCO in its expansion process.
- A draft of the member, marketing and provider materials at least 120 days before the planned expansion date. DMAS will review and respond within 30 days of receipt of the materials.
- A primary care network that includes contracting with <u>all</u> area health departments, major hospitals, community services boards (CSBs), Federally Qualified Health Centers (FQHC) & Rural Health Clinics (RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.

- A specialty care network plan detailing development for therapy, laboratory, vision, pharmacy, psychiatric, and transportation service providers.

A network development plan must include the specialties listed in Attachment XI. The Department will determine network adequacy based on specific utilization for the expansion area not later than 90 days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO must demonstrate adaptability to the special requirements of certain populations like pregnancy women in rural areas. The final MCO network must be submitted before assignment deadlines established by the Department.

A written plan indicating the date when BOI and VDH approval will be secured, if at the time of the initial letter of intent BOI and VDH approval are not secured. The MCO must provide the Department with copies of BOI and VDH letters in addition to a written plan outlining a plan for achieving an acceptable accreditation ranking (NCQA), outlining plans for achievement of major milestones as appropriate.

In order to pursue the expansion, if approved by the Department, the MCO will submit a letter accepting the terms of the contract and of these guidelines. The MCO must provide written assurances that it will accept both FAMIS and Medallion 3.0 members, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

ATTACHMENT XI – SPECIALTY SERVICES REQUIRED

The Contractor shall maintain in its network and in its referral listing a number of specialists in the following specialties which is adequate to support medically necessary needs to its Medallion 3.0 members. Similarly, a network development plan must also include the following specialties:

Adolescent Medicine	Oncology
Allergy and Immunology	Ophthalmology
Anesthesiology	Oral Surgery
Audiology	Orthopedics
Behavioral/Mental Health	Otolaryngology
Cardiology	Pain Management
Certified Nurse Midwifery	Pathology
Child Psychiatry	Pediatric Allergy & Immunology
Colon/Rectal Surgery	Pediatric Critical Care
Community Service Boards	Pediatric Development
Dermatology	Pediatric Endocrinology
Endocrinology	Pediatric Gastroenterology
Family Medicine	Pediatric General Surgery
FQHC	Pediatric Genetics
Gastroenterology	Pediatric Hemotology/Oncology
General Surgery	Pediatric Nephrology
Genetics/Metabolism	Pediatric Orthopedics
Geriatrics	Pediatric Physical Medicine & Rehab
Gynocologic Oncology	Pediatric Pulmonology
Health Department	Pediatric Specialist
Hematology	Pharmacy
Home Health	Physical Medicine
Hospice	Physical Therapy
Hospitalist	Prosthetics and Orthotics
Infectious Disease	Pulmonary Medicine
Internal Medicine	Radiation Oncology
LCSW	Rehabilitation
Maternal and Fetal Medicine	RHCS
Neonatal/Perinatal Medicine	Substance Abuse Treatment Services
Rheumatology	Surgery (various
Nephrology	Thoracic Surgery
Neurological Surgery	Transplant Surgery
Neurology	Transportation
Nurse Practitioner	Urgent Care
Occupational Medicine	Urology
Occupational Therapy	Vision

ATTACHMENT XII – MMIS GENERATED PAYMENT XXX MCO

		Region				
Aid Category	Age Group	Northern Virginia	Other MSA	Richmond/ Charlottesville	Rural	Tidewater
Aged, Blind / Disabled	Under 1					
	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					
Temporary Assistance to Needy Families	Under 1					
	1-5					
	6-14					
	Female 15-20					
	Female 21-44					
	Male 15-20					
	Male 21-44					
	Over 44					

Note: Aged category applies only to the 'Over 44' group

ATTACHMENT XIII – CERTIFICATION OF DATA (NON-ENCOUNTER)

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

> **The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.**
>
> **NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.**

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

_____

_____.

This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

_____

(INDICATE NAME AND TITLE

(CFO, CEO, OR DELEGATE)

on behalf of

_____

(INDICA)

ATTACHMENT XIV - DOCUMENTS CONSTITUTING THE CONTRACT

The documents that constitute this Contract are the following:

a. This document;

b. Subsequent modifications approved in writing by the Contractor and the Department.

The Contract hereby incorporates the following attachments:

- Authorized Workforce Confidentiality Agreement
- Summary of Medicaid and Medallion 3.0 Covered Services
- Network Provider Agreement
- Confidentiality Agreement
- Format for Data Security Plans
- Open Enrollment Effective Dates by Region
- Annual Notice of Health Care Rights
- Health Status Survey Questionnaire
- DMAS Managed Care Expansion Requirements
- MCO Specific Contract Terms/Signature Pages and Disclosure of
- Ownership and Control Interest Statement (CMS 1513)
- The Managed Care Technical Manual
- Any MCO specific terms & conditions negotiated and approved by the Department.

ATTACHMENT XV – MEDALLION CARE SYSTEM PARTNERSHIP QUALITY MEASURES

Menu of "Health Home Model Effectiveness" Measures for all MCOs - MENU #1

For Each MCSP Model Chosen, PLEASE CHOOSE AT LEAST ONE MEASURE FROM THIS MENU.

Measures in this Menu indicate success of the medical home/health home model. The measures chosen reflect structural and population health improvement on a measureable, comparable basis both between and within MCOs. The "Health Home Model Effectiveness" Measures listed below will allow DMAS and the MCOs to track progress and effectiveness of the MSCPs over time. For this purpose, the source-definition of an MCSP can be found in the Contract (Section 7.8.A) , and must be applied through the MCSP. While NCQA or URAC accreditation of medical homes is outlined as a measure of performance, it is not intended to be a requirement. The choice of measures below allows for variation of model types.

Measure	Rationale
Percent of primary care physicians in Medicaid network whose main practice site is an NCQA accredited medical home or a URAC recognized Patient Centered HealthCare Home Practice.	Accreditation requirements are in alignment with the Exchanges whereby eligible providers must be accredited as an NCQA medical home or URAC recognized patient centered healthcare home. NCQA is in the process of unveiling updated standards for medical home accreditation in 2014.
Percent of eligible primary care physicians in Medicaid network who attain at least Stage 2 Meaningful Use.	The use of electronic health records is intended to increase efficiencies, improve quality care, and reduce the administrative burden of paper-based medical records.
Percent eligible PCPs who record more than **75%** of unique patients" vital signs and chart changes (height, weight, blood pressure, calculate and display body-mass index, plot and display growth charts for children). "	This measure is applicable to all patients **ages 3** and over. Core measure #8 for Meaningful Use (MU). The measure per MU is that More than **50%** of all unique patients seen by the Eligible Provider (EP) during the reporting period. The elements within this measure (ht, wt, BP) are key indicators of health for all ages and are known risk factors for some of the preventable chronic conditions, such as CAD, diabetes, etc. The Nationally Recognized Million Hearts Campaign is widely accepted across health care settings, delivery systems, and providers.
MCO member Emergency Department (ED) utilization rate (use existing HEDIS measure for this indicator).	There should be an overall decrease in the utilization of the Emergency Department if medical home model is effective.

Relative Resource Use (RRU) for: • Asthma • Diabetes • Hypertension • COPD • Cardiovascular conditions	Select 2 Conditions from the box to the left. These are all measures currently calculated and scored in quality compass, so the numbers are available. When evaluated with the corresponding quality of care measures, they provide more information about the efficiency or value of organizations services.

Menu of "Outcome Measures Tied to Identifiable MCSP Models" - MENU #2

For Each MCSP Model Chosen, PLEASE CHOOSE AT LEAST ONE MEASURE FROM THIS MENU.

The quality measures identified in Menu #2 are targeted to highlight outcomes of each distinct type of MCSP innovation model. While these outcome measures are considered more resource intensive for measurement than those measures listed in Menu #1, each individual measure in Menu #2 relates directly to the desired outcome of each MCSP model & payment type. The "Outcome Measures Tied to Identifiable MCSP Models" will allow DMAS to take an in depth look at the quantitative improvements over time for each health plan and model, and ultimately, to compare which MCSP innovation models are the most/least effective.

Reference Number	Model and payment options	Measures criteria
1.1.A	MCO contracts with Primary Care Providers; Performance rewards: performance pool or pay for performance	One diabetes and one asthma HEDIS measures of condition management.
1.2.B	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees; Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Evidence of payment structure for primary care providers who are included in this model. MCO would provide details on payment disparity between those providers within the model and those who are not, and, show improvements in condition management visits to the PCPs for those who are included in the model.
2.C	MCO contracts with provider Care System or a collaborative (primary care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/ performance payment models across services, Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Important to monitor transitions of care; Improvements, efficiency & effectiveness, and transitions of care.
3.A	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes Performance rewards: performance pool or pay for performance	Measures should be geared toward early identification and treatment of physical health issues, common chronic conditions, and use of preventive services, while simultaneously treating for MHSA. Also, consider measures of care transition; readmission rates for mental health; hospital admissions for diabetes, asthma, and /or cardiovascular conditions.

Reference Number	Model and payment options	Measures criteria
3.B	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within MCSP.	Same as above.
3.C	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration/coordination of Chemical/Pharmaceutical and/or Mental Health services with acute/ primary care services. May include designated HCH or Health Homes. Sub-capitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Same as above.
4.D	Alternative defined by proposal Alternative Proposals	Mutually agreed upon.