

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



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

July 1, 2020 - June 30, 2021

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SECTION 1.0 SCOPE OF CONTRACT

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

Under this Contract, the Contractor shall operate in all six (6) regions of the Commonwealth and in all localities in each region, except as outlined in Section 2.2 *Readiness Review*. The Contractor shall provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described, and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by this Contract.

1.1 APPLICABLE LAWS, REGULATIONS, AND INTERPRETATIONS

The documents listed herein shall constitute the Contract between the parties, and no other expression, whether oral or written, shall constitute any part of this Contract. Any conflict, inconsistency, or ambiguity among the Contract documents shall be resolved by giving legal order of precedence in the following order:

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

Any ambiguity or conflict in the interpretation of this Contract shall be resolved in accordance with the requirements of Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices, and provider manuals.

Services listed as covered in any member handbook shall not take precedence over the services required under this Contract or the State Plan for Medical Assistance.

1.1.1 Guidance Documents and Department Forms

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

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

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

1.3 DEPARTMENTAL MEETINGS

The Contractor shall participate in meetings with the Department, including DMAS Managed Care Advisory Committee, MCO Workgroup, Quality Collaborative, CFO Quarterly Meetings, Compliance Collaborative, Program Integrity, CMO and Pharmacy Director, ARTS Workgroup, or any other groups as necessary or when requested to do so by the Department. In-person attendance is expected unless otherwise noted by the Department.

SECTION 2.0 REQUIREMENTS PRIOR TO OPERATIONS

2.1 ORGANIZATIONAL STRUCTURE

2.1.1 Virginia Based Operations

The Contractor shall have a Virginia-based operation that is dedicated to this Contract. The Department does not require claims, utilization management, customer service, pharmacy management, or Member services to be physically located in Virginia; however, these service areas must be located within the United States.

2.1.2 Dedicated Project Director and Project Manager

The Contractor shall have a dedicated Virginia CCC Plus Project Director and dedicated Project Manager located in an operations/business office within the Commonwealth of Virginia. The Contractor's Project Director and Project Manager, if desired, may provide oversight for both the Virginia CCC Plus program and the Virginia D-SNP program. The Contractor's Project Director and Project Manager are expected to attend all meetings required by DMAS.

2.1.2.1 Project Director

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

2.1.2.2 Project Manager

The CCC Plus Project Manager shall have the ability to make timely decisions about the CCC Plus program issues and shall represent the Contractor at the Department's meetings. The CCC Plus Project Manager must be able to respond to issues involving information systems and reporting, appeals, quality improvement, Member services, service management, pharmacy management, medical management, care coordination, claim payment, provider relations/contracting, and issues related to the health, safety, and welfare of the Members.

2.1.3 Medical and Behavioral Health Leadership Staff

The Contractor's Virginia-based location shall also include a dedicated full-time Virginia-licensed Medical Director/Chief Medical Officer, starting July 1, 2019, a dedicated full-time, or contracted, Medical Behavioral Health Director who is a Virginia-licensed psychiatrist and is qualified in the diagnosis of mental illness, a Virginia-licensed Behavioral Health/Addiction Recovery Treatment Clinical Director, Long Term Services and Supports Director, and Care Coordination Manager able to perform comprehensive oversight and comply with all requirements covered under this Contract.

2.1.4 Provider Relations Staff

The Contractor shall have a Provider Network Manager responsible for network development, recruitment, credentialing, and management. The Contractor's provider relations staff must be located within the geographic region where the Contractor operates. The Contractor's regional

provider relations staff shall work with providers, including face-to-face when necessary, to ensure that appropriate and accurate information is collected during the credentialing process. The Contractor shall also ensure that this provider information is accurately reflected in the Contractor's provider directory, including but not limited to information on the provider's cultural competency, disability accessibility and open panels.

The Contractor shall have dedicated staff available at all times during business hours for providers to call for assistance regarding the CCC Plus program including but not limited to community based providers and nursing facilities. These dedicated provider assistance staff shall be able to guide providers in all areas of the program and in all long term services and supports offered by the program. Refer to Section 12.0 *Provider Services and Claims Payment*.

2.1.5 Consumer Direction Services Manager

The Contractor shall have a dedicated project manager for Consumer-Directed (CD) services. The complexities of Consumer Direction require that the CD project manager focus on the many areas of consumer direction, patient pay and working with the Fiscal/Employer Agent (F/EA). The CD project manager shall be the chief liaison with the F/EA and serve as the Contractor's Subject Matter Expert (SME) for consumer direction. The CD project manager shall troubleshoot payment issues, review submitted fraud allegations and report suspected fraud waste and abuse issues to the agency. This individual shall not have major responsibility for any other portion of the CCC Plus contract. Refer to the various sections of this Contract referencing Consumer Direction and/or Patient Pay. 2.1.6 First-Tier, Downstream, and Related Entities.

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

2.1.6 Care Coordination Staffing

The Contractor's Care Coordination staff must be sufficient for its enrolled population and located within the geographic region where the Contractor operates. Additionally, in each region where the Contractor participates and serves CCC Plus Members, the Contractor shall have at least one (1) dedicated Care Coordinator without a caseload to assist individuals with the goal of transitioning from institutional care to the community. See Section 5.0 *CCC Plus Model of Care* for more information.

2.1.7 Key Personnel

The Contractor's Project Director, Project Manager, Chief Medical Officer/Medical Director, Pharmacy Director, Medical Behavioral Health Director, Behavioral Health Director, Director of Long Term Services and Support, Chief Financial Officer, Chief Operating Officer or Director of Operations, Quality Director, Senior Manager of Clinical Services, Claims Director, IT Director, Compliance Officer, ADA Compliance Director (can be the same as the Compliance Officer), and/or equivalent position(s) are "key personnel." Upon request by the Department effective July 1, 2019, the Contractor shall submit to the Department the name, resume, and job

description for each of the key personnel to the Department within five (5) business days of the request. Reference Section 2.1.3 *Medical and Behavioral Health Leadership Staff* for additional staffing qualifications for the Medical Behavioral Health Director. Reference Section 10.5 *QI Staffing* for additional staffing qualifications for the Quality Director and quality management and improvement related staffing requirements.

2.1.8 Notification of Key Personnel Changes

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

2.1.9 Department Concerns Related to Staffing Performance

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

2.2 READINESS REVIEW

The Department and/or its duly authorized representatives shall conduct readiness review(s) which may include desk reviews and site visits. This review may be conducted prior to enrollment of any Members in the MCO, prior to the renewal of the Contract, prior to the Contract being amended to add a new covered population or any new aid categories, and anytime thereafter upon the Department's request and at the Department's discretion. This review(s) shall be conducted prior to enrollment of any Members with the Contractor and/or prior to the renewal of the Contract. The purpose of the review is to provide the Department with assurances that the Contractor is able and prepared to perform all administrative functions and to provide high-quality services to enrolled Members.

The review will document the status of the Contractor with respect to meeting program standards set forth in the Federal and State regulations and this Contract, as well as any goals established by the Department. The scope of the readiness review(s) shall include, but is not limited to, a review of the following elements:

- 1) Network Provider composition and access;
- 2) Staffing, including Key Personnel and functions directly impacting Members (e.g., adequacy of Member Services staffing);
- 3) Care coordination capabilities;
- 4) Content of Provider Contracts, including any Provider Performance Incentives;
- 5) Member Services capability (materials, processes and infrastructure, e.g., call center capabilities);
- 6) Comprehensiveness of quality management/quality improvement and utilization management strategies;
- 7) Internal grievance and appeal policies and procedures;
- 8) Monitoring of all first tier, downstream, and related entities;

- 9) Fraud and abuse and program integrity policies and procedures;
- 10) Financial solvency;
- 11) Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, including IT testing and security assurances.

In the instance where there is a change to the Contract terms that does not affect one or more of the elements above, and when the Department has previously conducted a readiness review on the non-impacted element(s), the Department has the discretion to deem that the previously conducted readiness review for non-impacted items is sufficient to meet readiness requirements.

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

As a result of findings from the Readiness Review, the Department may make a determination that the Contractor is not able to perform any or all of its obligations under this Contract. The Department reserves the right to deny participation in some or all areas of the Commonwealth for the CCC Plus program if the Contractor fails the Readiness Review within the timeframe specified.

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

2.3 LICENSURE

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

2.4 CERTIFICATION OF QUALITY

Pursuant to § 32.1-137.1 through § 32-137.6 *Code of Virginia*, and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the VDH Office of Licensure and Certification (formerly State Health Commissioner Center for Quality Health Care Services and Consumer Protection) to confirm the quality of the health care services they deliver. Failure to maintain certification may result in termination of this Contract. A copy of this certification shall be submitted with the signature page at each annual contract renewal.

2.5 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

The Contractor shall obtain and retain health plan accreditation by the National Committee for Quality Assurance (NCQA). If the Contractor is not accredited at start-up, the Contractor shall adhere to NCQA standards while working toward accreditation based on the most current version of NCQA Health Plan Accreditation Standards. Refer to Section 10.19 *National Committee for Quality Assurance (NCQA) Accreditation* for more details regarding requirements, milestones and related timelines.

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

2.6 DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

The Contractor shall have an approved Dual Eligible Special Needs Plan (D-SNP) contract in all localities in each region where the health plan provides services under the CCC Plus program Contract or begin operating a D-SNP in all localities in each region where the health plan provides services under this Contract within three (3) years of being awarded a CCC Plus program Contract. In any instance when the CMS approved D-SNP service areas do not match the State's approved CCC Plus service areas, the State may restrict the CCC Plus service area to align with the CMS approved D-SNP service areas. When appropriate, the State may work with the Contractor to achieve fully aligned service areas prior to terminating the Contract.

At the Department's discretion, failure to comply with this requirement may deem the Contractor non-compliant and subject to termination of this Contract. Refer to Section 21.0 *Renewal/Termination of Contract*.

2.6.1 Default Enrollment

Effective January 1, 2020, state-Contracted D-SNPs not previously approved by CMS for default enrollment activities shall submit to CMS an initial application to perform such activities subject to the requirements of 42 CFR § 422.66, as outlined below, and applicable CMS regulatory subguidance, including the Medicare Managed Care Manual, Chapter 2, Section 40.1.4.

CMS approval of an initial application to perform default enrollment activities shall be obtained by no later than five (5) calendar days before initiating Default Enrollment activities. Once authorized by CMS to perform default enrollment activities, state contracted D-SNPs shall renew such authorizations in accordance with the requirements and timeframes of 42 CFR § 422.66 and applicable CMS regulatory subguidance. State-contracted D-SNPs shall coordinate default enrollment of newly Medicare eligible individuals who are currently enrolled only in its companion Medicaid plan, who are aging-in to Medicare, as well as those qualifying for Medicare upon completion of the 24-month waiting period due to a disability.

The conditions of default enrollment in 42 CFR § 422.66 are listed below. The Contractor shall ensure that the following conditions are met before initiating default enrollment activities, including enrolling individuals into a Medicare Advantage dual eligible special needs plan.

1. During an individual's initial coverage election period, an individual may be deemed to have elected a MA special needs plan for individuals entitled to medical assistance under a State plan under Title XIX (including a fully integrated dual eligible special needs plan as defined in § 422.2) offered by the organization provided all the following conditions are met:
 - (A) At the time of the deemed election, the individual remains enrolled in an affiliated Medicaid managed care plan. For purposes of this section, an affiliated Medicaid managed care plan is one that is offered by the MA organization that offers the dual eligible MA special needs plan or is offered by an entity that shares a parent organization with such MA organization;
 - (B) The state has approved the use of the default enrollment process in the contract described in § 422.107 and provides the information that is necessary for the MA organization to identify individuals who are in their initial coverage election period;
 - (C) The MA organization offering the MA special needs plan has issued the notice described in paragraph (c)(2)(iv) of this section to the individual;
 - (D) Prior to the effective date described in paragraph (c)(2)(iii) of this section, the individual does not decline the default enrollment and does not elect to receive coverage other than through the MA organization;
 - (E) CMS has approved the MA organization to use default enrollment under paragraph (c)(2)(ii) of this section;
 - (F) The MA organization has a minimum overall quality rating from the most recently issued ratings, under the rating system described in §§ 422.160 through 422.166, of at least 3 stars or is a low enrollment contract or new MA plan as defined in § 422.252; and
 - (G) The MA organization does not have any prohibition on new enrollment imposed by CMS.

The state-contracted D-SNPs shall report on default enrollment statistics monthly to the Department on an informational basis only, as specified in its state-contracted MIPPA Agreement.

The Department will continue to establish requirements to improve alignment for dual eligible members, including, but not limited to initiatives that enhance care coordination. State-contracted D-SNPs shall collaborate with the Department, and CMS as applicable, in developing and implementing additional strategies that enhance alignment of dual eligible members enrolled in D-SNPs and companion Medicaid Plans.

2.6.2 Medicare and Medicaid Integration

Beginning January 1, 2021, the Contractor's approved D-SNP will be required to integrate their Medicare and Medicaid service and benefit coverage in a manner that is consistent with, or similar to, CMS requirements for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP). DMAS will consider exceptions to this requirement on a case-by-case basis. Specific integration requirements are fully described in the State's D-SNP contract with the Contractor.

2.7 BUSINESS ASSOCIATE AGREEMENT (BAA)

The Contractor shall be required to enter into a DMAS-approved *Business Associate Agreement* (BAA) (attached) with the Department to comply with regulations concerning the safeguarding of protected health information (PHI) and electronic protected health information (ePHI). The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and regulations with regards to handling, processing, or using the Department's

PHI and ePHI. This includes but is not limited to 45 CFR Parts 160 and 164 Modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, January 25, 2013 and related regulations as they pertain to this agreement. The Contractor shall keep abreast of the regulations. The Contractor shall comply with all current and future HIPAA regulations at no additional cost to the Department or CMS. A sample of the BAA is shown as Attachment 2.

2.8 AUTHORIZATION TO CONDUCT BUSINESS IN THE COMMONWEALTH

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

2.9 CONFIDENTIALITY STATUTORY REQUIREMENTS

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

2.9.1 Federal Confidentiality Rules Related To Drug Abuse Diagnosis and Treatment

The Contractor shall comply with Federal confidentiality law and regulations (codified as 42 USC § 290dd-2 and 42 CFR Part 2 (“Part 2”)) outlines under what limited circumstances information about the patient’s substance use disorder treatment may be disclosed with and without the client’s consent. 42 CFR Part 2 applies to any individual or entity that is Federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any Federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser ...” (42 CFR § 2.12(a) (1)). With limited exceptions, 42 CFR Part 2

requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing. The Contractor will not be held accountable to provide care coordination under Addiction and Recovery Treatment Services (ARTS) (See *Definitions* in Section 23.1) if they have not received written disclosure from the Member's provider (See Attachment 4 of this Contract).

2.10 DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

In accordance with Federal regulations contained in 42 CFR §§ 455.100 through 455.106, 42 CFR § 438.604(a)(6), 42 CFR § 438.608(c)(2) and 42 CFR § 438.610 the Contractor shall disclose all of the following for the Contractor's owner(s) and managing employee(s) or persons or corporations with an ownership or control interest in the Contractor's plan:

- Information on ownership and control (42 CFR § 455.104);
- Name, address, date of birth, and Social Security Number of any managing employee;
- Information on whether a person or corporation with an ownership or control interest in the Contractor's plan of five percent (5%) or more interest is related to another person with ownership or control interest in the health plan as a spouse, parent, child or sibling (42 CFR § 438.604(a)(6); 42 CFR § 455.104(b)(2); 42 CFR § 438.608(c)(2));
- Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling;
- Information of any other disclosing entity in which an owner of the Contractor has an ownership or control interest;
- Information related to business transactions (42 CFR § 455.105); and,
- Information on persons convicted of crimes against Federally related health care programs (42 CFR § 455.106).

The Contractor shall provide the required information using the Disclosure of Ownership and Control Interest Statement (DMAS 1513), included as part of the Contractor Specific Contract Terms and Signature Pages, annually at the time of Contract signing. A copy of the form may be found on the DMAS website at

[http://www.dmas.virginia.gov/files/links/511/Disclosure%20of%20Ownership%20and%20Control%20Interest%20Statement%20\(DMAS-1513\)%20%20.pdf](http://www.dmas.virginia.gov/files/links/511/Disclosure%20of%20Ownership%20and%20Control%20Interest%20Statement%20(DMAS-1513)%20%20.pdf). The Contractor shall also disclose the information described in this section at least five (5) calendar days prior to any change in ownership, concerning each Person with Ownership or Control Interest. In accordance with Section 1903(m)(4)(B) of the Act, the Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the state, or other agencies available to its Members upon reasonable request.

Additionally, the Contractor shall submit the completed form to the Department within thirty-five (35) calendar days of the Department's request. Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, sanction as described in the Section 18.0 *Enforcement, Remedies and Compliance* of this Contract and/or termination of this Contract by the Department.

The Contractor shall maintain such disclosed information in a manner which can be periodically reviewed by the Department. In addition, the Contractor shall comply with all reporting and

disclosure requirements of 42 USC § 1396b(m)(4)(A), 42 CFR § 438.610 and 42 CFR § 455.436.

The Contractor shall conduct monthly checks for all of the Contractor's owners and managing employees against the Federal listing of excluded individuals and entities (LEIE) database. The LEIE database is available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp. Federal database checks shall be consistent with the requirements at 42 CFR § 455.436. The Contractor shall confirm the identity and determine the exclusion status of the Contractor's its subcontractors, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor/subcontractor through routine checks of Federal databases.

2.10.1 Change in Contractor Organizational Structure or Operations

Any changes to Contractor organizational structure and operations that have significant impact on Virginia Medicaid, as determined by the Department, shall require notification to the Department. The Contractor shall ensure, at a minimum, the following:

1. Uninterrupted services and ongoing adequate access to care and choice for Members.
2. The ability to maintain and support the Contract requirements including the commitments in the proposal submitted to DMAS during the procurement process, as modified by the contracting process with DMAS.
3. Major functions of the Contractor's organization, as well as DMAS programs, are not adversely affected.
4. The integrity of a fair, competitive DMAS procurement process for Managed Care contracts.

The Contractor shall submit notice to the Department for review and approval, no less than thirty (30) days in advance, all of the following:

1. Significant changes in operations, contracting, or to a change from the original Request for Proposal (RFP).
2. Organizational changes or major decisions affecting Medicaid business in Virginia or other states.
3. Contractor and subcontractor changes and terms directly related to the delivery of healthcare to Medicaid members, including, but not limited to:
 - PBM and specialty pharmacy
 - Transportation
 - Information management
 - TPA arrangements
 - Claims payment vendor
 - Medical management
 - Utilization management
 - Care coordination/case management
 - Program Integrity
 - Fraud Waste and Abuse
 - Specialty services
 - Marketing and outreach
 - Provider contracting services
 - Value Based Purchasing

- Actuarial Services
- Quality Improvement
- Data Management
- Financial Management
- Provider Relations and Network Management
- Member Materials
- Compliance

DMAS reserves the right to suspend a Contractor's new Member enrollment including, but not limited to, auto-assignment pending DMAS review and final determination regarding a Contractor's Change in Organizational Structure. In addition, DMAS may offer open enrollment to the Members assigned to the Contractor should a significant change in organizational structure that impacts Virginia Medicaid occur, as determined by the Department.

A change in organizational structure may require a Contract amendment.

2.11 PROHIBITED AFFILIATIONS WITH ENTITIES DEBARRED BY FEDERAL AGENCIES

In accordance with 42 USC § 1396 u-2(d)(1), and further explained in 42 CFR §§ 438.610 and 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at <http://www.cms.gov/smdl/downloads/SMD061208.pdf>), the Contractor or its subcontractors shall not knowingly have an employment, consulting, provider agreement, or other agreement or relationship for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under Federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor. Additionally, the Contractor and its subcontractor are further prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste and abuse.

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

In accordance with 42 CFR § 438.610(d)(3); 42 CFR § 438.610(a); Exec. Order No. 12549, if the Department finds that the Contractor is not in compliance and has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR), or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549, or if the Contractor has a relationship with an individual who is an affiliate of such an individual, the Department:

- i. shall notify the Secretary of the noncompliance;

- ii. may continue an existing agreement with the Contractor unless the Secretary directs otherwise; and,
- iii. may not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

In accordance with 42 CFR § 438.610(d)(3) and 42 CFR § 438.610(b) if the Department learns that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, the Department may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Department's and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

2.12 EXCLUDED ENTITIES

The Contractor shall, upon obtaining information or receiving information from the Department or from another verifiable source, exclude from participation in the Contractor's plan for this Contract all provider or administrative entities who have been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the DMAS Medicaid or FAMIS programs. The Contractor shall also exclude from participation in the Contractor's plan any provider or administrative entities which have a direct or indirect substantial contractual relationship with such an excluded or debarred individual or entity. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

- (i) The administration, management, or provision of medical services;
- (ii) The establishment of policies pertaining to the administration, management, or provision of medical services; or
- (iii) The provision of operational support for the administration, management, or provision of medical services.
- (iv) Entities who are to be excluded per *Code of Virginia* § 32.1- 325.
- (v) Prohibited Affiliations with Entities Debarred by Federal Agencies, see §13.3(a).

2.13 CONTRACTOR COMPLIANCE PROGRAM

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

1. Articulate the Contractor's commitment to comply with all applicable Federal and State standards;
2. Describe compliance expectations as embodied in the standards of conduct;
3. Implement the operation of the compliance program;
4. Provide guidance to employees and others on dealing with potential compliance issues;
5. Identify how to communicate compliance issues to appropriate compliance personnel;
6. Describe how potential compliance issues are investigated and resolved by the Contractor; and,

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

SECTION 3.0 ENROLLMENT AND ASSIGNMENT PROCESS

3.1 ELIGIBILITY AND ENROLLMENT RESPONSIBILITIES

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

3.1.1 Eligible Populations

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

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

This includes individuals who transition from Medallion.
- 3) ABD population (non-duals and those who do not receive LTSS). The majority of this population transitioned from the Department's Medallion program to the CCC Plus program on January 1, 2018.
- 4) The CCC Plus program populations listed above may include individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance, individuals with Alzheimer's disease and persons with dementia, and individuals approved by DMAS as inpatients in long-stay hospitals (the Department recognizes two facilities: Lake Taylor [Norfolk] and Hospital for Sick Children [Washington, DC]).
- 5) Individuals enrolled in the Developmental Disability (DD) Waivers will be enrolled in CCC Plus program for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services).
- 6) Medicaid expansion population, which includes individuals who meet the following criteria:
 - a) Adults ages nineteen (19) through sixty-four (64),
 - i) Who are not already eligible for Medicare coverage,
 - ii) Who are not already eligible for a mandatory coverage group (such as pregnant women or disabled),
 - iii) Whose income does not exceed 138% of the Federal Poverty Level (FPL), and
 - iv) Who have been identified as Medically Complex through the MCO Member Health Screening (MMHS) as described in Section 5.2, *Medically Complex Determination* (Non-medically complex individuals are covered under the Medallion 4.0 program.)

Individuals eligible through Medicaid expansion will be assigned to one of the following aid categories:

Medicaid Expansion Population Aid Categories	
Aid Category	Description
100	Caretaker Adult, less than or equal to 100% of Federal Poverty Level (FPL), and greater than the low-income families with children (LIFC) covered group
101	Caretaker Adult, greater than 100% FPL
102	Childless Adults, less than or equal to 100% FPL
103	Childless Adults, greater than 100% FPL

Individuals eligible through Medicaid expansion that are known to the Department, either because they were in a partial benefit plan (such as GAP or Plan First) will be enrolled with a Contractor with an effective date of January 1, 2019. The enrollment process for this group is described in Section 3.2.3, *Enrollment Process for Medicaid Expansion Population*.

Individuals eligible through Medicaid Expansion because they are in the Supplemental Nutrition Assistance Program (SNAP) or are a parent of a current Medicaid enrollee will be enrolled with a Contractor with an effective date as soon as January 1, 2019. The enrollment process for this group is described in Section 3.2.3, *Enrollment Process for Medicaid Expansion Population*.

Individuals eligible through Medicaid expansion who are not known to the Department will be enrolled through the standard Medicaid application process with a CCC Plus effective date as soon as January 1, 2019 and no later than sixty (60) days of approval of the application.

For the full list of covered services for this population, refer to Attachment 5, *Summary of Covered Services – Part 5 – Extended Benefits for Expansion Population* and Section 4.17, *ACA Minimum Essential Benefits for Medicaid Expansion Population*.

Individuals may apply for coverage through Cover Virginia at <http://www.coverva.org>, as well as through local Departments of Social Services.

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

3.1.2 Exclusions From CCC Plus Program Participation

Individuals enrolled in CCC Plus program who subsequently meet one or more of the criteria outlined below shall be excluded as appropriate by DMAS. The Department shall also have sole responsibility for determining the program exclusion for these individuals. Individuals excluded from CCC Plus program enrollment shall receive Medicaid services under the current FFS

system unless eligible for one of DMAS' other managed care programs. When individuals no longer meet the criteria for CCC Plus program exclusion, they shall be required to re-enroll in the CCC Plus program. DMAS shall exclude individuals who meet at least one of the exclusion criteria listed below:

- 1) Individuals enrolled in the Commonwealth's Medallion and Title XXI CHIP programs (FAMIS, FAMIS MOMS).
- 2) Individuals enrolled in a PACE program.
- 3) Newborns whose mothers are CCC Plus Members on their date of birth. However, the Contractor must adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form at https://www.viriniamedicaid.dmas.virginia.gov/wps/myportal/ProviderFormsSearch!/ut/p/z1/jY_LDoIwEEW_xqWdovjY1ogLExISY4BuyAgFS6BtoOLj6wX2oLO7yT33ZIBDBFxhJwu0Uius-hzzbXIOXOYcqONT7-RQtmabYx9We59COBboxDEK_B9-psDn50Pgvypxr9hNKjwXLsNGiR2-SCuarhKWSJVWj0wQg_aeSJVriBfUR6kCLAQpWzMgqa6JvNUkx1S0xOjGDmitMwFxFJ8VzfG7WbOprRjd4--Rv9gUIDLCO/#Z7_JP4A1B01M0EF10A3A5D01M28E4.
- 4) Dual eligible individuals *without full Medicaid* benefits, such as:
 - i. Qualified Medicare Beneficiaries (QMBs);
 - ii. Special Low-Income Medicare Beneficiaries (SLMBs);
 - iii. Qualified Disabled Working Individuals (QDWIs); or,
 - iv. Qualifying Individuals (QIs). Medicaid pays Part B premium.
- 5) Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program.
- 6) Individuals with temporary coverage or who are in limited coverage groups, including:
 - a. Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention) who are not included in the Medicaid expansion population.
- 7) Individuals enrolled in a Medicaid-approved hospice program will not be auto-enrolled. However, if an individual enters a hospice program while enrolled in the CCC Plus program, the Member will remain enrolled in CCC Plus for those services.
- 8) Individuals who live on Tangier Island.
- 9) Individuals under age twenty-one (21) years of age who are approved for DMAS Psychiatric Residential Treatment Facility (formerly known as Level C PRTC) programs) as defined in Emergency Regulation 12VAC 30-50-130 (<http://register.dls.virginia.gov/details.aspx?id=6233>).
- 10) Individuals with end stage renal disease (ESRD) and in fee-for-service at the time of enrollment will be auto-enrolled into the CCC Plus program but may request to be disenrolled and remain in fee-for-service. DMAS will manually exclude these individuals if requested by the Member within the first ninety (90) days of CCC Plus enrollment. However, an individual who does not request exclusion within the first ninety (90) days of CCC Plus enrollment or who develops ESRD while enrolled in the CCC Plus program will remain in CCC Plus.
- 11) Individuals who are institutionalized in State or private ICF/ID and State ICF/MH facilities. A State acute care facility **is not** excluded.
- 12) Individuals who reside at Piedmont, Catawba, Hiram Davis, and Hancock State facilities operated by DBHDS.

- 13) Individuals who reside in nursing facilities operated by the Veterans Administration, or individuals who elect to receive nursing facility services in The Virginia Home Nursing Facility or in local government-owned nursing homes. These include the following nursing facilities:

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

- 14) Individuals participating in the CMS Independence at Home (IAH) demonstration (DMAS will manually exclude these individuals). However, IAH individuals may enroll in the CCC Plus program if they choose to disenroll from IAH.
- 15) Individuals receiving care/treatment in facilities located outside of Virginia as authorized by DMAS prior to CCC Plus enrollment date.
- 16) Individuals who are incarcerated. (Individuals on house arrest are not considered incarcerated.)
- 17) Individuals who reside in the Virginia Home Nursing Facility will be temporarily excluded from CCC Plus. DMAS will transition the enrollment for Virginia Home residents to CCC Plus during a later implementation phase and through a transition plan that addresses the unique needs of the Virginia Home population and its system of care. DMAS will develop the transition plan in collaboration with the Virginia Home and the CCC Plus health plans.
- 18) Individuals enrolled in the Birth Injury Fund (refer to Section 23.1, *Definitions*).
- 19) Individuals who are included in the Medicaid expansion populations who are not identified as “medically complex” as described in Section 5.2, *Medically Complex Determination of this Contract*. These individuals are covered through the Medallion 4.0 program.
- 20) Pregnant individuals who are within their first ninety (90) days of initial managed care enrollment, in their third trimester of pregnancy, and their provider is not participating with the Contractor, upon request of the Member.

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

3.2 CCC PLUS ENROLLMENT PROCESS

Enrollment in the CCC Plus program is mandatory for eligible individuals as described in Section 3.1, *Eligibility and Enrollment Responsibilities* above. All eligible Members, except those meeting one of the exclusions outlined in Section 3.1.2, *Exclusions from CCC Plus Program Participation* above, shall be enrolled in CCC Plus program.

The Contractor may receive enrollment on an individual who lives in a locality (i.e., Richmond) outside of the enrollment region (i.e., Norfolk). Unless these individuals meet a specific

requirement for exclusion, these individuals shall remain enrolled with the Contractor for all contractually required and medically necessary services under this Contract. The Contractor shall coordinate care and work with providers in the locality where the Member is receiving services.

The Contractor shall designate a CoverVA liaison to assist Members with MCO related issues.

3.2.1 Enrollment and Health Plan Assignment Process

The CCC Plus program enrollment and auto assignment process runs monthly on the 18th. Individuals determined to be eligible as of the 18th of the month have an effective date of the first of the following month. (For example, an individual is identified as being eligible on May 7. The effective date is June 1.) Individuals found to be eligible after the 18th are enrolled with an effective date of the first of the second month. (For example, an individual is identified as being eligible on May 19. The effective date is July 1.)

The CCC Plus program will determine potential eligibility through a daily process. Newly eligible Members shall receive a notification letter and have the opportunity to select a health plan prior to auto assignment on the 18th. If no health plan is selected by the 18th of the month preceding the effective date (May 18 for a June 1 effective date), the Member is assigned to a health plan. The Member health plan default assignment is based upon the plans that have been approved by DMAS for participation in the Member's locality of residence and the Department's intelligent assignment rules.

3.2.2 Intelligent Assignment

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

- 1) If known, most recent previous Medicare (excluding Part D only plans) managed care enrollment within the past two (2) months;
- 2) Most recent previous Medicaid managed care enrollment (i.e., Medallion, CCC, CCC Plus) within the past two (2) months;
- 3) Individuals in a Nursing Facility will be assigned to a Contractor that includes the individual's Nursing Facility in its network, based upon the Contractor's successful submission of the provider record on the PSF106 file. If the Nursing Facility is in more than one Contractor's network, the assignment will be random between the Contractors with the Nursing Facilities in the network;
- 4) Individuals in the CCC Plus Waiver who receive adult day health care (ADHC) services will be assigned to a Contractor that includes the individual's ADHC provider in its network, based upon the Contractor's successful submission of the provider record on the PSF106 file. If more than one Contractor's network includes the individual's ADHC provider in its network, the assignment will be random between the Contractors;
- 5) Individuals in the CCC Plus program receiving technology assistance under the CCC Plus HCBS waiver will be assigned to a Contractor that includes the individual's private duty nursing provider, based upon the Contractor's successful submission of the provider record on the PSF106 file. If more than one Contractor's network includes the individual's private duty nursing provider in its network, the assignment will be random between the Contractors;

- 6) If the expansion Member has a child in Managed Care, the Member will be enrolled in the same MCO as the child. If the Member does not have a child in Managed Care, the Member will be randomly assigned an MCO; and,
- 7) If none of the above applies to the individual, the Member will be randomly assigned to a Contractor in the individual's locality (in approximately equal numbers by Contractor). A limit of 70% of enrolled lives within an operational region **may** be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an operational region exceed 70%, the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at 70% or below. However, the enrollment cap may be exceeded due to Member-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary.

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

3.2.3 Enrollment Process for Medicaid Expansion Population

DMAS will use the following Enrollment process for the Medicaid expansion population.

- 1) For Members with a Medicaid case history, such as parents of children already enrolled in Medicaid, who attest to having complex medical needs, the Department shall assign the parent to the same Contractor as their dependent is enrolled with. Those stating that they do not have complex medical shall be assigned to a Medallion 4.0 contracted health plan.
- 2) For other individuals who are known by the Department (as described in Section 3.1.1, *Eligible Populations (7) a.*), and who attest to having complex medical needs, or are deemed by the Department to have complex medical needs such as GAP Members, the Department shall randomly assign each Member to a health plan in the individual's locality. Those stating that they do not have complex medical needs shall be assigned to a Medallion 4.0 contracted health plan.
- 3) Notwithstanding the provisions in Section 3.2.18, *Loss of CCC Plus Enrollment* Members will have ninety (90) days from their enrollment start date to actively choose a different health plan until the next open enrollment period for expansion Members.

3.2.3.1 GAP Transition Special Provisions

The Contractor is required to honor existing Fee-For-Service authorizations through the Behavioral Health Services Administrator, KePRO, pharmacy, etc.

To ensure continuity of care and a smooth transition for all GAP Members at all times, the CCC Plus Contractor shall:

- 1) Maintain the Member's current GAP SMI providers for up to thirty (30) days;
- 2) Honor SAs issued prior to enrollment, including those through out of network providers, for up to thirty (30) days or until the authorization expires, whichever comes first; and,

- 3) Extend this timeframe as necessary to ensure continuity of care pending the provider's contracting with the Contractor or the Member's safe and effective transition to a qualified provider within the MCO's provider network or as authorized by the MCO out-of-network.

Exceptions to these continuity of care provisions include the following circumstances:

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

The Contractor must have a transition plan in place that utilizes the data that the Department shares with the Contractor. The Department shares medical, behavioral health, ARTS claims, and authorizations data with the Contractor. By December 1, 2018, the Contractor shall be prepared to load this data, honor the authorizations, and risk-stratify the GAP population to mitigate any service gaps and to outreach to these members as expeditiously as the Member's condition requires. Refer to the *CCC Plus Technical Manual*.

3.2.4 Enrollment Process for Individuals Hospitalized at Time of Enrollment

Individuals who are hospitalized under fee-for-service at the time of enrollment (other than those listed in the *Exclusions from CCC Plus Program Participation*, Section 3.1.2, *Exclusions from CCC Plus Program Participation* of this Contract) will be enrolled through the CCC Plus enrollment process described above. If payment for the facility is made using the DRG process, then FFS is responsible for coverage of the facility for the entire inpatient stay; however, the Contractor shall be responsible for coverage ancillary and provider services while the Member is inpatient. The Contractor shall be responsible for the Member's care from the effective date of enrollment with the Contractor, and as such shall make every effort to reach out to these Members immediately upon learning of their enrollment/ hospitalization to assure care coordination services and discharge planning are handled appropriately. Refer to Section 12.4.9, *Hospital Payment Using DRG Methodology* of this contract for payment of services for individuals hospitalized at time of enrollment.

3.2.5 Enrollment Process for Pregnant Individuals

Members who are pregnant, other than those listed in Section 3.1.2, *Exclusions from CCC Plus Program Participation* of this Contract, will be enrolled following the described CCC Plus enrollment process. The Contractor shall reach out to these individuals immediately upon learning of the pregnancy to assure continuity of care and care coordination services are handled appropriately.

3.2.6 Enrollment Process for Newborns

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

Call Center at (855) 242-8282 or by contacting the Member's local Department of Social Services. The Contractor must also adhere to a process that assures newborns get enrolled in Medicaid as soon as possible by completing the DMAS-213 form available at: https://www.viriniamedicaid.dmas.virginia.gov/wps/myportal/ProviderFormsSearch!/ut/p/z1/jY_LDoIwEEW_xqWdovjY1ogLExISY4BuyAgFS6BtoOLj6wX2oLO7yT33ZIBDBFxfhJwu0Uius-hzzbXIOXOYcqONT7-RQtmabYx9We59COBboxDEK_B9-psDn50Pgvypxr9hNKjwXLsNGiR2-SCuarhKWSJVWj0wOg_aeSJVriBfUR6kCLAQpWzMgqa6JvNUkx1S0xOjGDmitMwFxFJ8VzfG7WbOprRJd4--Rv9gUIDLCQ/#Z7_JP4A1B01M0EF10A3A5D01M28E4. Once Medicaid enrolled, the newborn is the responsibility of FFS Medicaid until such time as the newborn is enrolled in one of the Department's Medicaid managed care programs.

3.2.7 Enrollment Process for Foster Care and Adoption Assistance Children

The Contractor shall cover services for CCC Plus program enrolled foster care & adoption assistance children. Foster Care and Adoption Assistance children shall be considered one of the CCC Plus vulnerable sub-populations. Refer the attached *MOC Assessment (HRA) and Individualized Care Plan (ICP) Requirements by Population* for guidance on assessment, reassessment, and ICP development timelines.

For individuals enrolled with the Contractor who are former foster care children (Aid Category 070), the Contractor shall communicate with the Member directly for any care coordination, service and/or program related issues. These individuals have the same restrictions on health plan enrollment changes as any other CCC Plus program enrolled Member except foster care and adoption assistance individuals (See Section 3.2.15, *Health Plan Enrollment Changes*.)

3.2.7.1 Foster Care Transition Planning

Members in foster care enrolled in Medicaid who are aging out of the foster care system have their Medicaid coverage automatically renewed in VaCMS at the time the foster care coverage ends. These members are placed in an appropriate Medicaid group, such as the Former Foster Care coverage group and will continue to receive full Medicaid coverage. Annual redeterminations of eligibility are required, but youth can be eligible in this group until they turn age 26.

3.2.8 Assignment Process Related to Change in Medically Complex Determination

Members who attested to having complex medical needs but were later determined not to have complex medical needs through a MMHS conducted by the Member's health plan, as described in Section 5.2.2, *MCO Member Health Screening (MMHS)* and submitted to the Department by the end of the month, shall be transferred from the CCC Plus program to the Medallion 4.0 program at the beginning of the following month. Members shall remain in the same health plan in Medallion 4.0 that they had for CCC Plus.

Members who attested to not having complex medical needs, or who did not respond to the question regarding their medical complexity status, on the enrollment application, but are later determined to have complex health care needs through a MMHS conducted by the Member's health plan, as described in Section 5.2.2, *MCO Member Health Screening (MMHS)* and submitted to the Department by the end of the month, shall be transferred from the Medallion 4.0

program to the CCC Plus program at the beginning of the following month. Members shall remain in the same health plan in CCC Plus that they had for Medallion 4.0.

Upon being transferred from Medallion 4.0 to CCC Plus Members will have ninety (90) days to switch plans in accordance with Section 3.2.15, *Health Plan Enrollment Changes* and can make a request to change health plans as described in Section 3.2.16, *Cause for Enrollment Changes*.

3.2.9 Alignment with D-SNP

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

3.2.10 Contractor Responsibilities Related to Enrollment

The Contractor shall accept assignment for any eligible Member. Such determinations shall be final and are not subject to review or appeal by the Contractor. This does not preclude the Contractor from providing the Department with information to ensure that enrollment with the Contractor is correct.

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

The Contractor shall refer Members and Potential Members who inquire about CCC Plus eligibility or enrollment to the Department's Enrollment Broker, although the Contractor may provide factual information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker.

In conducting any enrollment-related activities permitted by this Contract, or otherwise approved by the Department, the Contractor shall assure that Member enrollment is without regard to health status, physical or mental condition or disability, age, sex, national origin, race, or creed.

The Contractor shall notify the Department within two (2) business days upon learning that a Member meets one or more of the CCC Plus exclusion criteria. The Contractor shall report to the Department any Members it identifies as incarcerated within two (2) business days of knowledge of the incarceration. (See *CCC Plus Technical Manual* for reporting requirements.)

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

The Contractor shall notify the Member of his or her enrollment in the Contractor's plan in accordance with requirements described in *Member Communications and Enrollment Materials*.

3.2.11 DMAS Initial Enrollment Notice

At the time an individual is determined to be eligible, a letter shall be sent to the individual by DMAS stating that the individual is being enrolled into the CCC Plus program and that the individual may pre-select a health plan.

This initial notification letter specifies a “call by” date for Members to pre-select a health plan and information about how to contact the Managed Care Enrollment Broker. The Member’s initial notice also explains if the Member does not call by the “call by date” they will be enrolled with a default MCO, and provides the default MCO enrollment effective date.

3.2.12 Enrollment Assignment Notice

The assignment letter is mailed to the Member and includes the Member’s MCO assignment and the CCC Plus MCO comparison chart. It explains the Member’s right to change from one MCO to another during their initial ninety (90) calendar days of CCC Plus program enrollment and during open enrollment.

3.2.13 Enrollment Effective Time

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

3.2.14 Automatic Re-enrollment

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

3.2.15 Health Plan Enrollment Changes

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

- 1) For the initial ninety (90) calendar days (3 calendar months) following the effective date of CCC Plus program enrollment with a health plan, the individual will be permitted to change from one Contractor to another without cause. This ninety (90) day time frame applies only to the individual’s initial program start date of enrollment. It does not reset or apply to any subsequent enrollment periods with a different Contractor. After the initial ninety (90) day period following the initial enrollment date, he or she may not disenroll without cause until the next open enrollment period.
- 2) In accordance with 42 CFR § 438.56(c)(2)(iv), when the Department imposes the intermediate sanction specified in 42 CFR § 438.702(a)(4).

- 3) Following their initial 90-day enrollment period, individuals (other than Foster Care and Adoption Assistance children) shall be restricted to their Contractor selection until the open enrollment period, unless disenrolled under one of the conditions described and pursuant to Section 1932 (a)(4)(A) of Title XIX. The individual may disenroll from any contracted Contractor to another at any time, for cause, as defined in Section 3.2.16, *Cause for Enrollment Changes* of this Contract.
- 4) DMAS will notify individuals of their ability to change Contractors during an annual open enrollment period at least ninety (90) calendar days before the end of their enrollment period.
- 5) Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the individual to miss the annual disenrollment opportunity.

3.2.16 Cause for Enrollment Changes

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

- 1) The Member moves out of the Contractor's service area;
- 2) The Contractor does not, because of moral or religious objections, cover the service the Member seeks;
- 3) The Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the Member's primary care provider or another provider determines that receiving the services separately would subject the Member to unnecessary risk;
- 4) The Member who receives LTSS would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment;
- 5) Other reasons as determined by the Department, including poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the Member's care needs; and,
- 6) A Medicaid expansion Member may disenroll from one health plan to another after transitioning from the Medallion 4.0 program to the CCC Plus program or vice versa.

The request may be submitted orally or in writing to the Department and cite the reason(s) why he or she wishes to disenroll. The Department will review the request in accordance with cause for disenrollment criteria defined in 42 CFR § 438.56(d)(2). The Department will respond to "cause" requests, in writing, within fifteen (15) business days of the Department's receipt of the request. In accordance with 42 CFR § 438.56(e)(2), if the Department fails to make a determination by the first day of the second month following the month in which the Member files the request, the disenrollment request shall be considered approved and effective on the date of approval.

If Member is dissatisfied with the good cause for disenrollment from one plan to another determination made by the Department the Member may appeal through the State Fair Hearing Process in Section 15.4.3.3, *State Fair Hearing Process* of this Contract.

3.2.17 Disenrollment Effective Time

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

3.2.18 Loss of CCC Plus Enrollment

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

- Death of the Member;
- Cessation of Medicaid eligibility;
- Member meets at least one of the exclusion criteria listed in Section 3.1.2, *Exclusions from CCC Plus Program Participation* of this Contract (the Department shall determine if the Member meets the criteria for exclusion);
- Transfer to a Medicaid eligibility category not included in this Contract; or,
- Certain changes made within the Medicaid Management Information System by eligibility case workers at the Department of Social Services.

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

3.2.19 Informing of Potential Ineligibility

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

3.2.20 Monthly and Weekly Enrollment File (834)

An 834 enrollment file will be sent to the Contractor weekly on the 6th and 13th of each month (known as weekly files), monthly on the 19th (known as mid-month), and on the last day of the month. The weekly 834 files will contain any changes of Member information, and enrollment adds and terminations (drops) for CCC Plus MCO program disenrollments. The monthly 834 file will contain information about the Contractor's CCC Plus membership, including audit, add and termination records for full eligibility/enrollment for current and future enrollment dates. Medicaid expansion Members will be included in the enrollment files described in this section. There will be no separate enrollment file for this population. The 834 includes all related CCC Plus Members' Level of Care (LOC) benefit information, including retro changes, based upon the transaction date. For example, the 834:

- 1) Includes current assignments;
- 2) Includes both future-ended and open-ended Members;

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

3.2.21 Medical Transition Report (MTR) File

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

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

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

On a weekly basis, the Contractor shall submit all Pharmacy service authorizations completed during the past week, for all CCC Plus members to DMAS via the NCPDP Standard Format, as defined in the *CCC Plus Technical Manual*. The Contractor shall submit no more than one (1) file per week. Should the Contractor not submit the file timely as outlined in the *CCC Plus Technical Manual* or should DMAS reject the file submitted due to not meeting NCPDP Standard Format requirements, the Contractor shall submit two weeks of Pharmacy service authorization information by the next weeks timeframe.

SECTION 4.0 BENEFITS AND SERVICE REQUIREMENTS

4.1 GENERAL BENEFITS PROVISIONS

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

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

The Contractor must provide written notification to all affected participating providers at least 30 days prior to the effective date of changes to any operational process that would affect services to members, including but not limited to claims processing, service authorizations, etc. This requirement applies to all services listed in Section 4.0, *Benefits and Service Requirements* of this Contract.

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

4.1.1 Laboratories

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

4.2 BEHAVIORAL HEALTH SERVICES

4.2.1 Inpatient and Outpatient Services

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

4.2.2 Community Mental Health Rehabilitation Services (CMHRS)

The Contractor shall provide coverage for the subset of behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS). CMHRS are listed in the table below and are explained in detail in the attached *CCC Plus Coverage Chart* (Attachment 5).

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

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

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

The Contractor’s CMHRS criteria shall be consistent with the Department’s criteria for the Community Mental Health Rehabilitation Services (CMHRS) benefit as defined in 12 VAC 30-50-130, 12VAC30-50-226, 12VAC30-60-5, 12VAC30-60-61 and 12VAC30-60-143 and 12VAC30-130-2000 [excluding C.4, D.2(d) and E(i)]. Providers are required to perform a Comprehensive Needs Assessment (CNA) as described in the CMHRS Manual prior to submitting a request for CMHRS. Behavioral Therapy services shall be consistent with the Department’s criteria as defined in the Behavioral Therapy Program Manual Supplement. All CMHRS Services will require a service authorization or registration to qualify for reimbursement. CMHRS service authorization and registration provider requirements are described in Section 6.2.5.2, *Community Mental Health Rehabilitation Services* of this Contract.

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

4.2.2.1 CMHRS Standards of Care

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

4.2.2.2 CMHRS Network Development Plan

The Contractor’s CMHRS network shall ensure sufficient Member access to high quality service providers with demonstrated ability to provide evidence based treatment services that consist of person centered, culturally competent and trauma informed care using a network of high quality, credentialed, and knowledgeable providers in each level of care within the access to care and quality of care standards as defined by the Department. Reference *Specialized Network Provisions*.

4.2.2.3 CMHRS Provider Qualifications

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-50-226, 12VAC30-50-130, 12VAC30-60-143 and 12VAC30-60-61. The Contractor shall verify that registration requirements for peer recovery specialists and qualified mental health professionals are met as directed by the Department of Health Professions in accordance with all applicable regulations.

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

Community Mental Health Rehabilitation Services	Billing Method	Urban Rate Per Unit	Rural Rate Per Unit
Mental Health Case Management	CMS-1500	N/A	N/A
Therapeutic Day Treatment (TDT) for Children	CMS-1500 or UB	N/A	N/A
Day Treatment/ Partial Hospitalization for Adults	CMS-1500 or UB	N/A	N/A
Crisis Intervention	CMS-1500	\$30.79	\$18.61
Intensive Community Treatment	CMS-1500	\$153.00	\$139.00
Mental Health Skill-building Services (MHSS)	CMS-1500	\$91.00	\$83.00
Intensive In-Home	CMS-1500	N/A	N/A
Psychosocial Rehab	CMS-1500	N/A	N/A
Crisis Stabilization	CMS-1500	\$89.00	\$81.00
Behavioral Therapy (ABA)	CMS-1500	N/A	N/A

Mental Health Peer Support Services – Individual	CMS-1500	N/A	N/A
Mental Health Peer Support Services – Group	CMS-1500	N/A	N/A
Mental Health Family Support Partners - Individual	CMS-1500	N/A	N/A
Mental Health Family Support Partners - Group	CMS-1500	N/A	N/A

4.2.3 Residential Treatment Services

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

The Contractor shall work closely with the Department’s BHSA to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. The Contractor shall collaborate with the BHSA to ensure physician engagement occurs on behalf of the Member during the independent certification of need process as required prior to any residential treatment service authorization.

The Contractor shall collaborate with the BHSA to facilitate Independent Assessment Certification and Coordination Team (IACCT) activities on behalf of the Member. The Contractor shall work collaboratively with the Department’s BHSA to ensure coordination of Medical, ARTS, and mental health services for its Members and shall provide coverage for transportation and pharmacy services necessary for the provision of, and as related to, TGH carved out services.

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

4.2.3.1 Collaboration with DMAS, DBHDS, and Interested Stakeholders in Residential Treatment Services

The Contractor shall work collaboratively with DMAS, as well as with DBHDS, DHP, VDH, OCS and local CSA Coordinators, DSS, providers, DMAS contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support successful transition of the Residential Treatment Services, Independent Assessment, Coordination and Certification Teams and Treatment Foster Care Case Management services and

to ensure that the Contractor's RTS benefit is fully operational upon notification from the Department, and through separately issued guidance on the planned transition of RTS into managed care, the date of which is to be determined.

4.2.3.1.2 Transition of Residential Treatment Services

The Contractor shall work collaboratively with DMAS, DBHDS, OCS and local CSA Coordinators, DSS, providers, DMAS contractors, relevant local, State, tribal, social service agencies, and other interested stakeholders to provide the infrastructure to support the successful transition of Residential Treatment Services, Independent Assessment, Coordination and Certification Teams and Treatment Foster Care services and to ensure that the Contractor's RTS benefit is fully operational upon notification by the Department with separate guidance of the planned transition of the RTS into managed care, the date of which is to be determined. To support this work, the Contractor shall identify to the Department a dedicated staff person (with dedicated email address and phone number) who will be the primary point of contact for the transition of residential treatment services into the CCC Plus program and who shall work with the current DMAS behavioral health services authorization contractor to provide requested information on members currently in PRTFs.

4.2.4 Addiction and Recovery Treatment Services (ARTS)

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

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

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

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

4.2.4.1.1 Comprehensive Evidence-Based Benefit Design

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

The Contractor shall provide coverage for services at the most appropriate American Society of Addiction Medicine (ASAM) level of care based on the most current version of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* and the Department's criteria defined in 12VAC30-130-5000 et al and the ARTS Provider

Manual, which includes inpatient detoxification services provided in an acute care hospital settings licensed by the Virginia Department of Health (VDH); residential treatment services provided in a facility licensed by DBHDS; and SUD outpatient services by licensed or credentialed staff through the Department of Health Professions (DHP). As directed by DMAS, the Contractor shall provide coverage in IMD settings as appropriate based on the ASAM Criteria for adults who are 21 through 64 years of age.

4.2.4.1.2 Appropriate Standards of Care

The Contractor shall use the DMAS defined medical necessity criteria for coverage of ARTS. In order to receive ARTS services, the Member must be enrolled in the CCC Plus program and must meet the following medical necessity criteria:

- 1) Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21);
- 2) Must meet the severity and intensity of treatment requirements for each service level defined by the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*. Medical necessity for all ASAM levels of care is based on the individual's assessed biopsychosocial severity and is defined by the extent and severity of the individual's problems as defined by a licensed clinician based on the individual's documented severity of need in all six (6) ASAM multidimensional assessment areas; and,
- 3) For individuals under the age of twenty-one (21) who do not meet the ASAM medical necessity criteria upon initial review, a second individualized review will be administered to ensure the individual's treatment needs are assessed and medically necessary services will be coordinated to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

The Contractor shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-130-5020 and in Section 4.2.4.1.4, *ARTS Provider Qualifications* of this contract. The Contractor shall use *The ASAM Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions* to review and coordinate service needs by applying the ASAM treatment criteria and determining medical necessity for ARTS services in accord with 12VAC30-130-5100. The Contractor's ARTS Care Coordinator, or a licensed physician or Medical Director employed by the Contractor, will perform an independent assessment of requests for all ARTS intensive outpatient (ASAM Level 2.1), partial hospitalization (ASAM Level 2.5), residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0) using Member information transmitted by providers via the *ARTS Service Authorization Review Forms*. The *ARTS Service Authorization Review Forms* are available at: <http://www.dmas.virginia.gov/#/artsregistration>. The Contractor shall review the requests on an individual basis and determine whether the length of treatment and service limits are based on the individual's most current multidimensional risk profile and apply the ASAM Treatment Criteria in accord with 12VAC30-130-5000 et al.

4.2.4.1.3 Strong Network Development Plan

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

4.2.4.1.4 ARTS Provider Qualifications

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

The Contractor shall credential the Preferred Office Based Opioid Treatment (OBOT) providers approved by the Department using the criteria as set forth by the Department in 12VAC30-130-5060. Approval will be based on the Office of the Chief Medical Officer’s review of the *ARTS OBOT Attestation Application* available online at: <http://www.dmas.virginia.gov/#/artscredentialing>. The Contractor shall provide the Department a report on a monthly basis of the OBOT credentialed organizations in the Contractor’s network as defined in the *ARTS Technical Manual*.

4.2.4.1.5 ARTS Benefit Management

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

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

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

ASAM Level	Billing Method
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB

2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Residential	UB
3.5 Inpatient	UB
3.7 Residential	UB
3.7 Inpatient	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Preferred Office Based Opioid Treatment	CMS-1500
Substance Abuse Case Management	CMS-1500
Substance Abuse Care Coordination	CMS-1500
Peer Recovery Support Services	CMS-1500

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

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

Authorizations may be approved retroactively based on established provider enrollment contractual requirements after a provider has engaged a Member in treatment to promote immediate entry into withdrawal management processes and addiction treatment. The Contractor shall respond to the provider's service authorization submission via the ARTS uniform service authorization request form with the results of the Contractor's independent assessment within three (3) calendar days for requests for placement at Intensive Outpatient and Partial Hospitalization (ASAM Levels 2.1, 2.5) and Group Home (ASAM Level 3.1). The Contractor must respond to the provider's service authorization submission via the *ARTS Service Authorization Request Forms* within one (1) calendar day for requests for placement in Residential Treatment Services (ASAM levels 3.3, 3.5, and 3.7) and Inpatient Hospitals (ASAM Level 4.0).

The Contractor shall employ an ARTS Care Coordinator who is a licensed practitioner of the healing arts, including a physician or medical director, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, nurse practitioner or registered nurse with clinical experience in treatment of substance use disorder. The ARTS Care Coordinator shall perform an independent assessment of requests for all ARTS residential treatment services and inpatient services (ASAM Levels 3.1, 3.3, 3.5, 3.7 and 4.0). The ARTS Care Coordinator shall also provide clinical care coordination as defined in section 4.2.4.1.8, *ARTS Clinical Care Coordination and 24/7 Toll-Free Access* of this Contract.

In accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, the contractor shall cover medication-assisted treatment (MAT), including FDA approved drugs, counseling services, and behavioral therapy. The Contractor shall require all ARTS Intensive Outpatient Programs (ASAM Level 2.1), Partial Hospitalization Programs (ASAM Level 2.5), and Residential Treatment Providers (ASAM Levels 3.3, 3.5, and 3.7) to ensure that Medicaid enrolled Members with an Opioid Use Disorder admitted to any of these programs have access to FDA- approved, evidence-based Medication Assisted Treatment, including buprenorphine, methadone, or naltrexone. The Contractor shall be responsible for ensuring that ARTS IOP, PHP, and RTS providers are assessing and referring members for Medication Assisted Treatment (MAT) in these settings.

4.2.4.1.6 Pharmacy

The Contractor shall be responsible for covering all Food and Drug Administration (FDA) approved drugs for Members based on the Common Core Formulary as well as follow the Department's approved fee-for-service clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the DMAS website at: <https://www.virginiamedicaidpharmacyservices.com>. The Contractor is expected to meet all other requirements as set forth in Section 4.8, *Pharmacy Services*.

The Contractor or its Pharmacy Benefit Manager, at a minimum, will cover all DMAS Preferred Drug List (PDL) "preferred" non-opioid pharmacologic therapies for pain. The Contractor shall cover naloxone injection and nasal spray without restrictions for all Members. The DMAS PDL can be accessed at <https://www.virginiamedicaidpharmacyservices.com>. The Contractor shall assure that coverage is no more restrictive than the applicable DMAS PDL requirements and that no additional service authorization criteria, quantity limits or clinical edits are applied.

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

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

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

The Contractor shall allow prescriptions for preferred/formulary buprenorphine/naloxone drugs written by providers of organizations that are credentialed by the Contractor as a Preferred Office

Based Opioid Treatment (OBOT) provider and an in-network buprenorphine waived providers (BWP) provider to by-pass all service authorization requirements when prescribed in dosages of 24 mg or less per day. The Contractor shall not authorize more milligrams per day than exceed the Board of Medicine allowance.

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

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

4.2.4.1.7 Integration of Physical Health, Behavioral Health, and Addiction and Recovery Treatment Services

The Contractor shall implement viable strategies to implement a fully integrated care model including coordination of physical and behavioral health, primary care, and pharmacy services. This includes clinically indicated infectious disease testing such as HIV, Hepatitis A/B/C, syphilis, and tuberculosis testing for members with SUD at initiation of and as indicated during treatment. The Contractor shall also ensure coverage of Hepatitis C treatment and HIV treatment and prevention including pre-exposure prophylaxis. For women of childbearing age, the Contractor shall promote contraception management with addiction treatment including long acting reversible contraception (LARC).

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

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

The Contractor, consistent with Federal and State confidentiality requirements, shall implement structured care coordination plans for achieving seamless transitions of care. These plans will address overall care coordination for the ARTS benefit, transitions between all ASAM Levels of Care, transitions between ARTS service providers, transitions between delivery systems (i.e., moving from fee-for-service to managed care), collaboration between behavioral health and physical health systems, and collaboration between the health plans and the BHSA. The Contractor shall emphasize care coordination for any Member with SUD transitioning from emergency departments or inpatient stays. The Contractor shall make every effort to provide outreach and care coordination to Members discharged from inpatient detoxification within seven (7) calendar days of notice of discharge. At minimum, this outreach shall include the sharing of information related to linkages of naloxone treatment and how to get prescriptions filled. The plan of care post-discharge will be developed by the provider and can be updated by the Contractor.

The Contractor shall use data from multiple sources (including utilization data, health risk assessments, state agency aid categories, demographic information, and Health Department epidemiology reports) to identify members with complex health needs, including members who need help navigating the health system to receive appropriate delivery of care and services. When clinically indicated, the Contractor will assign each member to a Care Coordinator to provide care coordination support throughout the course of treatment, ensuring that all relevant information is shared with the treating providers through care transitions.

The Contractor shall provide ongoing education to providers regarding the requirement to engage in discharge planning for all members, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care. The Contractor shall conduct chart reviews to ensure compliance and identify opportunities to improve quality of care (See Section 10.3, *Quality Infrastructure* of this Contract). The Contractor shall facilitate the transfer of clinical information between treating practitioners to foster continuity of care and progress towards recovery.

The Contractor shall refer to and collaborate with the Behavioral Health Services Administrator (BHSA) for mental health services not included in the contract. The BHSA shall communicate via medical records and other appropriate means to enable the Contractor to adequately track Member progress.

The Contractor shall develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current substance use, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

In order to minimize barriers to care, the Contractor shall ensure that its network includes behavioral health professionals performing addiction and recovery treatment service assessments via telehealth (where available). Services provided via telehealth shall be consistent with State regulations. ARTS Care Coordinators will be knowledgeable about the telehealth delivery system in Virginia and will refer Members in rural and other hard to access areas to these systems in order to receive an assessment. It is expected that there will be some Members who will not be able to access this evaluation through a telehealth solution or an office visit due to transportation, psychosocial, or health issues, thus the Contractor shall contract with a subset of evaluators to provide in home evaluations in order to accommodate the needs of these Members. Reference *Federal Confidentiality Rules Related To Drug Abuse Diagnosis and Treatment*.

4.2.4.1.9 Program Integrity Safeguards

The Contractor shall perform an annual review on all providers to assure that the health care professionals under contract with the provider are qualified to provide ARTS and that services are being provided in accordance with contract, the ASAM criteria and set forth in 12VAC30-130-5000 et al., and the ARTS Provider Manual, and CCC Plus program requirements. Reference *Provider Credentialing Standards*.

4.2.4.1.10 Community Integration

The Contractor shall ensure compliance with CMS established person-centered planning and community based setting requirements into all ARTS service planning and service delivery efforts. ARTS service planning and delivery will be based upon a person-centered assessment designed to help determine and respond to what works in the person's life and thus needs to be maintained or improved and what does not work and thus needs to be stopped or changed. The Contractor shall ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency as detailed in this contract.

Peer recovery support services shall be made available to CCC Plus Members receiving ARTS services at all levels of care. Peer recovery support resources are an integral component of community integration.

4.2.4.1.11 Services for Adolescents and Youth with SUD

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

4.2.4.1.12 ARTS Reimbursement

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

4.2.4.1.13 Quality Measurement and Improvement

The Contractor shall comply with the detailed requirements and expectations outlined in this Contract. The ARTS specific quality measures and reporting and monthly ARTS deliverables are described in Section 10.0, *Quality Management and Improvement* of this Contract.

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

4.2.4.1.14 Interventions to Prevent Controlled Substance Use

The Contractor shall be responsible for complying with all DMAS approved clinical criteria for drugs used in the treatment of opioid use disorder and pain management. Criteria may be located on the DMAS website at: <https://www.virginiamedicaidpharmacyservices.com/>.

The Contractor shall educate providers and Members about the risk factors for opioid-related harms and provide management plan strategies to mitigate risk including but not limited to benzodiazepine and opioid tapering tools, physician/patient opioid treatment agreements, and the offering of naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages or concurrent benzodiazepine use, are present.

The Contractor or its Pharmacy Benefits Manager shall implement point-of-sale denial edits consistent with the DMAS approved clinical criteria detailed in the DMAS Provider Memo dated

December 1, 2016 titled “Implementation of CDC Guideline for Prescribing Opioids for Chronic Pain – Coverage of Non-Opioid Pain Relievers and Uniform, Streamlined Prior Authorization for New Opioid Prescriptions Effective December 1, 2016.”

The Contractor shall have in place authorization procedures to override any of the denials when the prescriber provides compelling clinical documentation and medical necessity for the override.

4.2.4.1.15 Data Reporting

The Contractor shall report data specific to the ARTS benefits as detailed in the *ARTS Technical Manual*.

4.2.5 Court-Ordered Services

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

4.2.6 Temporary Detention Orders (TDO) and Emergency Custody Orders (EDO)

A Temporary Detention Order (TDO) is an order issued by a magistrate for a person who has been determined to be in imminent danger to themselves or others as a result of behavioral illness or is so seriously behaviorally ill and is unable to care for self and is incapable or unwilling to consent to treatment. The Contractor shall provide coverage for TDOs and ECOs pursuant to 42 CFR § 441.150 and the *Code of Virginia*, § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691. The 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 ninety-six (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.

Coverage for services for Members admitted to a freestanding psychiatric facility under a TDO shall be handled as follows:

If the Member is under age twenty-one (21) or over age sixty-four (64), and goes into private freestanding IMD or a State freestanding IMD for a TDO, the Contractor is responsible for the TDO. If the Member remains admitted to the IMD after the TDO expires, the Contractor is responsible for the psychiatric stay. Following expiration of the TDO, the Contractor can require that the Member transfer to a network facility.

For Members age twenty-one (21) through sixty-four (64), where the Member goes into private freestanding IMD or a State freestanding IMD for a TDO, providers should submit the TDO claim to the state TDO program. The Member will remain enrolled with the Contractor beyond

the TDO timeframe. The Contractor will manage the Member's treatment needs beyond the TDO timeframe and can require that the Member transfer to a network facility.

The duration of temporary detention shall be in accordance with the *Code of Virginia*, as follows:

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

4.2.7 Mental Health Parity

In accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) in general and 42 CFR § 438.910(b) specifically, the Contractor shall not apply any financial requirement or treatment limitation to behavioral health benefits, including mental health or addiction, recovery and treatment benefits, in any classification (inpatient, out-patient, emergency and pharmacy) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees. Additionally, and in accordance with 42 CFR § 438.910(b)(2), because the Contractor is required to provide behavioral health benefits in any classification of benefits, the behavioral health benefits must be provided to the member in every classification in which medical/surgical benefits are provided.

As permitted under MHPAEA, this does not preclude the Contractor from limiting coverage for medical surgical and behavioral health services on the basis of medical necessity.

4.2.7.1 Alignment with State Plan

The Contractor shall not place limits on behavioral health benefits that are more restrictive than limits in place under FFS Medicaid.

In accordance with 42 CFR § 438.3(e)(1)(ii), the Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance abuse benefits in 42 CFR § 438, subpart K.

4.2.7.2 Annual and Lifetime Dollar Limits

In accordance with 42 CFR § 438.905(b), because the State does not allow for aggregate lifetime or annual dollar limits on any medical/surgical benefits or aggregate lifetime or annual dollar limits that apply to less than one-third of all medical/surgical benefits provided to enrollees the Contractor may not impose an aggregate lifetime or annual dollar limit on any behavioral health benefit regardless of classification.

4.2.7.3 Non-Quantitative Treatment Limits (NQL)

In accordance with 42 CFR § 438.910(d), the Contractor may not impose NQL's for behavioral health benefits in any classification (inpatient, out-patient, emergency care or prescription drugs) unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQL to behavioral health benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. For example, the Contractor can limit coverage of behavioral health services based on medical necessity; however, the limits must be applied no more stringently than medical necessity limits on medical/surgical services. See 42 CFR 438.910(d)(2) for an illustrative list of NQL's.

4.2.7.4 Application Across Classifications

In accordance with 42 CFR § 438.910(b)(2), the Contractor is required to provide behavioral health benefits in any classification in which medical/surgical benefits are provided.

4.2.7.5 Access to Out-Of-Network Providers

In accordance with 42 CFR § 438.910(b)(2), if an enrollee of the Contractor is provided behavioral health benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), the behavioral health benefits must be provided to the member in every classification in which medical/surgical benefits are provided.

4.2.7.6 Mental Health Parity Reporting

The Contractor is required to provide documentation necessary to establish and demonstrate compliance with MHPAEA (42 CFR § 438, subpart K) regarding the provision of behavioral health benefits. Specific reporting requirements will be described in the *CCC Plus Technical Manual*.

4.3 DENTAL AND RELATED SERVICES

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

The Contractor shall be responsible for transportation and medication related to all covered dental services. In addition, the Contractor shall be responsible for working closely with the DBA to coordinate medically necessary procedures for adults and children, including but not limited to, the following:

- 1) CPT codes billed for dental services performed as a result of an accident.
- 2) Medically necessary procedures, including but not limited to, preparation of the mouth for radiation therapy; maxillary or mandibular frenectomy when not related to a dental procedure; orthognathic surgery to attain functional capacity; and surgical services on the hard or soft tissue in the mouth where the main purpose is not to treat or help the teeth and their supporting structures.
- 3) In accordance with § 38.2-3418.12 of the *Code of Virginia*, the Contractor shall cover anesthesia and hospitalization services when deemed medically necessary to effectively and safely provide dental care. The Contractor shall work with the Department's DBA to coordinate coverage for these services.
- 4) Coverage is required for children under the age of five (5), persons with severe disabilities, and persons who have a medical condition that requires admission to a hospital or outpatient surgery facility when determined by a licensed dentist, in consultation with the Member's treating physician that such services are required to effectively and safely provide dental care. The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the Department's DBA.

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

4.3.1 Coordination with Dental Benefits Administrator (DBA)

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

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

- The dental service provider must submit the request for authorization directly to the DBA;
- If the DBA reviews the request for dental related hospitalization and/or anesthesia based upon medical necessity;
- If the DBA approves the request, the DBA coordinates anesthesia and hospitalization authorization for Dental Services with the Contractor and within the Contractor's provider network.
- The Contractor shall honor anesthesia and hospitalization authorizations for medically necessary dental services as determined by the DBA.
- The Contractor shall respond in writing (via facsimile (262) 834-3575, secure email, or any agreed upon secure communication medium) to the DBA request for authorization within two (2) business days. An authorization shall include a valid date range for the outpatient request. The Contractor shall provide a comprehensive list of routine and escalation contacts. This list should be updated as changes occur. The Contractor shall adhere to all turnaround times.

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

Department's decision, however, does not override any decisions made as part of the Member's State Fair Hearing Process.

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

The Contractor is responsible for all EPSDT services for their Members under age twenty-one (21). EPSDT services for Members under age twenty-one (21) also apply to the Medicaid Expansion population as described in Section 3.1.1, *Eligible Populations*. The Contractor shall comply with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status. Refer to the *CCC Plus Coverage Chart* attached to this Contract for more information.

4.4.1 Enhanced Scope of Coverage

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

4.4.2 Contractor's EPSDT Review Process

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

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

4.4.3 Department Approval of Contractor's EPSDT Review Process

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

4.4.4 Contractor EPSDT Outreach and Education Responsibilities

The Contractor shall inform Members about EPSDT services and how to access care. The Contractor shall assure that a participating child is periodically screened following the American Academy of Pediatrics (AAP) and Bright Future recommendations, and treated in conformity with the AAP periodicity schedule. To comply with this requirement, the Contractor shall design and employ policies and methods to assure that children receive prescreening and treatment when due.

The Contractor must educate and inform Members identified as not complying with the EPSDT periodicity and immunization schedules, as appropriate. The Contractor shall provide copies of any such notices to the Department and provide documentation as to the frequency and timing of these notices, as well as further outreach if notices are not successful.

4.4.5 Documentation of Screenings

EPSDT services shall be subject to all the Contractor's documentation requirements for its network provider services. EPSDT services shall also be subject to the following additional documentation requirements: (1) The medical record shall indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT related services whether provided by the PCP or another provider; and, (2) Documentation of a comprehensive screening shall, at a minimum, contain a description of the components utilized.

4.4.6 EPSDT Quality Improvement Activities

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

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

4.4.7 Treatment and Referrals

When a developmental delay has been identified by the provider for children under age three (3), the Contractor shall ensure appropriate referrals are made to the Infant and Toddler Connection and documented in the Member's records. The Contractor shall work with the Department to refer Members for further diagnosis and treatment or follow-up of all conditions uncovered or suspected. If the family requests assistance with transportation and scheduling to receive services for early intervention, the Contractor is to provide this assistance.

4.4.8 Immunizations/Vaccinations

The Contractor shall ensure that providers render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the EPSDT screening and that Members are not inappropriately referred to other providers for immunizations. The Contractor shall work with its network providers to adhere to the ACIP recommendations.

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

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

4.4.9 Private Duty Nursing (PDN) Services for Children

The Contractor shall cover medically necessary PDN services for children under age 21, in accordance with the Department’s criteria described in the DMAS EPSDT Manual, and as required in accordance with EPSDT regulations described in 42 CFR §§ 441.50, 440.80, and the Social Security Act §§1905(a) and 1905(r)I. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing which provide for short term, intermittent care where the emphasis is on Member or caregiver teaching. Under EPSDT PDN, the individual’s condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring of unstable conditions, and skilled interventions.

4.5 EARLY INTERVENTION (EI)

Early Intervention (EI) services, authorized through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d), as well as the DBHDS Part C Manual and the Department’s EI Program Manual are covered under this Contract. Children from birth to age three who have (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are eligible for EI services. EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social or emotional, or adaptive).

EI services are not medically indicated for children aged three (3) and above. EI services are available to qualified individuals through Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EI services for children who are enrolled in a contracted MCO are covered by the health plan within the Department's coverage criteria and guidelines described in 12 VAC 30-50-131. By law, Part C funds are to be used as "payer of last resort" for direct services to children and families when no other source of payment is available pursuant to 20 U.S.C. § 1440 and 12VAC35-225-210.

The Contractor shall work collaboratively with the EI Service Coordinator to: (1) ensure the Member receives the necessary EI services timely and in accordance with Federal and State regulations and guidelines, (2) to coordinate other services needed by the Member, and (3) to transition the Member to appropriate services.

In Virginia, the EI services program is called the "Infant and Toddler Connection of Virginia" and is managed by the Department of Behavioral Health and Developmental Services (DBHDS). DBHDS contracts with forty (40) local lead agencies (LLAs) to facilitate implementation of local EI services statewide and also is responsible for certification of EI providers and service coordinators/case managers. Providers (or the agency) must be enrolled with DMAS as an Early Intervention Provider.

All EI service providers participating in the Virginia Medicaid Medical Assistance Services Program and Managed Care Organizations must adhere to the requirements and provide services in accordance with State and Federal laws and regulations governing the provision of Early Intervention services, as well as both of the Early Intervention Practice Manuals (DMAS and DBHDS Part C).

Children are first evaluated by the local lead agency to determine if they meet Part C requirements. If determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, the Department of Behavioral Health and Developmental Services (DBHDS) staff enters the early intervention (EI) level of care in the DMAS system. Once the LOC is entered, the EI services are billable based upon the physician's order on the IFSP. All EI service providers must be enrolled with the child's health plan prior to billing.

EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP), developed by the multidisciplinary team, including the MCO Care Coordinator and EI service team (two or more individuals from separate disciplines or professions and one of these must be the EI Service Coordinator), the MCO Care Coordinator, the family/caregiver. The Contractor's Care Coordinator may collaborate with the EI Service Coordinator if unable to attend the IFSP meeting. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. EI services are performed by EI certified providers in the child's natural environment, to the maximum extent appropriate. Natural environments can include the child's home or a community based setting in which children without disabilities also participate. In accordance with Chapter 53 of Title 2.2 of the *Code of Virginia*, the Contractor shall provide coverage for EI services as described in the Member's IFSP developed by the local lead agency. The Contractor shall work collaboratively as part of the Member's multidisciplinary team to: (1) ensure the Member receives the necessary EI services timely and in accordance with Federal and

State regulations and guidelines, (2) to coordinate other services needed by the Member, and (3) to transition the Member to appropriate services. Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, including in terms of amount, duration, and scope. Service authorization shall not be required.

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

The Contractor shall ensure that Members have access to EI providers who are certified by the Department of Behavioral Health and Developmental Services (DBHDS). The Contractor’s EI network shall be sufficient in all disciplines to provide assessments and ongoing services in accordance with Federal timelines and DMAS program requirements. EI providers shall be contracted with or have a memorandum of agreement (MOA) in place with the local lead agency for the catchment area in which the Member resides.

The EI Service Coordinator shall send to the Contractor the following sections of the IFSP:

- Section I – Child and Family Information
- Section V – Services Needed To Achieve EI Outcomes
- Section VI – Other Services

These sections shall be forwarded to the Contractor upon initial development of the IFSP, when a change of service is indicated, and annually. The IFSP shall become part of the Member’s records. The EI Service Coordinator shall forward to the MCO Section VII – Transition Planning - once the Transition Plan Section is developed. The Contractor may request other sections of the IFSP to assist in care management and provision on non-EI services.

If the IFSP (Sections I, V, and VI) is not on file, the Contractor shall make a reasonable effort to obtain the IFSP from the local lead agency EI Service Coordinator or provider prior to processing the claim in order to prevent a premature denial of a claim. Lack of an IFSP (Sections I, V, and VI) on file with the MCO will constitute a non-clean claim, except for the four codes noted in the chart below. The following codes/services are excluded from this requirement and should pay with or without the IFSP at the full EI rate.

Code	Description
T2022	<ul style="list-style-type: none"> • Service coordination
T1023	<ul style="list-style-type: none"> • Initial Assessment for Service Planning
T1023 U1	<ul style="list-style-type: none"> • Development of initial IFSP • Annual IFSP
T1024	<ul style="list-style-type: none"> • Team Treatment activities (more than one professional providing services during same session for an individual child/family)

	<ul style="list-style-type: none"> • IFSP Review Meetings (must be in person) • Assessments that are done <u>after</u> the initial Assessment for Service Planning • Providers may use T1024 and the T1024 U1 on the same day, same child, same date of service and potentially the same NPI number
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Early intervention reimbursement is defined by ten (10) distinct codes, inclusive of appropriate modifiers. These codes can only be billed for EI enrolled children (as indicated by the EI indicator on the 834-eligibility file) by providers who are certified by DBHDS and enrolled with DMAS/MCOs as an EI provider. EI codes require no authorization from the Contractor.

The Contractor shall reimburse EI services no less than the EI Medicaid fee schedule in place at the time of services. The Contractor also shall use the full EI rate when paying secondary claims for EI services submitted by EI providers for EI enrolled children.

Refer to Section 12.4.12.3, *Comprehensive Health Coverage* for information on the handling of TPL for EI services, the Attached *CCC Plus Coverage Chart* (Section 3B) for covered services and billing codes, and 12.4 *Provider Payment System* for special EI claim processing requirements.

4.6 EMERGENCY AND POST-STABILIZATION SERVICES

The Contractor shall cover emergency services without service authorization. The Contractor shall cover emergency services after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including 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 member’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.

In accordance with 42 CFR § 438.114, the Contractor shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week through the Contractor’s network. 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 CFR § 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 condition. The Contractor is also prohibited from denying payment for treatment obtained when a representative of the Contractor instructs the member to seek emergency services. Additionally, in accordance with 42 CFR §438.114, the Contractor is required to cover post-stabilization care services administered to maintain, improve, or resolve the Member’s stabilized condition without preauthorization, when the Contractor’s

representative and the treating physician could not reach agreement and the Contractor's physician was not available for consultation.

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 un-stabilized 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:

1. 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.

2. Post-Stabilization Care

The Contractor shall pay for all post-stabilization care that the treating emergency physician views as medically necessary provided subsequent to the stabilization of an emergency medical condition, even after an emergency medical condition has stabilized. . Coverage shall include treatment that may be necessary to assure, within a reasonable likelihood that no material deterioration of the patient's condition is likely to result from or occur after 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 un-stabilized 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 privileges to consult with the on-scene attending physician and potentially assume taking care of the patient, including stabilizing, treating, transferring, admitting, or discharging the patient.

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

- A. Coverage - The Contractor shall cover post-stabilization care services that are:
 - a. Pre-approved by a plan provider or the MCO;
 - b. Not pre-approved by a plan provider or the MCO, but administered to maintain the member's stabilized condition within one (1) hour of a

request to the MCO for pre-approval of further post-stabilization care services;

- c. Not pre-approved by a plan provider or the MCO, but administered to maintain, improve, or resolve the member's stabilized condition if:
 - i. The MCO does not respond to a request for pre- approval within one (1) hour;
 - ii. The MCO cannot be contacted; or
 - iii. 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.

B. Payment - In accordance with 42 CFR § 422.113 (c), the Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

- iv. A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- v. A plan physician assumes responsibility for the member's care through transfer;
- vi. The Contractor and the treating physician reach an agreement concerning the member's care; or,
- vii. The member is discharged.

3. Absence of a Clinical Emergency

If the medical screening examination leads to a 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 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.

4.7 LONG TERM SERVICES AND SUPPORTS

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

LTSS may be provided through a 1915(c) Home and Community Based Services (HCBS) waiver. Individuals enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) waiver shall receive waiver services furnished by the Contractor as well as medically necessary non-waiver services. Individuals enrolled in the Developmental Disability (DD) waivers are covered under this Contract only for their medically necessary non-waiver services. The Contractor shall

be responsible for knowledge of the services within the DD waivers to ensure the overall health and well-being of all CCC Plus program Members.

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

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

4.7.1 LTSS Screening Requirements

For all Members admitted to a Nursing Facility (NF) on or after July 1, 2019, the Contractor shall not reimburse a NF for services until a screening has been completed for the Member by an appropriate screening team (described below), the screening has been entered into the ePAS system (also described below), and the individual is found to meet NF level of care criteria. Payment shall not be made to the NF until the Contractor receives a copy of the screening.

In accordance with the §32.1-330 of the *Code of Virginia*, all individuals requesting community based waiver or nursing facility LTSS must receive a screening to determine if they meet the level of care needed for NF services. DMAS contracts with the Virginia Department of Health (VDH), Department for Aging and Rehabilitation Services (DARS), and hospitals to conduct screenings for individuals. Community screenings for adults (over the age of 18) are conducted by members of the local health departments (LHD) that include physicians and nurses along with social workers and family services specialists within the local department of social services (LDSS). Community screenings for children (up to the age of 18) are contracted to a DMAS designee, currently VDH, through the local health departments in the jurisdiction where the child resides. Acute care hospitals utilize persons designated by the hospital to complete the screening. The Nursing Facility LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital. Details about the screening process and the criteria for meeting the level of care required for eligibility for LTSS can be found in the Department's *Screening Manual for Medicaid-Funded Long-Term Services and Supports (LTSS)* on the Virginia Medicaid Provider Portal.

The screening process is automated through the DMAS Electronic Screening (ePAS) system (or DMAS approved electronic record system). The ePAS system is a mandatory paperless only, automated reimbursement and tracking system for all entities contracted by DMAS to perform screenings. DMAS requires all LTSS screenings to be entered by the appropriate screening team into the ePAS automated system. Timeframes for the validity of the screenings are outlined in the *Screening Manual for Medicaid Funded Long-Term Services and Supports (LTSS)*. Time frames for completing and submitting the screenings are set forth in 12VAC30-60-306.

A Medicaid LTSS Screening team which may be Community-based, hospital or nursing facility (only for those individuals transitioning from skilled care to LTSS) conducts the screening using the Uniform Assessment Instrument (UAI), the DMAS-96 (Medicaid Funded Long-Term Services and Supports (LTSS) Authorization Form), and other required forms. The LTSS

Screening team determines level of care needs and enters the Member's screening into ePAS. The LTSS Screening must successfully process and indicate Medicaid LTSS authorization in order for LTSS to begin.

As part of the screening, individuals who are technology dependent also receive an age appropriate DMAS Technology Assisted Waiver Adult Referral form (DMAS-108) or Technology Assisted Waiver Pediatric Referral form (DMAS-109). The CCC Plus Waiver shall be offered to individuals who meet criteria described in 12VAC30-60-303. Appropriate community based services shall be offered and explained to the individual prior to consideration of nursing facility placement; community based services include the CCC Plus Waiver and Program of all Inclusive Care for the Elderly (PACE) (excluded population).

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

1. Uniform Assessment Instrument (UAI)
2. DMAS-95 MI/DD/RC (and DMAS-95 MI-ID/RC Supplement Form, Level II, if applicable) for individuals who select nursing facility placement
3. DMAS-96 (Medicaid Funded Long-Term Services and Supports Authorization Form)
4. DMAS-97 (Individual Choice – Home and Community Based Services or Institutional Care or Waiver Services Form)
5. DMAS-108 (Adults) or DMAS 109 (Children) for individuals who are technology dependent and need private duty nursing.

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

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

Individuals should not be approved to receive Medicaid funded LTSS without having a screening on file that confirms the individual meets NF level of care. Exceptions to this process are outlined in 12VAC30-60-302. The Contractor shall work closely with DMAS and stakeholders to develop and implement a process that ensures the appropriate level of care documentation is on file for its Members prior to the Contractor's payment of nursing facility or community based LTSS claims. The term LTSS in this Section refers specifically to nursing facilities and the CCC Plus Waiver.

4.7.2 Commonwealth Coordinated Care Plus Waiver

On July 1, 2017, Virginia received approval from the Centers for Medicare and Medicaid Services (CMS) to operate the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. These services are described in Section 4.7.2.2, *Services* and in Attachment 5 of this Contract.

4.7.2.1 Populations

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

In accordance with 12 VAC 30-120-905, CCC Plus Waiver services shall not be covered for, or provided to, any individual who resides in a NF, an ICF/IID, rehabilitation hospitals, an assisted living facility licensed by VDSS that serves five (5) or more individuals, long-stay hospitals, a skilled or intermediate care nursing facility, a general acute care hospital, an adult foster home, or a group home licensed by DBHDS. Transition coordination and transition services may be available to individuals residing in some settings through the Contractor's transition services. Additionally, certain CCC Plus Waiver services shall not be available to individuals residing in an assisted living facility licensed by VDSS that serves four or fewer individuals. These services are: respite, PERS, ADHC, environmental modifications, assistive technology and transition services. Personal care services shall be covered for individuals living in these facilities but shall be limited to personal care not to exceed five (5) hours per day. Personal care services shall be authorized based on the individual's documented need for care over and above that provided by the facility. Services shall also be provided in settings that meet the *CMS Home and Community Based Settings Final Rule*; see Attachment 12 of this Contract for additional details.

4.7.2.2 Services

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

4.7.2.3 Level of Care

In order to be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a Nursing Facility, a specialized Nursing Facility, or a long stay hospital.

Enrollment into the CCC Plus Waiver requires a screening, performed by a hospital or community team as described in Section 4.7.1, *LTSS Screening Requirements*.

The Contractor shall be responsible for ensuring that the CCC Plus Waiver level of care is correct for its membership. It is important that the level of care information be revised timely so that the member has access to the appropriate services and also to enable DMAS to pay the Contractor at the correct capitation rate. See Section 19.11.8, *Recoupment/Reconciliation*. The Contractor shall follow the process described in Section 4.7.9, *LTC Portal Entry Access* for level of care entries and notifications to DMAS regarding certain level of care admissions, discharges, and changes.

4.7.2.3.1 Level of Care (LOC) Reviews

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

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

LOC Reviews shall be conducted using the *Level of Care Review Instrument (LOCERI)* also known as the DMAS 99 Series Form. The Contractor shall enter all required information for the LOCERI electronically using the Virginia Medicaid Web Portal, LOC review tab. All Contractor Care Coordinators who meet the requirements to conduct LOC reviews (consistent with the HCBS § 1915 (c) waiver) are required to complete the LTSS screening online training. Care Coordinators must pass the training before conducting LOC reviews and will need to complete the training every three years from the date of the initial training. This training is offered online through Virginia Commonwealth University through the following link: <https://medicaidtsstraining.partnership.vcu.edu/intromodule/intro.html> and the *Level of Care User Guide and Tutorial*, which is available on the Virginia Medicaid Web Portal, Provider Resources tab, at: <https://www.virginiamedicaid.dmas.virginia.gov>.

All LOC reviews for Members in CCC Plus Waiver must: 1) be conducted face-to-face; 2) be performed by individuals that meet the review requirements as outlined in the HCBS § 1915 (c) waiver; 3) be conducted timely (minimum within 365 calendar days of the last annual LOC review or waiver admission date); 4) be conducted when a Member experiences a change in status that could impact waiver eligibility; 5) include all the elements on the DMAS 99 Series Form (Level of Care Review Instrument) and 6) the review is to be conducted in the environment in which the Member spends the majority of his or her time (typically the home). For Members who are receiving private duty nursing services, the LOC annual review shall also include all of the elements on the DMAS 109 Private Duty Nursing Pediatric Referral for the Commonwealth Coordinated Care Plus (CCC Plus) Waiver-rev. 4/2019 or the DMAS 108 (Private Duty Nursing Adult Referral for the Commonwealth Coordinated Care Plus (CCC Plus) Waiver-rev. 4/2019.

The Contractor shall provide the Department with any LOC review data and results for CCC Plus Waiver participants via the Virginia Medicaid Provider Portal within two (2) business days of the LOC face-to-face review. All submitted information must be accurate and complete.

For individuals that do not meet criteria, DMAS will conduct a second level review. During this review, DMAS may contact the Contractor and/or the Member for additional information. The Contractor is to be available to DMAS for additional information as needed and respond to any request for additional information within two (2) business days. If DMAS' second level review confirms that the Member does not meet criteria, DMAS will notify the Member and the Contractor in writing of the termination of the waiver (with appeal rights) within no more than thirty (30) days.

Upon receipt of a copy of the waiver termination letter from DMAS, the Contractor is required to notify all active CCC Plus Waiver provider(s) in the method and timeframe established by DMAS.

The Contractor is also responsible for ensuring that all associated waiver service authorizations are terminated using the waiver termination date as the authorization end date. Within three (3) business days of receipt of the waiver termination letter, the Contractor shall notify all active rendering providers of waiver services that the Member's waiver eligibility has been terminated and any active authorizations have been closed as of the identified date. The Contractor shall assess the Member's remaining care needs to ensure continuity of non-waiver services or the appropriate transition to community or other available resources.

All related waiver activities resulting in a Member appeal will be led by DMAS. The Contractor shall work collaboratively with DMAS on all appeal related activities, ensure all case information is accurate and complete, have representation present for all appeals, and defend the LOC submitted. If the Member requests continuation of services during the appeal process or if the appeal decision results in the Member regaining waiver eligibility, the Department will notify the Contractor.

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

4.7.2.4 Health Risk Assessment (HRA) Elements

The Contractor shall use Care Coordinators who shall complete an initial face-to-face Health Risk Assessment (HRA) for newly enrolled Members as expeditiously as the Member's condition requires and according to the guidelines set forth in the *Health Risk Assessment (HRA)* Section 5.3, *Health Risk Assessments (HRA)* of this Contract.

4.7.2.5 CCC Plus Waiver Services Scope of Coverage

The Contractor shall provide CCC Plus Waiver services *at least* in equal amount, duration, and scope as available under Medicaid fee-for-service as described 12VAC30-120-924 and Attachment 5 of this Contract. Waiver services may be agency-directed (AD) or consumer-

directed (CD). CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

4.7.2.6 Consumer-Directed or Agency Directed Services

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

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

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

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

4.7.2.7 Adult Day Health Care (ADHC)

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

4.7.2.8 Personal Care Services

Assistance with Activities of Daily Living (ADL) includes assistance with eating, bathing, dressing, transferring, and toileting, as well as medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated pursuant to the Virginia Administrative Code 18VAC90-19-240 through 18VAC90-19-280. When specified in the individual service plan, personal care services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves. Supervision, as an allowable personal care service, shall be provided

pursuant to 12VAC-30-120-924 D.2.c. and d. and 12VAC-30-120-924 G.2.b. CD skilled services shall be provided pursuant to the *Code of Virginia* § 54.1-3001(12).

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

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

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

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

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

4.7.2.9 Respite Care Services

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

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

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

4.7.2.10 Services Facilitation (SF)

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

4.7.2.11 Environmental Modifications (EM)

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

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

4.7.2.12 Assistive Technology (AT)

Assistive Technology provided outside of the Medicaid State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver for Members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the Member's residence to

specifically increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live.

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

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

4.7.2.13 Personal Electronic Response System (PERS)

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

4.7.2.14 Private Duty Nursing (PDN)

PDN is a skilled nursing service ordered by a physician in the Plan of Care and provided by a licensed Registered Nurse (RN) or by a Licensed Practical Nurse (LPN). This service is provided to Members in the technology dependent subgroup who have serious medical conditions and complex health care needs. PDN is used as hands-on Member care, training, consultation and oversight of direct care staff, as appropriate. Adult Members who may qualify for PDN coverage must meet the criteria outlined in 12 VAC 30-120-924.M.5. Members under the age of 21 receive PDN coverage through EPSDT.

PDN hours for adult Members are determined by medical necessity on the DMAS-108 form. All Members receiving PDN services must have a trained primary caregiver who shall be responsible for all hours not provided by a RN or LPN and shall be documented in the provider's records along with a back-up plan.

4.7.2.15 Transition Services

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

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

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

4.7.2.16 Service Authorizations

Initial Service Authorizations (SA) as well as SA renewals shall comply with requirements in Section 6.2.6, *Service Authorization-LTSS*. Refer to Section 5.0, *CCC Plus Model of Care* of this Contract for more information.

4.7.2.17 Documentation Requirements

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

<u>Documentation</u>	<u>Frequency</u>
RN Supervisory Visit	Monthly for Members receiving PDN; Quarterly for all others
Plan of Care (CMS-485)	Every 60 calendar days
Plan of Care (DMAS 97 A/B; DMAS-7A)	Every 12 months or more frequently as needs change
Telephone Communications with individuals/caregivers, providers, physicians, etc.	Daily or as needed
Initial Screening* (UAI, DMAS-95 [as applicable], DMAS-96, DMAS-97, DMAS 108/109 as appropriate, MD order for Tech subgroup admission, etc. as applicable)	On admission
Functional Assessment for Waiver	Annually and if there is a lapse of LTSS services >30 calendar days and a waiver termination occurs, as defined in 12VAC30-120-905.H.
Hospital summaries, discharge orders, additional medical record information (i.e. tests, procedures, etc.)	Hospital admissions, change in health status
Service Authorization Documentation	Yearly, Change in hours or provider
Correspondence with Individual/Caregiver (letters)	Enrollment, Disenrollment, Change in provider, Change in hours
Medicaid LTC Communication Form (DMAS 225)	Enrollment, Disenrollment, other circumstances noted in Section 4.7.5.3, <i>Long-Term Care Communication Form – DMAS-225</i>

Health Risk Assessment	Refer to the <i>Model of Care Assessment and Individualized Care Plan Expectations</i> table
Individualized Care Plan	Refer to the <i>Model of Care Assessment and Individualized Care Plan Expectations</i> table
Interdisciplinary Care Team Report	As needed

*When available for members who had services prior to the member’s CCC Plus Program effective date.

4.7.3 Nursing Facility and Long Stay Hospital Services

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

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

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

4.7.3.1 Specialized Care Nursing Facility Units and Long Stay Hospitals

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

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

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

The Contractor shall work with the Members and facilities to explore the option of discharge to a less restrictive setting and the setting must ensure the medical/nursing needs can be met for the individuals. The target population for specialized care and long stay hospitals includes

individuals who may require mechanical ventilation, complex tracheostomy, comprehensive respiratory therapy, and other life sustaining services and treatment. The Contractor shall ensure the health, safety, and welfare and needs and preferences of these Members their family/representative involvement in any potential discharge.

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

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

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

4.7.3.2 Out of State or Out of Area Placements

4.7.3.2.1 Out of State

For consideration of out of state placement, the Contractor shall ensure that the Member's needs cannot be met within the Commonwealth before considering out of state placement. The Contractor shall document supporting evidence that there are no in state resources prior to approving an out of state placement. The process for an out of state placement is as follows.

The Contractor shall:

- 1) Notify the Department within two (2) business days of a request for an out-of-state placement;
- 2) Work with the Department on any out of state placement requests/referrals, and;
- 3) Immediately following the Contractor's notification to the Department of a referral for an out-of-state placement, the Contractor shall follow the Department's guidance document for out-of-state nursing facility placements. At a minimum, the process shall include the participation and involvement of the Regional Transition Care Coordinator.

When considering an out of state facility, the facility must meet all the standard licensing and certification requirements within that state and have an active license to operate within that state.

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

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

4.7.3.2.2 Out of Area

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

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

4.7.3.3 Nursing Facility Admissions and Discharges

In order to receive Nursing Facility services, an individual must meet the level of care (LOC) required for a Nursing Facility, a specialized Nursing Facility for technologically dependent individuals, or a long stay hospital. Enrollment into the Nursing Facility level of care requires a completed screening performed by a hospital or community team, prior to a nursing facility admission. The Nursing Facility LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital as described in Section 4.7.1, *LTSS Screening Requirements* of this Contract.

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

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

[http://www.dmas.virginia.gov/files/links/1569/Broadcast%20DMAS-31%20Use%20of%20DMAS-225%20by%20CCC%20Plus%20MCOs%20\(09.05.2018\).pdf](http://www.dmas.virginia.gov/files/links/1569/Broadcast%20DMAS-31%20Use%20of%20DMAS-225%20by%20CCC%20Plus%20MCOs%20(09.05.2018).pdf).

4.7.3.4 Contractor Attendance at Care Plan Meetings

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

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

4.7.3.5 Extraordinary Care Management During Involuntary Relocation

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

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

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

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

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

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

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

4.7.3.7 Nursing Facility Eligibility

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

4.7.4 Developmental Disability (DD) Waivers

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

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

All individuals enrolled in one of the DD waivers follow the same process to qualify for and access BI, CL and FIS services and supports. Services are based on assessed needs and are included in a person-centered ICP. Individuals receiving home and community based services through one of these waivers have a variety of choices of both types of services and providers.

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

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

4.7.5 Patient Pay for Long Term Services and Supports

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

of his/her LTSS. This contribution is known as the Patient Pay amount. The patient pay must not be confused with a co-pay or deductible.

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

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

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

4.7.5.2 Patient Pay for Members with Medicare

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

4.7.5.3 Long-Term Care Communication Form - DMAS-225

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

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

Immediately upon initiation of long term care services, and within no more than five (5) business days receipt of notice of initiation of long term care services, the Contractor shall send a DMAS-

225 to the eligibility unit of the appropriate local Department of Social Services (LDSS) indicating the Contractor's first date of long term care service delivery. The LDSS eligibility worker will complete a Medicaid eligibility redetermination and Patient Pay determination. The Contractor shall not contact the LDSS inquiring about the status of the form prior to 30 business days after submission. The Contractor shall not require providers to submit the DMAS-225 to the Contractor or to LDSS. A copy of the completed DMAS-225 must be kept by the Contractor in the Member's file.

The Contractor must notify the LDSS via the DMAS-225 of information pertaining to the following circumstances and to exchange information, other than patient pay information:

- There is a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- Notification of a change in the enrollee's physical residence (e.g., out of state, in state, incarceration);
- There are changes in the patient's deductions (e.g., a medical expense allowable);
- There are changes in eligibility status;
- There are changes in third party liability; and
- Any other changes that could impact Medicaid eligibility.

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

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

The Contractor must send the DMAS-225 to LDSS within five (5) business days of the above status changes. The Contractor must ensure that the health plan contact information is listed on the form and that the form is completed in its entirety. The DMAS-225 is submitted only for members who receive LTSS services. See Broadcast DMAS-31 regarding use of the DMAS-225 by CCC Plus managed care organizations located at

[http://www.dmas.virginia.gov/files/links/1569/Broadcast%20DMAS-31%20Use%20of%20DMAS-225%20by%20CCC%20Plus%20MCOs%20\(09.05.2018\).pdf](http://www.dmas.virginia.gov/files/links/1569/Broadcast%20DMAS-31%20Use%20of%20DMAS-225%20by%20CCC%20Plus%20MCOs%20(09.05.2018).pdf).

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

The Department offers home and community-based support services, approved by the Centers for Medicare and Medicaid Services pursuant to §1915(c) of the Social Security Act, for Medicaid individuals who would otherwise require a level of care provided in institutional settings the opportunity to remain in their homes and communities. Eligible CCC Plus Waiver Members may choose the Consumer-Directed model of service delivery for their personal care and respite services in which the Member, or someone designated by the Member, employs attendants and directs their care. The Member will receive financial management support in their role as employer by the Contractor's Fiscal/Employer Agent (F/EA) vendor.

Effective January 1, 2019, the Contractor shall sub-contract with a qualified vendor who will operate as a F/EA Fiscal/Employer Agent (F/EA) vendor under Section 3504-1 of the IRS code, including Agent Employment Tax Liability proposed Regulations (REG-137036-08) issued by the IRS on December 12, 2013 and Revenue Procedure 70-6.

A qualified F/EA vendor shall have a separate Federal Employer Identification Number (FEIN) for the sole purposes of filing federal tax forms (IRS Forms 2678, 940, 941, W-2 and W-3) and paying federal taxes (Federal income tax withholding, FICA and FUTA) on behalf of the Members (employers) it represents as Agent.

The F/EA shall obtain an FEIN for each Member or the Employer of Record and maintain copies of the FEIN, IRS FEIN notification, and copy of the filed form SS-4, in the Member's file.

A qualified F/EA shall have significant experience in withholding, filing, and paying state income and employment taxes for employers and Personal Care Assistants (employees).

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

- Pre-employment services, including enrolling Members (employers) and their Personal Care Assistants (employees);
- Criminal, child abuse and neglect, and other State and Federally required background checks;
- Processing employee timesheets;
- Deducting, filing, and paying State and Federal income and employment taxes and other withholdings;
- Paying Personal Care Assistants (employees);
- Providing customer service through a Call Center;
- Providing training on F/EA enrollment and payroll processing procedures to Members and Service Facilitators or the Designated Entity responsible for supporting the Medicaid Member in managing his or her Personal Care Assistants; and
- Providing an electronic visit verification (EVV) system compliant with the 21st Century Cures Act for personal care services.

The Contractor shall subcontract with a qualified F/EA to provide financial management services to Members who choose Consumer Direction for eligible services. The Contractor shall have policies and procedures (including timeframes), and internal controls for implementing F/EA services that includes defined processes for all required IT and data exchange processes.

The Contractor shall submit for approval to the Department, at implementation, revision, or upon request, the policies and procedures for handling Consumer-Directed services and the F/EA. The Contractor shall have a dedicated project manager for Consumer-Directed services.

The Department shall conduct a readiness review for implementation of F/EA services. The scope of the readiness review shall include all elements described in Section 4.7.6, *Consumer Direction and Contract with the Department's Fiscal/Employer Agent (F/EA)*. Readiness reviews shall be conducted 120 days prior to implementation of F/EA services.

4.7.6.1 Self-Service Web Portal and Website

The Contractor's F/EA shall have a secure system, policies, procedures and internal controls for implementation and maintenance of a self-service web portal for Members, their employees, and services facilitators or other designated entities (i.e., Care Coordinators, staff of the F/EA, etc.). The portal shall be integrated with the F/EA's financial management, enrollment, and electronic visit verification systems.

The roles based self-service web portal shall be user-friendly, and accessible twenty-four (24) hours seven (7) days a week, except for planned maintenance period.

The self-service web portal shall provide users with real time visibility of consumer-directed services information including:

- Enrollment status;
- Employer and employee demographics;
- Timesheets;
- Service authorization;
- Service use;
- Paystubs;
- Tax;
- Patient pay (if applicable);
- Garnishments;
- Withholdings; and
- Year end tax.

The Contractor's F/EA shall post the following information to a website or incorporate in the web portal:

- Routine program updates and communications;
- User tutorials and technical assistance;
- Applicable manuals;
- Instructions for web portal access;
- Alerts for program, payroll, tax, website maintenance periods, and other changes affecting Medicaid individuals and employees; and
- Instructions on how to obtain information in non-English languages.

4.7.6.2 Service Initiation/Enrollment System

The Contractor shall establish a process for F/EA service initiation for the Member. Services may be initiated by the services facilitator or other designated entity. The process shall include verification of Member demographics including the Virginia Federal Information Processing Standards (FIPS) Codes and a process to notify the appropriate entity when a request is incomplete or contains errors. All service initiation requests shall be processed including data verification and entry into the F/EA data base within three (3) business days of the receipt of the request.

4.7.6.3 Member/Employer Enrollment Packet Requirements

The Contractor's F/EA shall develop, distribute or make available in electronic format, enrollment packets for each Member referred to by the designated entity within three (3) business days. The enrollment packet shall be pre-populated to the maximum extent possible. The enrollment packet shall be presented in a format that is easily understood. At a minimum, the packet shall contain the following:

- Introductory letter;
- All required state and federal tax forms;
- F/EA services, roles and responsibilities information;
- Applicable federal forms to complete, sign, and submit;
- Customer service contact information and hours of operation;
- Criminal background, child abuse and neglect central registry information and requirements;
- Information on the federal List of Excluded Individuals and Entities (LEIE);
- Description of payroll periods, timesheet due dates and timelines for processing and payment distribution;
- Notice of Discontinued Employment form; and
- Electronic visit verification information.

4.7.6.4 Personal Care Assistant/Employee New Hire Packet Requirements

The Contractor's F/EA shall develop, distribute or make available in electronic format, new hire packets for each employee within three (3) business days of receipt of the request. The hire packet shall be pre-populated to the maximum extent possible. The hire packet shall be presented in a format that is easily understood. At a minimum, the packet shall contain the following:

- Introductory letter;
- F/EA services, roles and responsibilities information;
- Customer service contact information and hours of operation;
- Criminal background, child abuse and neglect central registry information and requirements;
- Information on the federal List of Excluded Individuals and Entities (LEIE);
- Required federal employment eligibility, tax, and related forms that the employee must sign and submit with accompanying instructions;
- Required state forms with accompanying instructions;
- Description of payroll periods, timesheet due dates and timelines for processing and payment distribution;
- Direct deposit information and debit card options;
- Notice of Discontinued Employment form;
- Disclose employee's relationship to the employer per IRS Publication 15-Circular E Form;
- Enrollment options when internet access is unavailable; and
- Electronic visit verification information.

4.7.6.5 Background Checks

State and Federal laws and regulations (Federal list of Excluded Individuals and Entities, or LEIE) require prospective Personal Care Assistants to pass background checks. Background checks include Virginia State Police Criminal Background checks; Virginia Department of Social Services Child Abuse and Neglect Central Registry checks when the Member is under the age of eighteen (18); the Federal list of Excluded Individuals and Entities (LEIE) database checks; and, employment eligibility checks.

Background checks are required at the time of initial employment, re-employment by the same employer, and employment by another Member. Personal Care Assistants may work and be paid for services for up to thirty (30) calendar days pending the results of criminal and child abuse and neglect background checks.

Personal Care Assistants must be terminated from employment and are prohibited from receiving payment effective the date of discovery of a barrier crime or a founded complaint by the DSS child protective services central registry by the Contractor's F/EA.

The Contractor's F/EA shall be obligated to perform and pay for reference checks. Members shall not be charged for the cost of background checks. The Contractor's F/EA shall have controls for processing all required employee background checks that minimally includes:

- Criminal, child abuse and neglect, and federal LEIE database background checks for prospective employees;
- Maintaining results in each employee's file and in the employer and/or employee's web portal self-service account;
- Written notification to the employer, upon discovery, when the results of the background check disqualify the employee from employment; and
- A system for blocking the employee in the F/EA payroll system from receiving payment effective the date that adverse findings are received by the F/EA.

4.7.6.6 Electronic Visit Verification

The Contractor's F/EA shall have an EVV system that will electronically verify and collect data and meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). At a minimum, the EVV shall capture in real-time the following data elements for consumer-directed personal care and respite services.

1. Type of service performed
2. Member receiving service
3. Date of service
4. Location of service delivery
5. Employee providing the service
6. Time service begins and ends

The EVV system shall be capable of securely transmitting all raw data elements to the Contractor in the approved format and in accordance with approved transmission schedules. The

system shall contain edits and audits to ensure correct and complete formatting of data submitted to the EVV system by Members and employee(s). Complete verification and documentation for each visit is required.

The F/EA shall have system edits in place preventing claims for services that are not electronically verified and documented using the EVV system or otherwise inconsistent with an approved Service Authorization.

The F/EA's EVV system shall support real time access to Members and employees. The EVV system shall meet the following requirements:

- Collect clock in/clock out time submissions, date of service, Member and employee ID numbers, and GPS technology used to verify location and visits using GPS enabled devices;
- Allow for review, approval, and submission of timesheets by the appropriate designee;
- Provide roles-based access controls that allow Members and employees to create user roles. The system shall provide real time jurisdictional views for Designated Entities and the Contractor; and
- Have the capability to limit authority to modify changes and modifications to service entries.

For technical assistance on submission of EVV encounters refer to the Encounter Processing System (EPS) Medicaid Enterprise Encounter (MES) Companion guide (<https://eps.dmas.virginia.gov/epsportal/#/guides>) For 837 Professional Health Care and Transportation Encounter Transactions.

4.7.6.7 Contractor Database and Automated Payroll Systems

The Contractor's F/EA shall have an automated system that has the capacity to exchange files with the Contractor. The automated payroll system shall verify data to ensure accurate payroll. The system shall receive, verify and maintain electronic Service Authorizations authorized by the Contractor. The system shall have the ability to request and receive eligibility and patient pay data as established by the Contractor.

The Contractor's F/EA shall conduct twice monthly payroll that meets federal and state Department of Labor and Industry wage, hour, and pay date requirements for hourly employees. Prior to payment, timesheets shall pass all system edits and are paid in accordance with the appropriate pay rate.

The Contractor's F/EA payroll processing system shall have the ability to calculate and make accurate payments to employees not to exceed forty (40) hours per work week for one Member. Employees that live in the home of the Member and work more than forty (40) hours in one work week shall be exempt from the forty (40) hour work week restriction and shall be compensated at the regular hourly rate in accordance with FLSA and Department guidelines. Overtime pay is not permitted.

Direct deposit and debit card payroll solutions shall be made available to all attendants.

The Contractor's F/EA shall capture the following data elements in the payroll database:

- Medicaid Individual and Employer of Record (EOR)
 - Name;
 - Medicaid ID number;
 - Eligibility status;
 - Birth date;
 - Social Security Number;
 - Demographics and contact data;
 - FIPS codes;
 - FEIN;
 - Individual's relationship to employee(s);
 - Individuals relationship to EOR;
 - Enrollment data;
 - Enrollment status;
 - Enrollment and Tax forms completion status; and
 - Tax filing data.
- Services
 - Procedure codes and names;
 - Waiver types;
 - Patient pay (if applicable);
 - Service Authorization (SA) Number;
 - SA units and date ranges; and
 - SA hours used and balance.
- Employee
 - Name;
 - Employee ID Number;
 - Social Security Number;
 - Demographics;
 - Enrollment Date;
 - Enrollment and Tax Forms Completion Status;
 - Enrollment Status;
 - Background Check Status and Results;
 - Pay Rates (Northern Virginia and rest of State);
 - Billable Rates (Northern Virginia and rest of State);
 - Payroll Schedule;
 - Pay Period;
 - Tax Status;
 - Employment Agreement Signed;
 - Tax Filing, Exemptions, Allowances, and Withholdings;
 - Garnishments and Liens; and

- Employee Pay Distribution - Bank Account/Debit Card Transit Number.
- Timesheet and Payroll
 - Timesheet Number;
 - Timesheet Authorized Signatures;
 - Dates Worked;
 - Hours Worked;
 - Timesheet Status;
 - Timesheet Pend Reasons;
 - Timesheet Import Type – Web, Manual;
 - Journal Posting Dates;
 - Pay Date;
 - Check/EFT/Debit Card Payments;
 - Payment Authorized/Blocked;
 - Check Number; and
 - Pay Check Amounts.
- Services Facilitator (if applicable)
 - Agency Name;
 - ID Number; and
 - Demographics and Contact Data.

4.7.6.8 Patient Pay Through the F/EA

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

Should the Contractor choose to withhold patient pay from consumer-directed payments, the Contractor shall develop a policy and procedure describing how the F/EA shall accurately deduct Patient Pay amounts from employee's paychecks.

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

The Contractor's reimbursement for consumer-directed personal care and respite shall be the same as the Department's reimbursement. The Contractor shall have two employee pay rates: (1) a higher rate for employees of Members residing in Northern Virginia; and, (2) a base rate for employees of Members residing elsewhere in the State. Billing rates are reviewed and adjusted in accordance with pay and tax rate changes. Data elements shall be determined by the Department and include unduplicated waiver Members service types, employees, timesheet dates, hours worked, net pay billable rates, and amounts billed. Refer to the following for a listing of CD pay rates: <http://www.dmas.virginia.gov/#/longtermwaivers>.

The F/EA shall submit timely, accurate, and complete reports and refunds to each Contractor as defined in the F/EA Reports and Refunds due to the Contractor. The Contractor shall provide

DMAS with written quarterly reports of findings and recommendations within thirty (30) days of receipt of a complete submission from the F/EA in accordance with the reports schedule.

F/EA Reports and Refunds due to the Contractor	Quarter Ending	Contractor Report & Refund Due
Quarterly Payroll Register	Mar 31	May 20
Quarterly Payroll Tax Reconciliation Summary	Jun 30	Aug 20
IRS Form 941	Sep 30	Nov 20
VA-5	Dec 31	Feb 20
VEC-FC-21/20		
Monthly Bank Statements for the Quarter	Mar 31	May 20
Monthly Bank Reconciliations for the Quarter	Jun 30	Aug 20
Quarterly Check Register	Sep 30	Nov 20
Monthly Cleared Checks Reports for the Quarter	Dec 31	Feb 20
Listing of Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue Date		
Employer Tax Filing Penalties & Interest Incurred Report & refund		
Amounts due to (from) Contractor's Payroll Tax Reconciliation Report	Mar 31	May 20
Refund due to Contractor for Uncashed and Cancelled (Voided) Checks over 180 calendar days from Issue	Jun 30	Aug 20
Report and refund to Contractor or proof of credit to the CD-Services Payroll Payment Account for bank	Sep 30	Nov 20
penalties and interest incurred	Dec 31	Feb 20
Copy of the Annual FUTA Tax Return with proof of receipt of payment from the IRS.	Annual	Feb 20
Refund, to Contractor, for employer portion of annual, over collected FICA immediately following F/EA's refund, for overpaid taxes, from the IRS	Annual	April

4.7.6.10 Tax Processes, Reconciliation, and Refunds

The Contractor shall ensure the following responsibilities are met and scope of services are performed in accordance with DMAS requirements. The Contractor's F/EA shall have a system, policies and procedures, timeframes and internal controls for the following:

- Withholding taxes and filing IRS form 941, *Employers Quarterly Federal Tax Return* and IRS form 941 Schedule R, *Allocation Schedule for Aggregate Form 941 Filers or Report of Tax Liability for Semi-weekly Schedule Depositors Schedule B* (as applicable depending upon required deposit frequency) in the aggregate, with its separate FEIN for all individuals it represents and maintain a copy of each IRS form;
- Paying FICA and federal income tax withholding in the aggregate for all individuals it represents using the F/EA's separate FEIN and for maintaining relevant documentation;

- Withholding and filing IRS for 940, Schedule R, to pay FUTA in the aggregate in an accurate and timely manner and maintain relevant documentation;
- Paying FUTA in the aggregate, per IRS depositing rules, and for maintaining relevant documentation;
- Obtaining employer registration numbers for state income and unemployment tax withholding, filing, payment, and retiring registration numbers when the individual no longer is an employer, and maintaining relevant documentation;
- Withholding and filing state income tax withholding for all employees, per state requirements and for maintaining relevant documentation;
- Paying state income tax withholdings in the aggregate using the F/EA's Fiscal/Employer Agent State Withholding Account Number per state requirements and maintaining relevant documentation;
- Withholding and filing state unemployment insurance for each individual it represents per Virginia Department of Labor and Industry requirements and maintaining relevant documentation;
- Paying state unemployment taxes in the aggregate using the F/EA's Employer Agent State Withholding Account Number for each individual per Virginia Department of Labor and Industry requirements and maintaining relevant documentation;
- Managing all garnishments, levies and liens on employee's payroll checks in an accurate and timely manner, as permitted by the *Code of Virginia* and Virginia Department of Labor and Industry and maintaining relevant documentation;
- All federal tax deposits shall be made by electronic funds transfer per IRS requirements; and
- Investigate and resolve uncashed or cancelled (voided) checks as required by § 55-210.1 - § 55-210.30 of the *Code of Virginia* and federal regulations (42 CFR § 433.30).

The Contractor shall provide to the Department quarterly reviews and analysis of F/EA withholdings and tax processes and supporting documents including withholdings, tax filings, and payments of State and Federal income and employment taxes. The Contractor shall require the F/EA to ensure the accuracy and timeliness of all enrollment and tax obligations. Refer to the *CCC Plus Technical Manual* for the required format.

The Contractor shall ensure the following responsibilities are met and scope of services are performed in accordance with DMAS requirements. The Contractor's F/EA shall have a system, policies and procedures, timeframes and internal controls for the following:

- Identifying employees due FICA refunds, determining their current mailing address and refunding FICA to applicable employees who did not earn the required annual gross wage amount for which employer and employee FICA is required to be calculated, withheld, and deposited for employees, per IRS requirements and maintaining relevant documentation;
- Preparing, filing, and distributing IRS form W-2, *Wage and Tax Statement*, for employees per *IRS Instructions for Agents* for electronic filing when processing 250 or

more IRS form W-2's by January 31st of each year and maintaining relevant documentation;

- Preparing, filing, and distributing IRS form W-3, *Transmittal of Wage and Tax Statements*, in the aggregate for all members per *IRS Instructions for Agents* and maintaining relevant documentation;
- Preparing, filing, and distributing IRS form VA-6, *Employer's Annual or Final Summary of Virginia Income Tax Withheld Return*, and form W-2, state copy, and maintaining relevant documentation;
- Complying with all applicable state and federal laws and requirements for transferring employer and employee records and information to another F/EA Vendor when applicable;
- The F/EA shall provide the Contractor with a copy of the Annual FUTA tax returns, with proof of receipt of payment from the IRS;
- The F/EA shall provide the Contractor with an electronic *VEC-FC-21/20* copy of the employers *Quarterly Tax Report*, including proof of funds received, by the Virginia Employment Commission;
- The F/EA shall provide the Contractor with an electronic copy of form *941-Employer's Quarterly Federal Tax Return*, including proof of funds received by the Internal Revenue Service and any amended returns;
- The F/EA shall provide the Contractor with an electronic copy of form *VA-5 Employer's Return of Virginia Income Tax Withheld*, with proof of funds received by the Virginia Department of Taxation;
- The F/EA shall provide to the Contractor, a report of all penalties and interest incurred on federal and state employer tax filings during the quarter that are not shown on the forms submitted. The report shall include an explanation of each charge and its disposition; and
- The F/EA shall provide to the Contractor, a Quarterly report of uncashed or cancelled (voided) checks beyond a period of 180 calendar days from the issuance date including the amount refunded.

4.7.6.11 Customer Service Call Center

The Contractor shall ensure the Members have access to consumer-directed F/EA information available by telephone. The Contractor shall provide and maintain a Call Center for F/EA services through a dedicated toll free number. The Contractor shall provide for language translation services and use Virginia Relay Service for Deaf and Hard of Hearing. The Call Center shall provide twenty-four (24) hours a day, seven (7) days a week access to timesheet and payroll inquires.

4.7.6.12 Satisfaction Survey

The Contractor shall assess Member and attendant satisfaction with F/EA services including but not limited to enrollment, timesheet (clock-in/clock-out), electronic visit verification, payroll

services, tax processing, call center responsiveness and customer service, and web-based services and information.

The Contractor shall ensure a minimum sample of 10% of the total number of unduplicated, active Members who had paychecks issued to employees at any time during review period. Survey specifications shall be reviewed and approved by the Department prior to conducting the survey. Survey results shall be provided to DMAS initially on August 15, 2019, and February 15, 2020, and annually on October 1st thereafter.

4.7.6.13 Employment and Earnings Verification

The Contractor's F/EA shall have a system for completing employment verifications, Social Security earnings verifications, and other ancillary requests within the timeframes established by the requestor. The Contractor must attend Virginia Employment Commission (VEC) hearings upon request from VEC.

4.7.6.14 Training, Education and Outreach

The Contractor shall ensure the following responsibilities are met and performed in accordance with DMAS requirements. The requirements may be performed by the Contractor, the Contractor's F/EA, or Subcontractor as approved by DMAS.

- Prepare written communication, participate in stakeholder meetings, training sessions and provide web-based outreach and training materials, as approved by the MCO, for users of the system;
- Provide initial, refresher, and ongoing system training at least annually to Medicaid individuals, employees, and Services Facilitators (as applicable); and
- Provide a detailed plan for initial and ongoing training, including a training manual and web-based training models. The Vendor F/EA must address how questions will be received and answered upon completion of implementation and ongoing support initiatives.

4.7.6.15 Disaster Recovery

The Contractor shall require the F/EA to develop a Disaster Recovery Plan that complies with federal guidelines 45 CFR § 164.308, identifying every resource that requires backup and to what extent the backup is required. The Disaster Recovery Plan shall at a minimum, include daily backups in the event of a system failure and include offsite electronic and physical storage located in the United States. The Disaster Recovery Plan shall identify the software and data backup requirements, demonstrating the ability to connect and interface with the system in the event of system failure. The Disaster Recovery Plan shall be provided to DMAS during readiness review.

4.7.6.16 Quality Assurance Plan

Beginning on January 1, 2019, the Contractor shall have an internal Quality Assurance (QA) plan and system in place with documented policies and procedures and internal controls for all key deliverables and requirements as described in the scope of work for Consumer-Directed

Services. The QA plan shall be submitted to DMAS during readiness review and the results shall be provided to DMAS quarterly. The QA plan shall at a minimum include the following:

- 10% per quarter sampling of each key operations area;
- Performance analysis as compared to each performance standard;
- Outcome measurement tools;
- F/EA Vendor annual performance review results; and
- F/EA staffing requirements that mirror industry standards.

The Contractor shall, at any time a deficiency in the F/EA's performance is identified, request a corrective action plan to address non-compliance. The Contractor shall notify DMAS of F/EA non-compliance on a monthly basis, outlining the approach to resolving the issues.

4.7.7 Hospice

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

To receive inpatient hospice services, an individual must be enrolled in the hospice level of care (LOC). The admitting facility's information is submitted by the hospice agency to the Contractor via a 421a hospice admission form. The Contractor shall enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of notification of admission/discharge.

4.7.8 Special Rules Related to Financial Eligibility for Long Term Care

In rare circumstances, individuals who are Medicaid eligible for most services may be determined by DSS to not be eligible for long-term care services. For example, a Medicaid applicant (or spouse) who transfers ownership of his/her property within the "look back period" without receiving adequate compensation may be ineligible for Medicaid to pay for long-term care during a penalty period. There is no transfer penalty imposed on Medicaid eligibility for care other than long-term care. In this scenario, the long term care service is considered non-covered. The LTSS provider is allowed to bill the Member for these as non-covered services if the provider has informed the Member prior to LTSS admission that if the Member is found by DSS to not be financially eligible for Medicaid funded long term services, the Member will be held financially liable for the costs of long term services. Reference the Medical Assistance For Aged, Blind or Disabled Individuals Handbook, pages 4-6, available at:

[http://www.dmas.virginia.gov/files/links/970/Medical%20Assistance%20Handbook_2014%20\(Aged,%20Blind%20or%20Disabled\).pdf](http://www.dmas.virginia.gov/files/links/970/Medical%20Assistance%20Handbook_2014%20(Aged,%20Blind%20or%20Disabled).pdf). The information is also detailed in the Virginia Department of Social Services Medicaid Eligibility Manual, Chapter M1450.000, available on the DMAS website at: <http://dmas.virginia.gov/#/assistance>.

4.7.9 LTC Portal Entry Process

4.7.9.1 Entry into the Virginia Medicaid Web Portal

The Contractor shall enter hospice, nursing facility (including specialized care and long-stay hospital) admissions, discharges and changes, admissions into excluded nursing facilities, and CCC Plus Waiver admissions directly into the Virginia Medicaid Web Portal (LTC Tab). The Contractor shall not enter LOC benefit information until the applicable services (NF, CCC Plus Waiver, Hospice) have started. The Contractor shall only enter changes into the DMAS Portal for the dates of service when the member is enrolled with the plan. The Contractor shall not enter these changes into the Portal for dates of service when the member was receiving Medicaid Fee-For-Service or was enrolled with a different health plan. Should the Contractor have difficulty entering changes into the Portal, the Contractor shall notify the Department using the method established by the Department.

4.7.9.2 Hospice

The Contractor shall enter hospice admissions and discharges into the Virginia Medicaid Web Portal (LTC tab) no later than two (2) business days of notification of admission/discharge. The 421-A *Hospice Enrollment / Disenrollment* form is the communication form used to by network providers to inform the Contractor of the change in a Member's status. A screening is not required for hospice services.

4.7.9.3 Nursing Facility (Including Long-Stay Hospital)

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

4.7.9.4 CCC Plus Waiver

The Contractor shall enter CCC Plus Waiver enrollments directly into the Virginia Medicaid Web Portal (LTC Tab). Such admission and change transactions shall be entered by the Contractor no later than two (2) business days of notification of the initiation of Waiver services, often the date the initial service authorization is processed. Also refer to Section 4.7.1, *LTSS Screening Requirements*.

The Contractor shall not enter CCC Plus Waiver discharges into the Virginia Medicaid Web Portal (LTC tab). Refer to Section 4.7.9, *LTC Portal Entry Process*.

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

4.7.9.5 DD Waiver Level of Care Entries

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

4.7.10 CCC Plus Waiver Benefit Plan Changes

For all CCC Plus Technology Assisted benefit plan (Benefit Plan A) admissions or discharges, including when the CCC Plus Waiver Member transitions to the technology assisted benefit plan from the standard benefit (i.e., Benefit Plan 9 to A), the Contractor shall enter these changes directly into the Virginia Medicaid Web Portal. The DMAS Care Management Unit will continue to monitor the Contractor's performance in the application of the Benefit Plan A criteria.

As part of the Care Management oversight in this area, DMAS will retrospectively review the portal entries and may request a copy of member records for further review. The Contractor shall submit complete clinical records upon request for DMAS review. DMAS will review the submitted clinical documentation to ensure that the Contractor is applying the Department's technology assisted benefit plan criteria correctly. DMAS will provide follow-up technical assistance to the Contractor as appropriate.

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

4.7.10.1 Refusal of LTSS Waiver Services or Annual LOC

The Contractor shall submit notification to DMAS for individuals who have refused services or refused Annual LOC evaluation. DMAS will review the notifications submitted and provide follow-up instruction to the Contractor regarding the Member's CCC Plus Waiver status after receiving the notification. DMAS will outline the notification communication details and requirements through separately issued guidance.

4.8 PHARMACY SERVICES

4.8.1 General Coverage Provisions

The Contractor shall be responsible for covering all medically necessary legend and non-legend Food and Drug Administration (FDA) approved drugs for Members as set forth in 12 VAC 30-50-210 and 42 CFR § 438.3(s)(1), and in compliance with § 38.2-4312.1 of the *Code of Virginia*. Legend drugs for which Federal Financial Participation is not available, pursuant to the requirements of §1927 of the Social Security Act (OBRA 90 §4401), shall not be covered.

The Contractor must allow access to all medically necessary non-formulary or non-preferred drugs, other than those excluded from coverage (see *Pharmacy Exclusions* below). The Contractor may subject non-formulary or non-preferred drugs to service authorization consistent with the requirements of the Contract.

The Contractor may not impose co-payments on any medications covered under this Contract.

4.8.1.1 Legend and Non-Legend Drug Coverage: Common Core Formulary

The Contractor is required to maintain a formulary to meet the unique needs of the Members they serve; at a minimum, the Contractor's formulary must include all preferred drugs on the DMAS Preferred Drug List (PDL), also known as the Common Core Formulary (CCF) available at <https://www.viriniamedicaidpharmacyservices.com>.

The DMAS PDL/CCF is not an all-inclusive list of drugs for Medicaid Members. The Contractor must develop a comprehensive formulary that includes drug classes not included on the CCF. The Contractor shall include the DMAS Preferred Drug List (PDL) as a "common core" formulary for all Members enrolled in the CCC Plus Program who have a pharmacy benefit covered by the Contractor's Medicaid plan. The plans are responsible for 100% accuracy for all PDL coding changes based on drug files provided by DMAS. The \$5,000 penalty will be deducted from the capitation rate in the next quarter for each coding error.

By October 1 of the contract year, the Contractor must post a copy of their January 1 formulary to enable members to make informed choices during open enrollment related to their medication coverage. The formulary can continue to be updated as needed over time, and accordingly should be labeled that it is subject to change.

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

The Contractor's formulary must be developed and reviewed at least annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit their formulary to DMAS annually, no later than September 30, after review by its P&T Committee and inform DMAS of changes to their formulary. The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including service authorizations and quantity limits. The Contractor shall submit changes for review and approval via email at least forty-five (45) calendar days prior to the effective date of the change. The Department will respond within fifteen (15) calendar days.

The Contractor must have an updated link to their formulary available on their website.

4.8.1.1.1 Formulary Closed Classes (DMAS Defined)

The Department will define closed classes on the CCF. The Contractor shall not add or remove drugs including alternative dosage forms to closed drug classes on the CCF. The Contractor shall not solicit additional rebates or discounts for drugs in closed classes on the CCF.. Supplemental PDL will apply only to non-dual Members.

The Department requires a 95% compliance rate to the CLOSED CLASSES of the Department PDL. The only exception will be for grandfathered authorizations up to thirty (30) days when a Member transitions from another plan. MCO will be penalized \$25,000 per quarter for failure to comply. The \$25,000 penalty will be deducted from the capitation rate in the next quarter.

4.8.1.1.2 Formulary Open (Non-Closed) Classes

The Contractor may add drugs to their formulary in CCF "open" drug classes. For open drug classes on the CCF, the Contractor retains the ability to negotiate rebates or discounts. All drug

rebates and discounts must be reported to DMAS as defined in Section 19.2, *Reporting of Rebates*.

4.8.1.2 Preferred Drug Access Requirements

The “preferred drugs” included on the DMAS PDL and the Common Core Formulary may still be subject to edits, including, but not limited to, service authorization requirements for clinical appropriateness as determined by the DMAS P&T Committee. The Contractor shall assure that access to all “preferred drugs” from the DMAS PDL is no more restrictive than the DMAS PDL requirements applicable to the “preferred drug” and that no additional service authorization criteria or clinical edits are applied. In addition, the Contractor must comply with the CMS requirement that health plans may not use a standard for determining medical necessity for a “non-preferred drug” that is more restrictive than is used in the state plan.

4.8.1.3 Contractor Responsibility to Deploy Changes to DMAS PDL

If DMAS makes any changes to its PDL, the Contractor shall have sixty (60) calendar days after notification of the changes to the PDL to comply with the DMAS changes.

4.8.3 Pharmacy Exclusions

The Contractor must exclude coverage for the following:

- Drugs used for anorexia or weight gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs; and,
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program.

4.8.4 Medication Therapy Management (MTM)

The Contractor shall implement a MTM program within the first ninety (90) days of operation. The MTM program shall include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists. The Contractor’s MTM program must meet or exceed the requirements described in 42 CFR § 423.153(d)(1) and is applicable to all eligible Members.

Reimbursement for MTM services provided by participating pharmacists shall be separate and above dispensing and ingredient cost reimbursement.

The Contractor’s MTM program shall be developed to identify and target Members who would most benefit from these interactions and report interventions quarterly. A quarterly report will identify the number and type of interventions performed. An annual MTM outcomes report will

be submitted by June 30, 2019 identifying positive changes in drug therapies and potential cost savings. Refer to the *CCC Plus Technical Manual*.

4.8.5 Utilization Management For Pharmacy Services

4.8.5.1 Transition of Care

The Contractor shall have in place policies and procedures to ensure the continuity of care for Members with established pharmacological treatment regimens. The Contractor shall also ensure that it is able to process pharmacy claims using either the Medicaid ID or the MCO ID number. Refer to Section 5.15, *Continuity of Care* for more information. The Contractor will allow a thirty (30) day transitional refill for all prescriptions the Member had received from the prior health plan.

4.8.5.2 Service Authorization

The Contractor shall have in place authorization procedures to allow providers to access drugs outside of the formulary, if medically necessary. This includes medications that are not on the Contractor's formulary, and especially in relation to the Attention-Deficit/Hyperactivity Disorder (ADHD) class of medications (e.g., safeguards against having individuals go back through the Contractor's step therapy program when pre-authorizations end).

The Contractor may require service authorization as a condition of coverage or payment for a covered outpatient drug. The Contractor shall follow service authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and comply with the requirements for service authorization for covered outpatient drugs in accordance with Section 1927(d)(5) of the Social Security Act. The Contractor shall incorporate the requirements into its pharmacy benefit manager (PBM) contracts. The Contractor shall not require a pharmacy service authorization as secondary payer as long as the primary payer has made any payment for the cost of the medication.

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

Pharmacy services for children must be reviewed in accordance with EPSDT requirements to cover medically necessary drugs when medically necessary based upon a case-by-case review of the individual child's needs, such as for off-label use.

The Contractor must submit all pharmacy service authorization and step therapy policies, procedures and any associated criteria to DMAS for review and prior approval.

The Contractor must submit any proposed pharmacy program changes, such as pill-splitting programs, quality limits, etc. to DMAS for review and approval prior to implementation.

4.8.5.3 Response to Service Authorizations and Denial of Services

The Contractor must provide a response by telephone or other telecommunication within twenty four (24) hours of a service authorization, pursuant to the Social Security Act, 1927, 42 U.S.C. 1396r-8. If the Contractor denies a request for service authorization, the Contractor must issue a

Notice of Action within twenty-four (24) hours of the denial to the prescriber and the Member. The Notice of Action must include appeal rights and instructions for submitting an appeal in accordance with the requirements described in Section 15.0, *Member and Provider Grievances and Appeals*.

4.8.5.4 Emergency Supply

A 72-hour emergency supply of a prescribed covered pharmacy service shall be dispensed if the prescriber cannot readily provide authorization and the pharmacist, in his/her professional judgement consistent with the current standards of practice, believes that the Member's health would be compromised without the benefit of the drug. For unit-of-use drugs (i.e., inhalers, eye drops, insulin, etc.), the entire unit should be dispensed for the 72-hour supply.

4.8.5.5 Notification Requirement

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

4.8.6 Pharmacy and Therapeutics (P&T) Committee

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

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

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

4.8.7 Drug Utilization Review (DUR) Programs

In accordance with 42 CFR§ 438.3, the Contractor shall develop and maintain a DUR program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR§ 456, subpart K including prospective DUR, retrospective DUR and the DUR Board.

The Contractor's DUR program shall comply with the requirements in the federal Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Public Law 115-271). The Contractor's DUR program, at a minimum, shall include all of the DUR activities conducted by the Department.

The Contractor's DUR Board will meet at least semiannually. The DUR Board must include a voting representative from the Department. The Department must receive meeting notification and associated meeting materials at least seven (7) business days prior to the meeting. The Contractor must provide the Department with the minutes from each DUR Board meeting within thirty (30) calendar days of the date of the meeting.

The Contractor is not required to have a separate DUR Board. The Contractor may utilize its P&T Committee or comparable committee to fulfill the DUR requirements defined at 42 CFR § 456, Subpart K and 1927 (g) of the Social Security Act. If the Contractor does not maintain a separate DUR Board, the Contractor must define, for the Department's review and approval, how it will fulfill the DUR requirements under the Contract.

The Contractor must submit to the Department a copy of its CMS DUR Annual Report, a detailed description of its DUR program activities as described in 42 CFR § 456.712, at least forty-five (45) days prior to the due date established by CMS. The Department will share with the Contractor all reporting requirements including the web link for the submission of the DUR Report to CMS.

The Contractor shall require all individuals participating on the DUR Board to complete a financial disclosure form annually which is reviewable by the Department upon request.

4.8.8 Drug Rebates

Any outpatient drugs dispensed to Members covered by the Contractor (including where the Contractor paid as the primary and/or secondary payer under this Contract) shall be subject to the same rebate requirements as the State is subject to under Section 1927 and that the State shall collect such rebates from pharmaceutical manufacturers.

Drug utilization data must include all drugs dispensed at point-of-sale (POS) and those administered in a provider's office or other outpatient setting. Pursuant to Section 2501(c)(1)(C)(III) of the Social Security Act, the Department will require encounters to include the actual NDC on the package or container from which the drug was administered and the appropriate drug-related HCPCS physician administered code. Unless otherwise specified by the Department in supporting documentation, the quantity of each NDC submitted, including strength and package size, and the unit of measurement qualifier (F2, ML, GR or UN) is also required. Each HCPCS physician administered code must be submitted with a valid NDC on each claim line. If the drug administered is comprised of more than one ingredient (i.e., compound or same drug different strength, etc.), each NDC must be represented on a claim line using the same HCPCS physician administered code. For the purpose of this contract the term "dispense" is defined to include the terms "provide" and "administer." Drug utilization data for MCO reporting must be reported based upon the date dispensed (date of service) within the quarter, as opposed to the claim paid date. As set forth in 42 CFR §438.3(s)(2), the Contractor must report drug utilization encounter data that is necessary for the Department to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period.

Managed care encounter claims are required to be submitted in a timely manner and in full compliance with the DMAS published Companion Guide (e.g. NCPDP Payer Specifications, NCPDP Post-Adjudication Standard). Any impact to the collection of manufacturer rebates

allowed under federal law that is the result of delayed encounter claim submission to DMAS or the omission of required claim level data elements will be assessed as a contract penalty at the full amount of lost manufacturer rebates.

As set forth in 42 CFR §438.3(s)(3), the Contractor must develop a process and procedure to identify drugs administered under Section 340B of the Public Health Service Act as codified at 42 USC § 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate program. Failure to identify aforementioned 340B drugs on submissions to the Department or its rebate vendor shall be treated as a compliance violation. The Contractor shall identify encounter claims administered under Section 340B in a manner, mutually agreed upon between DMAS and the Contractor, that supports an automated solution to identify and remove those encounter claims from Medicaid Drug Rebate processing. (See *CCC Plus Technical Manual* for reporting requirements.). If a Contractor engages a Pharmacy Benefit Manager (PBM) to provide outpatient drug services to Medicaid Members, the Contractor shall ensure that the PBM complies with the identification of 340B drugs on encounter claim data in a manner consistent with the NCPDP standards. This shall include the use of a unique BIN/PCN combination to distinguish Medicaid managed care claims from commercial or other lines of business. Drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies are not covered as part of the DMAS pharmacy benefit.

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

Refer to the Section 19.10, *Capitation Rates* for more information.

4.8.9 Long Acting Reversible Contraception (LARC) Utilization and Reimbursement

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

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

4.8.9.1 Immediate Post-Partum Coverage

The Contractor must provide reimbursement for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will

not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. The Contractor shall also reimburse practitioners for the insertion of LARC device immediately post-delivery insertion of a LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.

4.8.9.2 Outpatient Coverage

The Contractor must provide coverage for all LARC devices. The Contractor shall not impose service authorization requirements or quantity limits on LARCs. The Contractor shall reimburse practitioners for evaluation/management (E/M) visits, where the practitioner and Member discuss contraceptive options, in addition to same day LARC insertion or removal procedures. The Contractor must reimburse practitioners for LARC devices and procedures at a rate no less than the Medicaid fee schedule.

4.8.10 Prescription Monitoring Program (PMP)

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

Under § 54.1-2523 of the *Code of Virginia*, the Contractor may obtain information from the PMP about specific Members in order to determine eligibility and to manage the care of the specific Member participating in the PUMS or a similar program (Refer to Section 6.3, *Patient Utilization Management & Safety (PUMS) Program* for more information.) Information may only be obtained by a current employee of the Contractor who is also a physician or pharmacist licensed in the Commonwealth.

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

4.8.10.1 Process for Contractor Access to the PMP

The Contractor shall provide to DMAS, in the format specified by the Department of Health Professions, an actively maintained list of up to eight (8) Commonwealth-licensed pharmacists/physicians/nurses employed by the Contractor who will be utilizing the PMP. PMP access login credentials will be provided by the Department of Health Professions and shall not be delegated to or used by other staff. The Contractor, and its employees accessing the PMP, shall only use the PMP in accordance with all applicable State laws, including but not limited to § 54.1-2520, § 54.1-2523, and § 54.1-3400 et. seq of the *Code of Virginia*, and will be required to attest to such usage as a conditional term of access. The Contractor shall notify the Department of Health Professions immediately (within 24 hours) when an employee is terminated or of any other situation (such as a transfer of position or change in job responsibilities) arising that would render PMP access by the individual employee as no longer required or appropriate. The Contractor acknowledges that the Department of Health Professions

will be able to monitor Contractor use for compliance, outlier activity, and has the authority to sanction any misuse of the PMP without DMAS involvement.

4.8.11 Reporting Requirements for HB 1700 Item 317.T, Chapter 1289, 2020 Virginia Acts of Assembly for Contractor's Pharmacy Benefit Manager

The Contractor shall report as follows for all pharmacy claims:

- 1) The actual amount paid to the pharmacy provider per claim, including but not limited to cost of drug reimbursement; dispensing fees; copayments; and the amount charged to the plan sponsor for each claim by its pharmacy benefit manager. Reporting requirements are defined in the State Companion Guides.
- 2) In the event the Department identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the plan sponsor by its pharmacy benefit manager the Contractor shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. The Contractor shall submit such reports by the 15th of each month or the next business day.
- 3) For dual eligible enrollees, the Contractor shall report on pharmacy claims paid through Medicaid.

4.8.11.1 Prohibition Against Spread Pricing

Any agreement between the Contractor and a pharmacy benefits manager shall include provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the Contractor's managed care plan. The agreement shall be reviewed and approved by the Department.

4.9 TELEMEDICINE AND TELEHEALTH SERVICES

Telemedicine is a service delivery model that uses real time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the Member at an approved originating site to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to support remote or long-distance physical and behavioral health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth incorporates technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

The Contractor shall provide coverage for telemedicine and telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program as an innovative, cost effective means to decrease hospital

admissions, reduce emergency department visits, address disparities in care, increase access to and/or enhance existing services, and increase timely interventions.

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

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

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

1. Store and Forward Applications: The Contractor shall reimburse for teleretinal screening for diabetic retinopathy. The Contractor is required to provide coverage for teleretinal screening for diabetic retinopathy that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. The Contractor cannot be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. The Contractor may also reimburse for additional Store and Forward Applications, including but not limited to, tele-dermatology and tele-radiology.
2. The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the Member's primary care physician.

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

4.10 NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

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

Transportation for medical, behavioral health (including ARTS and CMHRS), CCC Plus Waiver services, dental, LTSS, and all services covered under the CCC Plus contract other than to/from

DD Waiver services or DD Waiver services when covered through EPSDT shall be the responsibility of the Contractor. The Contractor shall provide the NEMT benefit to all carved out services, except for DD Waiver services which are the responsibility of the Department's Fee-For-Service transportation broker.

The Contractor shall cover NEMT services within at least equal amount, duration, and scope available under the Department's Fee-For-Service program, as described in 12 VAC 30-50-530, and including but not limited to the following modes of transportation: emergency and non-emergency air ambulance, emergency and non-emergency ground ambulance, public transit, stretcher vans, wheelchair vans, mini-vans, sedans, taxis, transportation network companies (TNCs) and volunteer drivers. With prior approval from the Contractor, Members, family and friends shall also be able to transport Members and receive gas and/or mileage reimbursement.

At times, covered Medicaid services may include transportation services to and from out-of-state medical facilities for treatment that is not available in Virginia and is approved in advance by the Contractor. The Contractor shall honor authorizations (as outlined in this Contract) in place for out-of-state treatment, including transportation services. The Contractor shall maintain an adequate transportation network to cover all approved transportation requests. The Contractor is encouraged to enter into contracts with taxis and commercial carriers as well as public agencies, non-profit and for-profit private agencies, and public carriers.

At initial Contract implementation, at revision, or upon request by the Department, the Contractor shall provide its policies and procedures for review and approval, including requirements for how far in advance individuals need to call to schedule and receive routine, non-emergency, urgent, and/or emergency transportation services.

The Contractor shall participate in a transportation workgroup that will include representatives from DMAS, the MCOs, and stakeholders to review transportation issues, including level of assistance guidelines, capacity by level of assistance, data transfer, and other facets of transportation services. Recommendations from this workgroup will result in a collaborative and strategic approach that addresses Member access to transportation services.

4.10.1 Establish and Maintain Automated Transportation Information Management System

The Contractor shall ensure that the broker or internal transportation services provides and maintains a fully automated integrated Transportation Information Management System (TIMS) sufficient to meet the needs of the NEMT program in the Commonwealth. TIMS shall be provided to transportation providers, Members, and end users at no cost for access, applications, software, technology, interface and contractor's proposed devices. The broker or internal transportation services shall ensure the TIMS interface of proprietary or broker software with a transportation provider's software shall be at no charge to providers. TIMS system at a minimum shall consist of the following:

- A. Optimized Automated Scheduling
- B. Member Management
- C. Import, Export, Collect Data and Files
- D. Transportation Network Management and Support

E. Member Data Elements

4.10.2 Transportation NPI

All transportation providers shall have an individual National Provider Identifier (NPI). The recommended process for transportation providers to obtain this number is as follows: See paragraph D of the NPI application (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10114.pdf>); follow the link in paragraph D to the “Health Care Provider Taxonomy” (<http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/>); find the category that fits the service provided in order for NPPES to issue the NPI. Examples of transportation NPIs are: Non-emergency Medical Transport (VAN) - 343900000X; Private Vehicle - 347C00000X; Secured Medical Transport (VAN) - 343800000X; Taxi - 344600000X; Transportation Broker - 347E00000X.

4.10.3 Transportation Expenses

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

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

4.10.4 Administrative Costs

Administrative costs are the Contractor’s costs of the transportation operations, not including expenses or payment to transportation providers or subcontractors for direct services. If the Contractor operates a pool of volunteer drivers, the administrative costs associated with the Contractor’s volunteer management (e.g., volunteer recruitment, screening, training, etc.) are administrative costs, while the costs associated with a volunteer’s mileage or reimbursement of other expenses are considered direct service costs. If the Contractor has expenses such as mailing, delivery of bus passes, tickets, and/or gas cards, such costs are administrative costs. The actual purchase of bus pass, tickets or tokens, gas cards are direct service costs.

4.10.5 Transportation Provider Network

The Contractor shall recruit, credential, maintain, and negotiate reimbursement to ensure an adequate network of qualified NEMT providers. Qualified NEMT providers shall furnish high-quality transportation services that are safe, reliable, and on-time. NEMT provider capacity shall include all of the following:

- a. Sedans;
- b. Vans;
- c. Mini-buses;

- d. Wheelchair vans;
- e. Stretcher vans;
- f. Ambulances (non-emergency ambulance services, Basic Life Support (BLS), Advanced Life Support (ALS), Paramedic ALS Intercept (PI), and Specialty Care Transport (SCT), as defined in 42 CFR § 414.605);
- g. Alternate transportation (e.g., fixed-route public transportation, volunteer drivers, vouchers, and gas reimbursement); and
- h. Taxi cabs.

The use of metered taxis shall be limited to safety net or last resort, unless specifically authorized by DMAS.

The Contractor shall make use of innovative ideas for alternative transportation methods such as fixed route public transportation, trained volunteer drivers, as defined in Section 4.10.17, *Volunteer Driver* and providing gas reimbursement or vouchers.

The Contractor, NEMT broker, or internal transportation services shall ensure transportation to covered services is available 24 hours per day, 7 days a week, 365 days per year, including evenings, weekends, and holidays. Furthermore, the Contractor shall ensure that Members can access transportation services without communication barriers.

The Contractor may authorize out-of-state NEMT services to enrolled DMAS providers located in cities and counties on or near the Virginia state border (District of Columbia, Kentucky, Maryland, North Carolina, Tennessee, and West Virginia).

The Contractor, broker, or internal transportation services shall:

- a. Ensure that it has a sufficient number of vehicles and drivers available to meet the timeliness requirements for access to care standards as described in Section 9.3, *Member Travel Time and Distance Standards* of this Contract.
- b. Partner with NEMT providers to support their success.
- c. Document its provider relations strategy, which shall include procedures and personnel dedicated to the efforts described in this section.
- d. Conduct monthly written performance reviews with providers taking into consideration quality of service, on time performance, company safety (accidents/incidents) as well as other NEMT contract requirements.
- e. Have a corrective action plan for under-performing providers, and a means to track and report to the Contractor and DMAS on actions and results.
- f. Enroll bordering out-of-state ambulance companies as needed for facility to facility transfers that occur within the bordering state boundaries. Virginia ambulance companies are not permitted to transport Members unless pick up or drop off addresses are located in Virginia. Virginia ambulance providers are not allowed to transfer Members within the boundaries of other states.
- g. Ensure that any NEMT providers accepting out-of-state trips have authority including, but not limited to US DOT Regulations, and applicable federal, state and local licensing requirements.

- h. Assure that all contracts entered into comply with all terms and conditions of the Contractor's broker or internal transportation services contract. Requirement compliance remains the responsibility of the Contractor, broker, or internal transportation services.
- i. Process all complete provider enrollment packets within 30 calendar days of receipt. Have an applicant tracking system for the enrollment process with real-time access for DMAS upon request.
- j. Assure that all documentation required for enrollment is current, within 90 days of application.
- k. Assure that any provider approved or denied to provide NEMT services is notified within 15 days of approval/denial. Approved providers shall have a contract negotiated and executed within 30 days of approval notification.
- l. Assure that no contracted providers are permitted to deliver NEMT transportation services before driver and vehicle requirements are completed, contracts are executed, and provider is approved by the Contractor or Contractor's Broker.
- m. Develop a re-evaluation and notification process for renewal of contracts and rate negotiation.
- n. Have a system in place to track and exclude suspended or terminated providers or drivers from participating in any Virginia Medicaid NEMT covered services upon notification by DMAS.
- o. Report to DMAS upon request subsequent suspensions or terminations of providers and drivers for various safety or erroneous acts.
- p. Contractor or Contractor's "Broker" must have a "Broker" license from DMV and be registered with the State Corporation Commission of Virginia (SCC).

The Contractor, broker or internal transportation services shall ensure that for all NEMT providers:

- a. All vehicles are titled and licensed by the Virginia Department of Motor Vehicles to operate in Virginia and have the proper operating authority or meet DMV's exception criteria for state and local license "Exempt Operations" section titled Exempt Passenger Carrier Operations: https://www.dmv.virginia.gov/commercial/#mcs/programs/intrastate/exempt_op.asp.
- b. Vehicles garaged in adjacent localities in adjoining states meet State inspection and safety requirements.
- c. Those transportation providers with "taxi" license plates are in compliance with state and local ordinances for taxis and are currently licensed by the local taxi authority, if one exists, in the jurisdictions in which they operate.
- d. Transportation Network Companies meet driver and vehicle requirements outlined in this addendum and as required by DMV.
- e. The correct and current USDOT Number as an Interstate Carrier from the Federal Motor Carrier Safety Administration (FMCSA) if the provider is assigned trips that cross the Virginia border.
- f. Provide copies of required permits and licenses from the counties and cities in which they operate to the Contractor.
- g. Have contracted providers, drivers, and vehicles that can access military installations to transport Members.

The Contractor, broker, or internal transportation services shall have contingency plans for unexpected peak transportation demands and plans for back-up drivers, (e.g. TNCs), for

instances when a vehicle is late or is otherwise unavailable for service. Upon request the Contractor, broker, or internal transportation services shall describe its capacity (including providers of bariatric transport and equipment available) to transport bariatric patients throughout the Commonwealth of Virginia. The provider must meet the requirements and guidelines established for bariatric transport by the Virginia Department of Health, Office of Emergency Medical Services.

The Contractor should be aware of Coordinated Human Services Transportation programs in Virginia. Since the beginning of the federal United We Ride initiative, the Virginia Department of Rail and Public Transportation (DRPT) has provided resources to regional and local human services agencies to develop plans for close coordination of their transportation programs with public transit systems, both urban and rural. Most of the coordination plans cover a multi-county Planning District. The service areas of Virginia's Community Services Boards (CSBs) and Area Agencies on Aging (AAAs) usually follow the Planning District boundaries as well. A number of these coordination plans are now in operation and others will follow. The Department encourages the Contractor to contact DRPT (info@drpt.virginia.gov) to determine the roles these agencies may play in the development of the NEMT provider network.

4.10.6 Adequacy of Network for the NEMT Program

The Contractor shall ensure that its NEMT brokers or internal transportation services have a sufficient number of vehicles available to meet the on time performance requirements. If the Contractor or DMAS identifies insufficient transportation resources in an area, the Contractor shall notify the broker or internal transportation services, and the broker or internal transportation services shall have ten (10) business days after the date of such notice to recruit sufficient NEMT providers to meet the needs of the Members in the identified area. If the broker or internal transportation services identifies an area with insufficient transportation resources, the broker or internal transportation services shall immediately notify the Contractor, and shall have ten (10) business days to recruit sufficient NEMT providers to meet the needs of the Members in the identified areas.

4.10.7 Ambulance Transports To and From Bordering States

The Contractor, broker, or internal transportation services must ensure the following non-emergency ambulance transport guidelines are followed:

- a. Ambulance transports originating in Virginia going to out of state Medicaid services can be conducted by a Virginia Office of Emergency Medical Services (OEMS) licensed ambulance company if the transport originates and returns to a Virginia address (i.e. Bristol, VA to Greensboro, NC and Greensboro, NC back to Bristol, VA.)
- b. Ambulance transports originating at an out of state address going to another out of state address must be completed by an ambulance company licensed in that state. Unless the Ambulance company is licensed to do so, Virginia ambulance companies cannot transport out of state to out of state addresses (i.e. Virginia Medicaid Member in a Greensboro, NC hospital needs to be transported to Duke Hospital then back to Greensboro, NC.)

- c. Unless the Ambulance company is licensed to do so, an out of state licensed ambulance company cannot enter the State of Virginia to transport Medicaid Members Virginia to Virginia (i.e. Greensboro based ambulance company going to Bristol, VA to transport Member to Abingdon, VA and back to Bristol, VA.)
- d. Virginia ambulance companies can cross the border to bring a Member back to Virginia (i.e. VA Medicaid Member in Duke Hospital being discharged back to a Virginia address.)

4.10.8 Alternate Transportation

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

4.10.9 Option to Leverage Transportation Network Companies (TNCs)

If the Contractor elects to utilize a TNC for its Members, the Contractor shall provide written notice to the Department through the submission of a TNC Project Plan which shall be reviewed and approved by the Department. The Contractor shall adhere to the TNC requirements below. The Contractor's TNC Project Plan shall be sent via email to cccplus@dmas.virginia.gov and transportation@dmas.virginia.gov sixty (60) days prior to the startup of the TNC. See the *CCC Plus Technical Manual* for TNC Report and TNC Project Plan specifications. The Department reserves the right to adjust/add/remove limitations as well as rescind the use of TNCs, if necessary, at any time during this or future contracts.

TNCs may be used as a provider of last resort or for trip recovery if the Member meets the criteria to ride with a TNC. Members requesting that they not ride with a TNC should not be permitted to utilize a TNC.

In order to maintain the viability of the NEMT network, the Contractor shall comply with the following TNC requirements:

1. Ensure the TNC has additional liability insurance to cover accidents and incidents not covered by the TNC driver's insurance;
2. Obtain a Virginia State TNC Certificate of Fitness from the Virginia State DMV;
3. Waive the signature requirement for TNC trips that will be acknowledged by electronic means (See Section 4.10.28.1, *NEMT Signature Waived*);
4. Ensure Transportation Brokers are paying for trips directly and not reimbursing Members for TNC transportation;
5. Ensure TNC software meets HIPAA, MCO, and the Department's System Security requirements.

The Contractor shall notify the Department in writing which TNC(s) and type the Contractor will be using, if any, for its Members. The Contractor shall also assure the Department that the TNC(s) has been notified of and understands the limitations set forth below.

4.10.10 Transportation Network Company (TNC) Types

Type 1 TNCs consist of drivers and vehicles that meet the State of Virginia DMV TNC driver and vehicle requirements (i.e., Lyft, Uber). The following Member requirements must be met in order to utilize a Type 1 TNC.

1. The Member must have a smart phone or cell phone that is able to receive information texted from the TNC.
2. The Member must be able to interpret and understand information texted from the TNC.
3. The Member must be able to redirect the driver if the TNC is at the wrong address.
4. All Members enrolled in a CL, BI, FIS (IDD) and CCC Plus (EDCD) Waiver shall be excluded unless the Member is approved by the parent or guardian as well as their case manager/Care Coordinator, and if applicable, Group Home Manager.
5. No minor children seventeen (17) years of age and younger shall ride alone.
6. No Members requiring hand-to-hand or door-to-door assistance should utilize a TNC.
7. No Members who need assistance from the TNC driver (i.e., wheelchair, walker, etc. should use a TNC.

Type 2 TNCs consist of drivers and vehicles that meet or exceed State of Virginia DMV TNC requirements and the Department's NEMT MCO driver training and vehicle requirements (i.e., UZURV, internal TNC). The scheduling software is able to send the TNC driver special transport instructions to include hand to hand or door to door levels of service as well as all special instructions required to transport the Member safely.

4.10.11 On-Time Arrival

On-time means from fifteen (15) minutes before the scheduled pick-up time until fifteen (15) minutes after the scheduled pick-up time of an A-leg. If the vehicle arrives within this thirty-minute span of time, the vehicle is on-time for the pick-up.

No more than one percent (1%) of all trips shall be late or missed per day. The Contractor shall ensure that the broker reports the percent of all trips late or missed per day on a weekly and monthly basis.

Subsequent trip legs must be at the scheduled return time or within 45 minutes of a "will call" to the ride assist for a return trip.

4.10.12 Travel Time on Board

For multi-passenger trips, every effort shall be made by the Contractor, broker, or internal transportation services and the NEMT providers to ensure Members do not remain in the vehicle for more than 45 minutes plus direct travel time for transport of the Member. No Member shall have a travel time on board of more than one hour fifteen minutes unless the trip is a long distance trip (see definition of "long distance trip" in Section 23.1, *Definitions*.)

4.10.13 Choice of Provider

Members do not have freedom to choose transportation by a particular NEMT provider. However, the Contractor shall strive to maintain existing relationships between NEMT providers and Members and shall try to accommodate a Member's request for a specific provider in the Contractor's network, especially for the transportation of Members with disabilities, including Alzheimer's disease and other forms of dementia.

4.10.14 Back-Up Services

The Contractor, broker, or internal transportation services shall ensure that NEMT providers inform the Contractor, broker, or internal transportation services immediately of a breakdown, accident, incident, or any other problems that might cause a trip delay beyond the scheduled and contracted window of time for pick up and/or arrival. Immediately after the Contractor, broker, or internal transportation services is notified of a delay, the Contractor, broker, or internal transportation services must notify the Member or their representatives and the facilities or families at the destination points, and document the notification. Other transportation should be arranged to ensure the transport is recovered. Ultimately, it is the responsibility of the Contractor, broker, or internal transportation services to make sure trips are provided and to have a continuity of operations plan in place for recovery of trips to ensure Member safety and timely recovery of trips.

After any delay in scheduled Member pick-up, the Contractor, broker, or internal transportation services must secure alternate transport and notify appropriate parties of any changes. In the event alternate transport cannot be secured, a follow-up call must be made to all appropriate parties to notify and re-schedule. The follow-up call shall be documented.

4.10.15 Urgent Trip Recovery

Occasionally, the Contractor may not be able to identify a provider in its network for a Member's trip (e.g., a late night hospital discharge). In these instances, the trips still must be provided.

4.10.16 Gas Reimbursement

Gas reimbursement can be used for transportation to covered services that can be provided safely by a spouse, by the parent or guardian of a minor child, or by the Member. Family members and friends are also able to receive gas reimbursement for transporting Members to their Medicaid covered services. The family member or friend must call the broker before transport to receive authorization and instructions to receive the gas reimbursement. The driver must have a valid operator's license and there must be an available registered vehicle at the home. The vehicle must be in operable condition and available for use at the time of the appointment.

4.10.17 Volunteer Driver

A volunteer driver is an individual who transports Members in a personal vehicle that meets the driver, insurance, vehicle inspection and other safety requirements of a contracted driver, and who accepts occasional trips (e.g., long-distance trips or recovery trips) from the Contractor in exchange for gas and/or mileage reimbursement.

4.10.18 Transportation Needs of Member

The Contractor is expected to provide services by assigning and scheduling trips on a per-trip or recurring basis with the most appropriate cost-effective non-emergency medical transportation (NEMT) provider, consistent with the transportation needs of the Member. Consideration must be made regarding:

1. **Level of Assistance** – Member assistance requested or when necessitated by the Member’s mobility status or personal condition. This includes door-to-door and hand-to-hand assistance. Curb to Curb is the default level of assistance. At the time of scheduling, the Contractor or their transportation broker shall ask the Member or the Member’s representative if special assistance is needed.
2. **Members with Disabilities** – Members with a physical, sensory, intellectual, developmental, or cognitive disability. Members with disabilities, especially those residing in nursing facilities, dialysis or attending Day Support programs or Adult Day Health Care programs, may require door-to-door or hand-to-hand transportation assistance.

4.10.18.1 Determining Level of Assistance Needs

Transportation services shall be scheduled and provided for Members based upon the Member’s level of assistance need, i.e., whether the Member requires hand-to-hand, door-to-door, or curb-to-curb service. The Contractor shall ensure that Members receive the appropriate level of assistance.

Level of assistance needs shall include the following and shall be based upon consideration of the Member’s needs and condition:

1. **Hand-to-Hand Transportation** – Transporting the Member from a person at the pick-up point into the hands of a facility staff member, family member or other responsible party at the destination. Some Members with dementia or developmental disabilities, for example, may need to be transported hand-to-hand.
2. **Door-to-Door Service** – Transportation provided to passengers who need assistance to safely move between the door of the vehicle and the door of the passenger’s pick-up point or destination. The driver exits the vehicle and assists the passenger from the door of the pick-up point (e.g., residence), escorts the passenger to the door of the vehicle and assists the passenger in entering the vehicle. The driver shall assist the Member throughout the trip and to the door of the destination. It does not include the lifting of any Member. Drivers, except for ambulance or stretcher van personnel, should not enter a residence.
3. **Curb-to-Curb Service** – The default level of assistance. Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The assistance provided by the driver includes opening and closing the vehicle doors, helping the passenger enter or exit the vehicle, folding and storing the Member’s wheelchair or other mobility device as necessary, or securing the wheelchair or other wheeled mobility device in the vehicle. It does not include the lifting of any Member. Drivers are to remain at or near their vehicles and are not to enter any buildings.

4.10.19 Availability of Services

The Contractor shall ensure that covered transportation services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

4.10.20 NEMT Driver Outreach, Training, and Education

The Contractor, broker, or internal transportation services shall ensure that all NEMT drivers (contracted, non-contracted, in-network, out-of-network, volunteers) including any taxi company or independent (i.e., broker driver, Uber, Lyft, UZURV) drivers providing NEMT services receive or have received initial orientation training and ongoing refresher training. The Contractor, broker, or internal transportation services shall ensure drivers who perform transports for CCC Plus Waiver enrolled Members, Members with dementia or cognitive impairments, Members who require hand-to-hand or door-to-door level of assistance complete appropriate training prior to performing any trips for those levels of assistance.

The Contractor, broker, or internal transportation services shall:

- a. Develop a NEMT driver's manual that documents the Contractor, broker, or internal transportation services' operating procedures. The manual shall be provided to all transportation providers with whom the Contractor, broker, or internal transportation services has entered into provider agreements with, as well as their drivers. The manual shall be reviewed in a mandatory orientation program to be provided by the Contractor, broker, or internal transportation services to all contracted transportation drivers.
- b. Provide initial training before driver is placed in service to perform NEMT transports. Provide refresher training as needed when the driver causes an accident or incident which results in unsafe transport conditions (such as not securing a wheelchair correctly or transporting Members without seat belts fastened.) The Contractor, broker, or internal transportation services shall schedule and arrange all training sessions, and all costs of the training sessions shall be borne by the broker or internal transportation services. Certification of completed refresher training is required every 3 years.
- c. Assure that all drivers complete orientation training prior to transporting Members under this contract. Upon satisfactory completion of training, drivers shall be certified. This certification must be renewed via completed refresher training every three years.
- d. Require that all taxi company drivers complete PASS training prior to performing any trips.
- e. Create an ongoing program for NEMT refresher training.
- f. Accept third party training that meets all requirements including PASS certifications from other sources.
- g. All training curricula and materials must be reviewed and updated annually to incorporate changes in requirements, regulations and/or procedures.
- h. Store, maintain and update a database of all training participants.
- i. Ensure that NEMT Broker(s) or internal transportation staff undergo staff training to include TNC utilization, call center, reservations, ride assist/customer service, and operational staff as well as training on the exceptions list for each type of TNC utilized in the NEMT program; j. Develop an orientation program for all NEMT drivers. The initial orientation plan for providers and a training plan for drivers shall be required. At a minimum, the orientation program shall include:

- An overview of the transportation program and the division of responsibilities between Contractor and NEMT drivers;
- Vehicle requirements;
- Procedures for handling and reporting accidents, moving violations, and vehicle breakdowns;
- Driver qualifications;
- Driver conduct;
- Proper use of attendants;
- Scheduling procedures, including criteria for determining the most appropriate mode of transportation for the Member;
- Procedures for handling requests for urgent trips;
- Criteria for trip assignments;
- Dispatching and delivery of services;
- Procedures for obtaining reimbursement for authorized trips;
- Driver customer service standards and requirements during pickup, transport, and delivery;
- Record keeping for scheduling, dispatching and driver personnel, including completion of required logs for reimbursement;
- Procedures for handling complaints from Members, facilities, or other service providers;
- Procedures for submitting claims to the Contractor for reimbursement;
- Procedures for reporting suspected fraud and abuse; and
- A written policy that includes all of the above items.

Initial orientation or ongoing refresher Driver training shall also encompass the following areas:

- Customer service;
- Passenger Assistance Safety;
- Sensitivity training (PASS) (The Contractor, broker, or internal transportation services shall issue an NEMT Program ID Badge to every driver who completes PASS certification);
- Basic first aid;
- Safety and precautions needed for Members with dementia, cognitive impairments, and special needs populations;
- Behavioral health and substance abuse issues;
- Title VI requirements (Civil Rights Act of 1964);
- Applicable HIPAA privacy requirements;
- ADA requirements (Americans with Disabilities Act of 1990);
- Wheelchair securement/safety and proper use of wheelchair lifts, if applicable, before transporting Members under this Contract;
- Seat belt usage and child restraints;
- Emergency evacuation;
- Daily vehicle inspection;
- Defensive driving (such as a commercial driver improvement clinic certified by the Department of Motor Vehicles or the National Safety Council);
- Risk management;
- Communications; and

- Infection control.

4.10.21 NEMT Provider (Owner and Manager) Outreach, Training, and Education

All persons providing transportation services to the Virginia NEMT Program must undergo required training prior to transporting Members.

The Transportation Provider Communication Strategy must facilitate a smooth operation and participation for both new and established providers in the NEMT program. The frequency of regular communications must meet the needs of both providers and the program, and must effectively communicate changes to policies and procedures.

The Contractor, broker, or internal transportation services shall assure that all initial and refresher trainings for Owners/Managers include the following:

- An overview of the transportation program and the division of responsibilities between Contractor and NEMT drivers;
- Vehicle requirements;
- Vehicle maintenance;
- Procedures for reporting accidents, moving violations, and vehicle breakdowns;
- Driver qualifications;
- Driver conduct;
- Proper use of attendants;
- Scheduling procedures;
- Procedures for providing urgent trips;
- Criteria for trip assignments;
- Dispatching and delivery of services;
- Procedures for submitting claims to the Contractor for reimbursement;
- Procedures for obtaining reimbursement for authorized trips;
- Payment schedule;
- Customer service standards and requirements for drivers during pickup, transport, and delivery;
- Record keeping and documentation requirements for scheduling, dispatching and driver personnel, including completion of required logs for reimbursement;
- Procedures for handling complaints from Members, facilities, or other service providers;
- Procedures for reporting suspected fraud and abuse; and
- A written policy that includes all of the above items.

4.10.22 Attendants

The use of an attendant must be prior approved by the Contractor, broker, or internal transportation services. The transportation attendant can be an employee of a transportation provider, and or Member's attendant, approved and reimbursed by the Contractor, broker, or internal transportation services and is responsible for assisting the driver and accompanying a Member or group of Members during transport while ensuring safe operation of the vehicle and the Members. The Contractor, broker, or internal transportation services shall submit attendant

claims as part of encounters. The attendant, when required, must be identified and provided for the Member's transportation needs within five (5) business days of approval.

4.10.23 Transferable Driver and Attendant Requirements

The following shall be transferable between Virginia NEMT transportation brokers or internal NEMT transportation program services.

1. Passenger Assistance Safety and Sensitivity training (PASS) or equivalent;
2. Basic first aid training;
3. Defensive driving training;
4. HIPAA training;
5. Wheelchair securement training (if applicable);
6. State of Virginia Criminal background check or National Data Base Criminal Background check report;
7. Drug screen (if applicable); and
8. DMV Driving record or National Data Base Driving Record Report.

Virginia OEMS credentialing or licensing of EMTs meets all ambulance NEMT driver requirements as long as the license has not expired.

4.10.24 Honoring OEMS Licenses of Ambulance Companies

When the Department updates or enrolls ambulance companies, it requires a copy of ambulance company VDH Office of Emergency Medical Services (OEMS) licenses. (See Section 23.1, *Definitions*, for the definition of OEMS). The OEMS license ensures the ambulance company employees and vehicles meet or exceed State of Virginia OEMS requirements to conduct business as a licensed ambulance company.

The Contractor's NEMT program is required to honor the OEMS license of the ambulance company as the only requirement for provider enrollment. By honoring the EMS license as enrollment, this prevents duplicate work on behalf of the ambulance company and NEMT MCO programs.

The Department's NEMT OEMS requirement can be found at <http://dmas.virginia.gov/#/nemtservices>.

4.10.25 Transportation Services for Minors

An escort or personal assistant is a parent, caretaker, relative or friend who is authorized by the Contractor to accompany a Member or group of Members who have special needs or who are minor children (defined as under age 18). No charge shall be made for escorts or personal assistants.

The Contractor shall authorize transportation services for children under the age of 18. The Contractor shall have guidelines that include transporting children by themselves to after school Medicaid programs with an attendant or escort. If an escort cannot be found, then the Contractor

will work with the Member/designated representative to identify and secure an attendant to ensure timeliness and reduce behavioral problems while in route.

4.10.26 Driver, Attendant, and Vehicle Requirements

At a minimum, the Contractor's transportation broker or internal transportation services shall verify that all vehicles and drivers meet the requirements for training, licensing, vehicle inspection, registration, and insurance coverage as defined by the Department's Fee-For-Service NEMT program at <http://www.dmas.virginia.gov/#/nemtservices>. The Contractor's transportation broker or internal transportation services shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer's safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits. These requirements shall be included in all agreements with NEMT providers. With prior approval from the Department, the Contractor may establish additional driver and attendant requirements.

The Contractor shall ensure that all vehicles transporting Members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

The Contractor shall conduct all driver and attendant credentialing reviews prior to implementation and at least annually thereafter. All the records of these reviews shall be maintained by the Contractor. The Contractor shall assure compliance with driver requirements.

The Contractor and its transportation broker must abide by Department of Motor Vehicle (DMV) rules in the *Code of Virginia* with respect to non-emergency transportation requirements. The *Code of Virginia* exempts certain providers such as non-profits (e.g., AAAs, CSBs) from Intrastate Operating Authority and from requiring "For Hire" plates. The list of exempt provider types can be found in the "Intrastate Operating Authority - Exempt Operations" section titled Exempt Passenger Carrier Operations and found in:

https://www.dmv.virginia.gov/commercial/#mcs/programs/intrastate/exempt_op.asp. The exemption links for the Code of VA for vehicles that qualify for government license plates, who are exempt from needing "For Hire" tags are available at the following Links:

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

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

4.10.27 Passenger Safety Requirements

The Contractor, NEMT providers, drivers, and attendants shall ensure compliance with the following passenger safety requirements:

1. Passengers shall have their seat belts buckled at all times while they are inside the vehicle. The driver shall assist passengers who are unable to fasten their own seat belts.
2. The driver shall not move the vehicle until all passenger seat belts have been buckled.
3. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer's designed seating capacity.
4. Upon arrival at the destination, the vehicle shall be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination.
5. Vehicles should always be visible by the driver.

6. If passenger behavior or other conditions impede the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic and notify his dispatcher to request assistance. Member behavior issues are to be reported to the Contractor.

4.10.28 Transportation Provider/Driver Trip Logs

The Contractor shall require that transportation providers maintain trip logs. The Contractor shall provide training, support and periodic refresher training to ensure compliance. The Department, as part of monitoring this Contract, will audit the log for compliance and completeness. At a minimum, the following information shall be contained in the trip log:

1. Date of service;
2. Driver's name;
3. Driver's signature (written or digital);
4. Attendant's full name (if applicable);
5. Member's name;
6. Member's or attendant's signature (if applicable);
7. Vehicle Identification Number (VIN) or other identifying number on file with the Contractor;
8. Mode of transportation authorized;
9. A unique transportation provider number, assigned by Contractor. For providers of ambulance service, the Department's ambulance provider number shall be utilized;
10. Actual start time (from base station) (in military time);
11. Each authorized Member transported with the actual pick-up time (in military time);
12. Trip indicator (i.e. Trip completed, Member no-show, etc.);
13. Each actual drop off time (military time) for authorized Member;
14. Actual number of wheel chairs, attendants, and children, per trip;
15. Actual return time (to base station) in military time;
16. Authorized stamp or signature of the transportation provider; and,
17. Other pertinent information regarding completion of the trips.

The Contractor shall:

1. Ensure that all information trip logs are complete and accurate.
2. Ensure that trip logs approved by the Department shall be maintained and available in an easily retrievable electronic format for no less than 5 years.
3. Provide training, support and regular monthly monitoring for trip log compliance to all transportation providers.

4.10.28.1 NEMT Signature Requirement Waived

The NEMT requirement for Member signatures on trip logs or trip manifests is waived for NEMT providers who have software, scheduling systems, apps, or a device that does not capture Member signatures (i.e. Jaunt, Community Service Boards (CSB), and Transportation Network Company (TNC)) or for NEMT providers who have fully automated routing software capable of tracking vehicles with Global Positioning Systems (GPS) and that are able to capture trip arrival and trip completion times that have been acknowledged by the driver. The Contractor shall require its broker to ensure that providers in these categories are subject to validation audit, utilizing a statistically significant random sample, to ensure Members were transported. The Department may request the list of providers who are waived and subject to the validation audit..

The Contractor shall submit to the Department for review and approval prior to implementation, upon revision, or upon request, its audit policies and procedures that reflect how the Contractor will validate Members were transported by providers who are waived from the signature requirement.

4.10.29 Reporting Missed Trips

The Contractor shall report the total number of missed trips and types of trips missed. The report shall include information on the resolution. The report shall be submitted at the same time as the dashboard, and shall cover the same reporting period as the dashboard. *Refer to the CCC Plus Technical Manual* for more information. The resolution information shall be member-focused and shall identify follow-up contacts with the Member as well as additional information regarding rescheduled appointments, strategies for ensuring standing trips are covered in the future, etc. For Member no-shows for critical services such as dialysis, chemotherapy, etc., the resolution information shall describe if the Member made it to the appointment by alternate means or reason for no-show, etc. Reporting of missed trips shall be Member-specific.

4.10.30 Department of Justice (DOJ) Settlement

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

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

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

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

1. Separate out individuals with DD Waivers;

2. Complete an analysis related to the delivery of transportation services for DD Waiver Members: and
3. Evaluate the quality of the transportation services provided to individuals in DD Waiver services by the Contractor.

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

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

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

4.10.30.1 Transportation Services Consultation and Support

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

4.11 CARVED OUT SERVICES

The Contractor shall have Care Coordinators and staff familiar with all carved out services. Carved out services include: School Health Services, DD Waiver Services, DD case management services, and transportation services to and from DD Waiver Services. DD Waivers include: Community Living (CL), Family and Individual Supports (FIS), and Building Independence (BI) Waiver services. The Contractor shall not provide authorizations for or pay claims for these carved-out services. The Contractor shall have the ability to refer and communicate with the Department, DBHDS, LTSS provider staff, and other formal and informal supports to ensure coordination of care. The Contractor must ensure that the carved out services

are included in the person-centered Individualized Care Plan (ICP) in order to most effectively coordinate services for the Member. Refer to the *CCC Plus Coverage Chart* attached to this Contract for more information on each of these Waivers and carved out services.

4.12 STATE PLAN SUBSTITUTED (IN LIEU OF) SERVICES

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

For individuals aged 21 through 64, and in accordance with 42 CFR § 438.6(e), the Contractor may provide coverage for a Member receiving inpatient treatment in an Institution for Mental Diseases, as defined in 42 CFR § 435.1010, only within the following guidelines:

- 1) The Member elects such services in an IMD as an alternative to otherwise covered settings for such services;
- 2) The facility providing services is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services;
- 3) The length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly capitation payment; and,
- 4) The provision of inpatient psychiatric or substance use disorder treatment in an IMD meets the requirements for *in lieu of services* as described above and in 42 CFR § 438.3(e)(2).

The Contractor shall refund the full capitation payment paid by the Department for any treatment provided to the Contractor’s Member in an IMD where the length of stay in the IMD exceeds fifteen (15) days during the period of the monthly capitation payment. The fifteen (15) calendar day limit does not apply to IMD treatment for substance use disorders; reference *Addiction And Recovery Treatment Services (ARTS)*.

4.13 ENHANCED BENEFITS

Enhanced benefits are services offered by the Contractor to Members in excess of the CCC Plus program’s covered services. No increased reimbursement shall be made for enhanced benefits provided by the Contractor. When being developed, the Contractor shall consider the population to whom they are being offered, and should address the Members’ needs. At least ninety (90) calendar days prior to each annual open enrollment period, the Contractor shall provide to the Department for approval the list of enhanced benefits it would like to offer and to whom the benefits would be available, the benefit limits, and criteria for each enhanced benefit. By October 1 of the contract year, the Contractor must post a copy of their January 1 formulary to enable members to make informed choices during open enrollment related to their medication coverage. The formulary can continue to be updated as needed over time, and accordingly should be labeled that it is subject to change. Enhanced benefits do not have to be offered to individuals in

every category of eligibility; however, must be available to all individuals if placed on the CCC Plus program comparison chart).

Enhanced benefits offered by Contractors will be listed in the Department's CCC Plus program comparison charts. Comparison charts are revised once annually. Revisions to enhanced services shall be made only prior to open enrollment.

The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of and expenditures for enhanced benefits provided to Members during the Contract.

The Contractor shall provide to DMAS any additional enhanced services provided to the Medicaid expansion population and shall provide such services for at least one (1) year from the effective date of this Contract. Additionally, the Contractor shall submit to DMAS ninety (90) days prior to the start of this Contract a list of the enhanced services that will be provided to Medicaid expansion Members for inclusion in the DMAS comparison chart.

The Contractor shall not obtain enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services which have been added by the Contractor and approved by the Department.

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

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

4.14 SERVICES RELATED TO FEDERAL MORAL/RELIGIOUS OBJECTIONS

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

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

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

4.15 TRANSLATION & INTERPRETER SERVICES

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

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

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

4.16 MEDICAID WORKS

Medicaid Works is a work incentive opportunity offered by the Virginia Medicaid program for individuals with disabilities who are employed or who want to work. Medicaid Works individuals are at least 16 years of age and less than 65 years of age. Additional background information about Medicaid Works is available at: <http://dmas.virginia.gov/#/medicaidworks>.

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

- 1) Dietary Counseling Services are covered when medically necessary, for example for Medicaid Works enrolled individuals who have hyperlipidemia (high cholesterol) and/or other known risk factors for cardiovascular and diet-related chronic disease (for example, heart disease, diabetes, kidney disease, obesity).
- 2) Medicaid Works individuals are also eligible to receive personal careservices, including agency-directed or consumer-directed, or both. Medicaid Works individuals shall not be simultaneously enrolled in a HCBS waiver. Medicaid Works individuals are not required to have a Medicaid LTSS Screening. Individuals who receive personal care services through Medicaid Works do not have a patient pay responsibility for the personal care services. The coverage criteria for personal care services for Medicaid Works enrolled Members shall be the same as the personal care coverage criteria described under the CCC Plus HCBS waiver. Criteria information regarding personal care can be found in the Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapter IV, and the CCC Plus Coverage Chart, Attachment 5 to this Contract.

4.17 ACA MINIMUM ESSENTIAL BENEFITS FOR MEDICAID EXPANSION POPULATION

Medicaid expansion populations, as described in Section 3.1.1, *Eligible Populations* shall receive the same amount, duration and scope of services as other CCC Plus Program Members, with the following four (4) additional federally-required essential health benefits, according to the United States Preventive Services Task Force (USPSTF).

- 1) Annual adult wellness exams;

- 2) Individual and group smoking cessation counseling;
- 3) Nutritional counseling for individuals with obesity or chronic medical diseases;
- 4) Recommended adult vaccines or immunizations.

The above USPSTF recommended preventive and wellness services and chronic disease management shall be covered in addition to the benefits listed in Attachment 5, *CCC Plus Coverage Chart*.

“Preventive” must meet evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the USPSTF. The USPSTF definitions of “A” or “B” ratings are listed below.

- a) USPSTF Grade A – The USPSTF recommends the service. There is a high certainty that the net benefit is substantial. The USPSTF’s suggestion is to offer or provide this service.

- b) USPSTF Grade B – The USPSTF recommends the service. There is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. The USPSTF’s suggestion is to offer or provide this service.

For best practice guidelines and up-to-date resources visit the USPSTF website at <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>.

4.18 FOSTER CARE AND ADOPTION ASSISTANCE CHILDREN

4.18.1 Foster Care and Adoption Assistance Requirements

The Contractor shall work collaboratively with DMAS and Department of Social Services in meeting the Federal requirements related to the Virginia Health Care Oversight and Coordination Plan for children in foster care. The Contractor shall comply with the following rules:

- 1) For decisions regarding the foster care child’s medical care, the Contractor shall work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child’s medical care, the Contractor shall work directly with the adoptive parent.
- 2) The social worker will be responsible for all changes to MCO enrollment for foster care children. The adoptive parent will be responsible for all changes to MCO enrollment for adoption assistance children. An enrollment change can be requested at any time that the child is placed in an area not serviced by the MCO where the child is enrolled.
- 3) Coverage shall not be limited to emergency services and must extend to all medically necessary EPSDT or required evaluation and treatment services of the foster care program, even out of area.
- 4) If the Contractor has found that the foster care child has been placed in an area other than the one where the Contractor participates, the Contractor may contact the social worker to request a change of health plan be initiated.
- 5) The Contractor shall work with DSS in all areas of care coordination.
- 6) Foster care children are not restricted to their health plan selection following the initial ninety (90) day enrollment period.

- 7) The Contractor shall provide coverage for all contractual covered services until DMAS disenrolls the child from the Contractor's plan. This includes circumstances where a child moves out of the Contractor's service area.

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

SECTION 5.0 CCC PLUS MODEL OF CARE

5.1 GENERAL REQUIREMENTS AND COVERED POPULATIONS

Effective January 1, 2019, the Department made significant changes to the CCC Plus Model of Care including implementation of the Medically Complex Determination, changes to the Health Risk Assessment process, changes to the Person-Centered Individualized Care Plan requirements, changes to the Interdisciplinary Care Team requirements, etc. The Contractor's model of care shall align with the Department's CCC Plus program goals to provide comprehensive care coordination that integrates the medical and social models of care through a person centered approach; that promotes Member choice and rights; and, engages the Member and family members throughout the process. In addition, the Contractor's model of care shall also include processes that prioritize continuity of care, and seamless transitions for Members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits. Reference Attachment 11, *MOC Assessment (HRA) and Individualized Care Plan (ICP) Requirements by Population*.

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

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

5.1.1 CCC Plus Other Vulnerable and Emerging Vulnerable Subpopulations

The Contractor's model of care design shall have the capacity to effectively manage the following complex populations that will participate in CCC Plus. Reference Section 5.9, *Care Coordinator Staffing Ratios* for subpopulation classification and related Care Coordinator ratios. Reference Attachment 11 for HRA and ICP deliverable requirements by population. See Section 23.1, *Definitions*.

- a. Members with serious mental illnesses and serious emotional disturbances (institutional and community dwelling);
- b. Members enrolled in the DD Waivers (Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers);
- c. Members with intellectual/developmental disabilities (I/DD);
- d. Members with cognitive or memory problems (e.g., dementia);
- e. Members with brain injuries;
- f. Members with physical or sensory disabilities;
- g. Members with substance use disorders;
- h. Members with end stage renal disease;
- i. Members receiving hospice benefits;
- j. Children in foster care or adoption assistance;
- k. Women with a high risk pregnancy;
- l. Members with other complex or multiple chronic conditions; and
- m. Members who have limited or no current medical, behavioral health, or LTSS needs but may have needs in the future.

5.2 MEDICALLY COMPLEX DETERMINATION

Medically complex individuals are those who have a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability. The medically complex designation is used to assign the Member to either the CCC Plus or Medallion 4.0 programs.

Determination of medically complexity will be made as follows:

1. Individuals that are part of the Medicaid Expansion population and are known to the Department (See Section 3.1.1, *Eligible Populations*) may be deemed by the Department to be medically complex or not medically complex. Medically complex individuals will be automatically enrolled in the CCC Plus Program. Non-medically complex individuals will be automatically enrolled in the Medallion 4.0 program.
 - a. Individuals deemed as non-medically complex, and therefore enrolled in Medallion 4.0, shall be screened by the Contractor using the MMHS to verify they are not medically complex.
2. Individuals, eligible through Medicaid Expansion, that are determined to be eligible for Medicaid through the standard Medicaid application process will be asked to attest that he or she is medically complex (See Section 5.2.1, *Standard Application Attestation*). Those that reply that they are medically complex shall be assigned to CCC Plus. Those that attest that they are not shall be assigned to Medallion 4.0.
 - a. Following the initial assignment, the Contractor will conduct the MMHS to confirm the Member's attestation.

3. The Contractor shall conduct ongoing Data Surveillance/Identification of their Members to determine if there has been a change in a Member's medically complex status. If a change has been identified, or if the Contractor's Medical Director deems the Member to be medically complex, the Contractor must complete the MMHS and submit the results to the Department. The Contractor may use surveillance to identify claims that support CCC Plus enrollment. Upon validation by the Department, the Member shall be transferred from CCC Plus to Medallion 4.0 or vice versa. (See Section 5.2.2.4, *Contractor Data Surveillance / Identification*)
4. The Department shall conduct ongoing Data Surveillance/Validation or Identification to ensure Members are enrolled in the correct program. (See Section 5.2.2.5, *DMAS Data Surveillance / Validation*)
5. If the Contractor is unable to contact the Member or the Member's authorized representative to administer the MMHS or if the Member refuses to participate in the MMHS in its entirety, the Contractor shall notate this on the MMHS and the Member shall be covered under the Medallion 4.0 program at the beginning of the following month (this excludes Members in the Waiver and NF populations). See Section 23.1 *Definitions* for "Unable to Contact (UTC) for the MMHS".

Refer to Section 3.2.8 *Assignment Process Related to Change in Medically Complex Determination* for more information on the assignment process related to changes in the medically complex determination.

5.2.1 Standard Application Attestation

Effective November 1, 2018, the standard Medicaid application shall require Medicaid applicants to indicate whether they attest to being "medically complex" or "not medically complex." An applicant who is presumed medically complex shall be enrolled in the CCC Plus Program and a Member who is presumed to not be medically complex shall be enrolled in the Medallion 4.0 program. An individual shall not be switched between the CCC Plus and Medallion 4.0 programs unless the Member's attestation of medical complexity is rebutted by the results of Part 1 of a MMHS.

5.2.2 MCO Member Health Screening (MMHS)

The MMHS consists of questions, separated into two (2) parts, that provide insight on the population, identify opportunities for supports, and support clinical pathways to improved outcomes.

Part 1 of the MMHS contains questions that shall be used to verify/determine if a Member is medically complex. Part 2 of the MMHS contains questions regarding social determinants of health, and in conjunction with Part 1, will be used to determine when the Member's HRA must be completed. See Section 5.2.2.2, *MMHS Completion Timeframe* for MMHS completion timeframes.

The Contractor must complete both parts of the MMHS on all Medicaid expansion and any newly eligible individuals. All Members eligible through Medicaid Expansion (See Section 3.1.1, *Eligible Populations* for relevant Aid Categories), must have the MMHS completed to determine if and when an HRA is needed and to determine or confirm medical complexity.

For Members in a Nursing Facility and CCC Plus Waiver, the MMHS does not have to be completed to determine when an HRA is needed. Refer to Section 5.3.4, *Initial HRA Completion Timeframes*.

For former GAP Members, the HRA shall be completed no later than sixty (60) days from the date of enrollment but may need to be completed sooner if the Member is screened and determined to be high risk.

If, upon completion of the MMHS, the Contractor determines that the individual is medically complex, a re-screening of medically complex classification is not required unless there are changes to the individual's medically complex classification as stated by or on behalf of the individual or through the Contractor's analysis of the Member-specific health data.

5.2.2.1 Global MMHS Tool Elements

The MMHS tool, including Parts 1 and 2 can be found as Attachment 16 of this Contract. At a minimum, the Contractor shall ask the Member or the Member's representative(s) all of the questions in Parts 1 and 2 when administering the MMHS. If additional questions are necessary to determine a Member's medical complexity or a Member's social determinants of health, the Contractor may ask additional questions as necessary.

The MMHS shall be conducted telephonically unless the Member's health condition(s) or place of residence requires face-to-face contact or where claims on service authorizations identify complexity and precede a plan's ability to complete the MMHS.

5.2.2.2 MMHS Completion Timeframe

In accordance with 42 CFR § 438.208(b)(3), the Contractor shall complete the MMHS for all Medicaid expansion populations described in Section 3.1.1, *Eligible Populations* and any new CCC Plus enrollee beginning January 1, 2019, within three (3) months of each Member's enrollment with the Contractor, unless the Contractor is unable to screen the Member after three (3) good faith attempts. See Section 23.1, *Definitions*, "Unable to Contact (UTC) for the MMHS".

If the Member cannot be reached after three (3) good faith attempts, the Contractor shall mail the MMHS to the Member. All mailed MMHS's must meet the following conditions:

- The content of the MMHS must be maintained. If the Contractor changes anything on the MMHS, it must be submitted to DMAS for review. The Contractor must submit its materials to the Department for review and approval thirty (30) days prior to its use. DMAS will review and approve according to applicable contract requirements.
- Each mailed MMHS is required to include a cover letter that meets state and federal requirements for readability. The cover letter and MMHS are considered documentation critical to obtaining services, therefore shall include the appropriate taglines. Cover letters must be approved by DMAS before mailing.
- A mailed MMHS is considered completed on the date the MCO receives it. The MMHS shall be submitted to the Department within no more than five (5) business days of the

date on which the screening was received. A mailed MMHS must also meet the contractually required completion timeframe.

- If a Member returns the MMHS and has selected either, “Other chronic (long term) disabling condition” under Part 1 Question 1 or “Other chronic (long term) mental health condition” under Part 1 Question 3, the Member Complexity Attestation must be completed. In these instances the MMHS is not considered completed until the attestation is received.
- All mailed MMHS must include a self-addressed, postage paid return envelope.

The MMHS shall be submitted to the Department within no more than five (5) business days of the date on which the screening was completed, upon the third instance of the inability to contact the Member, or the date on which the Member refused to participate. While the MMHS is required to be completed within three (3) months, in order to affect enrollment changes the MMHS must be submitted prior to the end of the Member’s initial four (4) months.

The Contractor shall report to DMAS the identifying information of those Members who could not be screened within the Member’s initial three (3) months. Refer to the *CCC Plus Technical Manual*.

5.2.2.3 MMHS Requirements

1. As long as it is completed within the first three (3) months of the Member’s enrollment, the Contractor may conduct the MMHS at the same time as the HRA, and in such circumstances, the MMHS may be conducted face-to-face.
2. The Contractor shall make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and shall consider a Member’s physical and cognitive abilities and level of literacy in the screening process.
3. The Department reserves the right to require the Contractor to conduct re-screenings as deemed necessary.
4. The Department shall give the Contractor one hundred twenty (120) days notice before making changes to the MMHS unless mandated by law.
5. The Department reserves the right to conduct reviews, including reviews based on claim data or chart reviews to validate that Members classified as “medically complex” meet Medically Complex criteria. The Department also reserves the right to determine the Member’s medically complex status, including an over-ride of the Contractor’s determination.
6. The Contractor shall document efforts made to outreach and conduct the MMHS for Members whom the Contractor has difficulty locating. The Contractor shall notate on the MMHS the number of attempts and date(s) of attempts made to contact the Member.
7. When conducted face-to-face, The Contractor shall conduct MMHS’s in a location that meets the needs of the Member.
8. The Contractor’s staff conducting the MMHS shall have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.

9. As necessary, relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) shall be used by the Contractor in the completion of the MMHS.
10. Elements from the MMHS shall be considered and incorporated into the ICP.

5.2.2.4 Contractor Data Surveillance / Identification

Upon completion of Part 1 of the MMHS, the Contractor shall send the screening information via batch file to the Medicaid system. When the MMHS criteria is met, the individual receives a medically complex indicator (X). The Indicator “X” is reflected on the Contractor’s 834 file, which includes the Contractor ID that completed the screening. Where criteria is pending, the individual receives an indicator “XP.”

Upon completion of Part 2 of the MMHS, the Contractor shall send the screening information via batch file to the Medicaid system. The Screening information is shared on the medical transition file when Members transition between health plans. The screening information is used to support Member risk stratification, identify Members who may require program supports, and for HRA triage purposes.

5.2.2.5 DMAS Data Surveillance / Validation

The Department shall carry out statistical sampling and other data analysis techniques to audit the Contractor to ensure that Medicaid expansion Members are being placed in the appropriate managed care program as a result of the appropriate utilization of the medically complex screening processes and other processes.

The Department shall use available data sources including claims/encounters and Member responses to the MMHS to validate that Members are in the correct delivery system (Medallion 4.0 or CCC Plus). This may include identification of emerging or existing healthcare risk, confirmation of reported physical or behavioral health conditions reported by the Member or the Contractor, and other delivery system monitoring and assessments.

The Department reserves the right to conduct desk or on-site audits of the Contractor’s completed MMHS’s and related systems, policies and process.

Identification of issues or potential inappropriate delivery system assignment may result in additional screening events or in the disenrollment of a Member from one program delivery system and enrollment in an alternate program or delivery system. This may include Members moving from Medallion 4.0 to CCC Plus or from CCC Plus to Medallion 4.0. These actions shall occur in consultation with the Member’s assigned Contractor.

The Contractor shall advocate for and support enhanced fraud prevention efforts as described in Section 10.17 *Medicaid Expansion Population Specific Measurement And Reporting*.

5.2.3 Housing and Employment Supports for Individuals with High Needs

The Contractor shall work collaboratively with DMAS and its identified stakeholders to support DMAS in its implementation of the infrastructure to support successful operations of the new High Needs Employment and Housing Supports Medicaid program within Virginia's §1115 waiver. Upon notification from the Department, and through separately issued guidance on the implementation of the High Needs Supports benefit, the Contractor will ensure Contractor readiness of targeted MCO operational functions to ensure the implementation and evaluation of this new benefit.

5.3 HEALTH RISK ASSESSMENTS (HRA)

The Contractor shall use a Health Risk Assessment (HRA) as a tool to develop the Member's person-centered Individualized Care Plan (ICP) (see Section 5.4, *Person-Centered Individualized Care Plan (ICP)* of this Contract for more information). The Department reserves the right, providing the Contractor with at least sixty (60) calendar days advance notice, to require the Contractor to add additional elements to its HRA. The Contractor shall participate in an HRA workgroup initiated in the Summer of 2018 that includes representation from all plans, DMAS, and relevant stakeholders. The goal of the HRA workgroup is to create a universal HRA that is portable and that can follow the Member from one MCO to another. The Contractor shall comply with the additional HRA elements discussed in the workgroup as well as the agreed upon implementation date.

5.3.1 HRA Tool Required Elements

5.3.1.1 Global HRA Tool Elements

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

The Contractor's HRA shall include all elements agreed upon during the HRA Collaborative workgroup between the health plans and the Department. The revised HRA Tool Elements will include standardized questions from the interRAI Assessment Instrument(s), as well as mutually agreed upon supplemental questions. (For more information on the interRAI Assessment Instrument visit www.interrai.org). The revised HRA elements will be decided upon in the Spring of 2019 and implemented at a later mutually agreed upon date.

Prior to implementation of the standardized HRA in the Spring of 2019, the Contractor shall comply with the current HRA Tool Elements for CCC Plus Waiver Members, Technology Dependent Members, and Nursing Facility Members as indicated below using the Department approved HRA.

The Contractor's HRA shall also:

- 1) Document that during the initial health risk assessment, the Member was informed of the program name, covered benefits, and the role of the Care Coordinator.

- 2) Document the source of information for the HRA i.e. the Member, providers, facility staff, family/caregivers, etc. to include name and title) and location of completion (face-to-face or telephone and physical location).

5.3.1.2 HRA Tool Elements for CCC Plus Waiver Members

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

- 1) Pertinent information from the Uniform Assessment Instrument (UAI), when available.
- 2) Discussion with Member/caregiver regarding satisfaction with services received;
- 3) Evaluate the environment for appropriateness, safety, and Member comfort;
- 4) Confirmation of the Member's needs;
- 5) Clarification with Member/caregiver program services, limits, and rights and responsibilities of everyone involved in providing care;
- 6) Confirmation that the waiver provider(s) is working to meet Member's care plan as written; and,
- 7) Confirmation that all appropriate documentation is available in the home (i.e. Plan of Care).

5.3.1.3 HRA Tool Elements for Technology Dependent Members

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

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

5.3.1.4 HRA Tool Elements for Nursing Facility Members

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

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

5.3.2 HRA Staff Qualifications

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

5.3.3 HRA Requirements

- 1) The Contractor shall ensure that its HRAs conducted by telephone interview, if recorded, shall have the Member's consent to be audio recorded. The Contractor shall provide the audio recording including the Member's consent to DMAS upon request.
- 2) The Contractor shall conduct HRAs for Members in the CCC Plus Waiver, for Members residing in nursing facilities, and for Members with serious mental illness, via face to face communication. DMAS may recognize HRAs conducted via telehealth as an accepted means of face to face communications. The Contractor shall ensure that any telehealth communication processes are an effective and appropriate option based upon the Member's condition, communication abilities, and preferences. The Contractor shall submit any telehealth HRA protocols to DMAS for approval prior to implementation.
- 3) The Contractor's Care Coordinators shall make accommodations available at no charge to the Member that address the needs of Members with communication impairments (e.g., hearing and vision limitations) and Members with limited English proficiency, in a culturally and developmentally appropriate manner and shall consider a Member's physical and cognitive abilities and level of literacy in the assessment process.
- 4) The Contractor's Care Coordinators shall document efforts made to outreach and conduct HRAs for Members the Contractor has difficulty locating.
- 5) The Contractor shall conduct HRAs in a location that meets the needs of the Member.
- 6) The Contractor's Care Coordinator shall have the demonstrated ability to communicate with Members who have complex medical needs and may have communication barriers.
- 7) Relevant and comprehensive data sources (including the Member, providers, family/caregivers, etc.) shall be used by the Contractor. Results of the HRA shall be used to confirm the appropriate stratification level for the Member and as the basis for developing the ICP.
- 8) The Contractor shall ensure that each element of the HRA, including a description of the CCC Plus Waiver and other covered services to be provided until the next person-centered ICP review, is reflected in the ICP. In addition, the Contractor shall ensure that its ICT process ensures that all relevant aspects of the Member's care is addressed in a fully integrated manner on an ongoing basis (Refer to Section 5.5, *Interdisciplinary Care Team (ICT)* of this Contract.)
- 9) During assessments and reassessments, the Contractor's Care Coordinator shall gather advance directive information. This includes educating the Member about advance directives, obtaining any advance directives documentation, and complying with all Federal and State requirements for advance directives, including maintaining a copy of all related documents in the Member's file.
- 10) The Contractor shall ensure that its systems allow the Care Coordination Platform and Triage Algorithm to be continuously updated with the real-time Admission Discharge

Transfer (ADT) feeds from the Emergency department Care Coordination solution. If an ADT feed arrives with the third (3rd) or fourth (4th) emergency room visit or hospitalization in ninety (90) calendar days, it indicates a moderate risk Member, as defined in *Moderate Risk Populations*, and immediately starts the sixty (60) calendar day time period to complete the HRA. If an ADT feed arrives with the fifth (5) emergency room visit or hospitalization in ninety (90) calendar days, it indicates a high risk Member, as defined in *High Risk Populations*, and immediately starts the 30 (thirty) calendar day time period to complete the HRA. If a Member who the plan has been unable to contact is in the hospital, the Contractor shall prioritize making contact with the Member while he or she is in the hospital. The Contractor shall contact the hospital where the Member resides to get more updated information.

- 11) The Contractor shall continuously monitor all Members via Emergency Department Care Coordination. Notification of an Emergency Department visit or hospitalization related to the Member's chronic health condition from an ADT feed may lead to immediate elevation to a higher category and therefore a different initial HRA completion timeframe.
- 12) The Contractor shall continuously monitor information received from other sources that may indicate the need to change the Member to a different risk category.

5.3.4 Initial HRA Completion Timeframes

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

For former GAP Members, the HRA shall be completed no later than sixty (60) days from the date of enrollment but may need to be completed sooner if the Member is screened and determined to be high risk.

The HRA timeframes may change if the Department and the health plans mutually agree on revised timeframe through collaborative meetings between the Department and the Contractor.

5.3.4.1 Initial HRAs for CCC Plus Waiver and EPSDT Populations

- 1) For CCC Plus Waiver or EPSDT Members who receive Private Duty Nursing Services, the Contractor shall ensure that HRAs are completed face-to-face within thirty (30) calendar days of plan enrollment,
- 2) For CCC Plus Waiver or EPSDT Members who do not receive Private Duty Nursing Services, the Contractor shall ensure that HRAs are completed face-to-face within sixty (60) calendar days of plan enrollment.

5.3.4.2 Initial HRAs for Nursing Facility CCC Plus Populations

For CCC Plus Members who reside in a nursing facility, the Contractor shall ensure that HRAs are completed face-to-face within one hundred twenty (120) calendar days of plan enrollment. The Contractor shall contact the nursing facility and Member and Member's responsible party, if

applicable within thirty (30) calendar days of enrollment, and provide the contact name and number of the Care Coordinator.

5.3.4.3 Initial HRAs for High Risk Populations

For CCC Plus Members who are categorized as a “high risk” population, as described below and in Section 23.1, *Definitions* the Contractor shall ensure that HRAs are completed within thirty (30) calendar days of completion of the MMHS.

A Member is categorized as “high risk” if he or she meets one or more of the following conditions. Each of the following conditions is verified through the Member’s answer to questions on the MMHS, Part 2 – Social Determinants of Health and HRA Triage Questions (Attachment 16 of this Contract).

Member Condition	MCO Member Health Screening Question
1) The Member is homeless	MMHS Part 2, Question 1
2) The Member has had a combination of five (5) or more emergency room visits or hospitalizations related to their chronic medical, physical, and/or behavioral health condition in the past 90 (ninety) calendar days).	MMHS Part 2, Question 3; DMAS history; or Emergency department Care Coordination ADT feed
3) The Member has had three (3) or more falls resulting in an ED visit, hospitalization or physician visit within the past ninety (90) calendar days	MMHS Part 2, Question 4
4) Member is covered under the CCC Plus Waiver with Technology Assistance (Indicator A) (services are described in Section 4.7.2.2, <i>Services</i> and in Attachment 5 of this Contract)	N/A

The Contractor shall conduct HRAs for high risk Members with serious mental illness, via face-to-face communication. Otherwise, excepted as noted in 5.3.4.1, *Initial HRAs for CCC Plus Waiver and EPSDT Populations* the Contractor is not required to conduct HRAs face-to-face except in circumstances where appropriate based upon the Member’s needs and preferences.

5.3.4.4 Initial HRAs for Moderate Risk Populations

For CCC Plus Members who are categorized as a “moderate risk” population, as described below and in Section 23.1, *Definitions* the Contractor shall ensure that HRAs are completed within sixty (60) calendar days of completion of the MMHS.

A Member is categorized as “moderate risk” if he or she meets one or more of the following conditions. Each of the following conditions is verified through the Member’s answer to questions on the MMHS, Part 1 – Medically Complex Classification Questions and Part 2 – Social Determinants of Health and HRA Triage Questions (Attachment 16 of this Contract).

Member Condition	MCO Member Health Screening Question
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1) The Member has had a combination of three (3) to four (4) emergency room visits or hospitalizations related to his or her chronic medical, physical, and/or behavioral health condition in the past 90 (ninety) calendar days).	MMHS Part 2, Question 3; DMAS history; or Emergency department Care Coordination ADT feed
2) The Member has had one (1) to two (2) falls resulting in an ED visit, hospitalization or physician visit within the past ninety (90) calendar days	MMHS Part 2, Question 4
3) The Member needs assistance with ADL's	MMHS Part 1, Question 2
4) Member's ability to perform daily tasks is impacted by SMI/SUD condition	(Question 4 from MCO Member Health Screening/Medically Complex Classification Questions)
5) Foster Care (if not already High Risk)	N/A
6) The Member is covered under the CCC Plus Waiver (Indicator 9) (if not high risk) as described in Section 5.3.4.3 <i>Initial HRAs for High Risk Populations</i> (CCC Plus services are described in Section 4.7.2.2, <i>Services</i> and in Attachment 5 of this Contract).	N/A

The Contractor is not required to conduct face-to-face HRAs for moderate risk Members except for conditions described in Section 5.3.3, *HRA Requirements* and in circumstances where appropriate based upon the Member's needs and preferences.

5.3.4.5 Initial HRAs for Low Risk Populations

For those individuals who are Aged, Blind, or Disabled, are not in a Medicaid expansion aid category, and do not meet the moderate or high risk category, the Contractor shall ensure that HRAs are completed within ninety (90) calendar days of completion of the MMHS. SMI Members must be face-to-face, all others can be telephonic.

5.3.4.6 Initial HRAs for Minimal Risk Populations

For individuals categorized as a "minimal risk" population, the Contractor shall not be required to ensure that an HRA is completed. An HRA shall be completed if the Member is re-categorized. Because an HRA is not required for a "minimal risk" Member, the Contractor may, but is also not required to, develop a person-centered individualized care plan (ICP), as described in Section 5.4, *Person-Centered Individualized Care Plan (ICP)*, or to arrange an Interdisciplinary Care Team (ICT), as described in Section 5.5, *Interdisciplinary Care Team (ICT)*.

5.3.4.7 HRA for Members Who Transition To or From the Contractor

For Members who have transitioned from the Contractor's health plan to a different MCO, the Contractor shall share the most recent HRA data with the "newly receiving MCO" upon request.

If the Contractor is the “newly receiving MCO,” the Contractor shall submit a request to the “originating MCO” for the most recent HRA data. The Contractor is not required to conduct a new HRA unless the Member has experienced a triggering event or a new HRA is due per the requirements in Section 5.6, *Reassessments* of this Contract. This also applies in the event that a Member is disenrolled and re-enrolled with the Contractor. A new HRA is required when the Member has experienced a triggering event or by the due date of the next HRA, based upon the timeframes listed in Section 5.6, *Reassessments* of this Contract. This is an interim process for sharing the HRA until a more efficient method for sharing the information is available.

5.3.4.8 HRA When Member Refuses

The Contractor shall oversee and coordinate quality services for the Member, even in the absence of communication with the Member. In order to adequately manage the case and ensure appropriateness of care to the maximum extent possible, a comprehensive care review is needed based on any and all available information. It is the Contractor review of a Member's existing care that determines what services are needed and if provided appropriately. A full completed HRA is not required in the circumstance that a Member refuses to participate in a HRA. If a Member refuses to participate in the HRA, the Care Coordinator shall complete a comprehensive care review based on available clinical information from rendering providers or caregivers and information received from transition reports, service authorizations, and claims. Other sources of information may include, but are not limited to, MDS, UAI, early intervention individualized family service plan, etc.

The Contractor shall document internally in the care plan for the Member why the HRA was not completed without the Member's involvement. The comprehensive care review shall include the sources of information, the Member's conditions and diagnoses, current needs and services, identified risks, concerns related to non-adherence, access to care and contradictory provider treatment plans and Contractor recommendations. An ICP must be established based on the outcome of the comprehensive care review and updated accordingly. The Department reserves the right to request the Contractor's comprehensive care review information.

5.3.4.9 Reclassification of Members into Minimal Risk Category

If after completion of the MMHS, a Member is unable to be contacted by the Contractor using reasonable efforts as defined in Section 23.1, *Definitions*, to conduct the initial HRA, the Member may be reclassified into the Minimal Risk Subpopulation. See definitions for “Unable to contact (UTC) for initial HRA” and “Minimal Risk Subpopulation” in Section 23.1, *Definitions*.

5.3.4.10 Reclassification of Members With Effective Dates Prior to January 1, 2019

For those Members enrolled with an effective date prior to January 1, 2019, the MMHS is not required. See Section 5.2.2.2, *MMHS Completion Timeframe*. If the Initial HRA or reassessment of a Member with an enrollment date prior to January 1, 2019 indicates the need for re-classification, the Contractor shall ensure the following:

- 1) For those Members in a Nursing Facility or CCC Plus Waiver prior to January 1, 2019, Members should not be re-classified as “unable to contact” or placed in the Minimal Needcategory.
- 2) For those Members categorized as “Emerging Vulnerable” prior to January 1, 2019, and who require a re-assessment, the reassessment is required annually and upon a triggering event such as a hospitalization or significant change in health or functional status.
- 3) For those Members categorized as “Other Vulnerable” prior to January 1, 2019, and who require a re-assessment, the reassessment is required annually and upon a triggering event such as a hospitalization or significant change in health or functional status.

5.3.5 HRA Reassessment Completion Timeframes

Following the initial HRA, Care Coordinators shall complete a HRA reassessment for CCC Plus Members within the timeframes set forth below.

The HRA timeframes, and therefore HRA reassessment timeframes, may change if the Department and the health plans mutually agree on revised timeframe through collaborative meetings between the Department and the Contractor.

The Contractor shall ensure that the HRA reassessment for each CCC Plus Member is conducted upon a triggering event such as a hospitalization or significant change in health or functional status.

5.3.5.1 Reassessments for CCC Plus Waiver and EPSDT Populations

- 1) For CCC Plus Waiver or EPSDT Members who receive Private Duty Nursing Services, the Contractor shall ensure that HRA reassessments are completed face-to-face every six (6) months following the initial HRA,
- 2) For CCC Plus Waiver or EPSDT Members who do not receive Private Duty Nursing Services, the Contractor shall ensure that HRA reassessments are completed face-to-face every six (6) months following the initial HRA.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.3.5.2 Reassessments for Nursing Facility CCC Plus Populations

For CCC Plus Members who reside in a nursing facility, the Contractor shall ensure that HRA reassessments are completed face-to-face every six (6) months following the initial HRA.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.3.5.3 Reassessments for Other Vulnerable Populations

For CCC Plus Members who are categorized as “other vulnerable” population for ongoing care coordination purposes, the Contractor shall ensure that HRA reassessments are completed annually. The Contractor shall ensure that for those Members with SMI, the HRA reassessment is completed face-to-face. For those Members without SMI, the HRA reassessment may be done telephonically.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.3.5.4 Reassessments for Emerging Vulnerable Subpopulations

For CCC Plus Members who are categorized as “emerging vulnerable” populations for ongoing care coordination purposes, the Contractor shall ensure that HRA reassessments are completed annually. The Contractor shall ensure that for those Members with SMI, the HRA reassessment is completed face-to-face. For those Members without SMI, the HRA reassessment may be done telephonically.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.3.5.5 Reassessments for Minimal Need Subpopulations

For individuals categorized as a “minimal need” subpopulation, the Contractor shall not be required to ensure that a reassessment is completed. A reassessment shall be completed in accordance with the reassessment timeframes defined in Section 5.3.5, *HRA Reassessment Completion Timeframes* if the Member is re-categorized.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4 PERSON-CENTERED INDIVIDUALIZED CARE PLAN (ICP)

The Contractor shall develop a person-centered, culturally competent ICP for each of its enrolled Members. The person-centered ICP shall be tailored to the Member’s needs and preferences and completed in the timeframes specified in this Contract and based on the results of the Contractor’s risk stratification analysis. For those who qualify as “minimal risk” as described in Section 5.3.4.6, *Initial HRAs for Minimal Risk Populations* and therefore do not receive an HRA, the Contractor may, but is not required to, develop an ICP as described in this section.

5.4.1 General Requirements

The Contractor’s Care Coordinator shall:

- 1) Engage each Member in the ICP process;
- 2) Ensure that the Member receives any necessary assistance and accommodations to prepare for and fully participates in the care planning process that includes ICT participation and person-centered ICP development;
- 3) Develop and maintain the ICP and make the ICP or information related to the ICP accessible to providers and Members as needed and upon request;
- 4) Revise the ICP based on triggering events, such as hospitalizations or a decline or improvement in health or functional status;
- 5) Ensure information is secured for privacy and confidentiality in accordance with all applicable State and Federal requirements;

- 6) Obtain Member's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is conducted telephonically, if the audio is recorded, the Contractor shall have the Member's consent for the audio recording. Also document all efforts when Members or their representatives refuse to sign, including a clear explanation of the reason for the Member's refusal;
- 7) Communicate any ICP revisions to the Member, ICT, and other pertinent providers;
- 8) Develop and implement the ICP no later than the end date of any existing SA. Services must be continued until the HRA has been completed and the ICP has been developed.

5.4.2 ICP Required Elements

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

- 1) ICP Completion date; ICP attainable goals and objectives with start date; target end dates; completion dates; and outcome measures based assessments;
- 2) Strategies and actions, including interventions and specific services to be implemented to meet the Member's needs and preferences (including community-based resources, service provider information, quantity, frequency, and duration of the services or the person(s) responsible for the specific interventions/services (including peer recovery support services);
- 3) Documentation within the ICP regarding progress towards goal completion noting success; rationale for extending target end goal dates; updating of ICP with new goals; any barriers or obstacles;
- 4) Identification of the Member's primary care provider and specialists, including plans for follow-up care;
- 5) Member's informal support network and services;
- 6) Addressing all needs of the Member (functional, medical, behavioral, cognitive, social, LTSS, wellness and preventive) as well as any preferences as identified by the Individualized Care Team (ICT) and agreed upon by the Member. Social needs include but are not limited to: housing, food, security, economic security, community and informational supports, and personal goals (e.g. go to school, have a job, be at granddaughter's wedding);
- 7) Prioritized list of concerns, preferences, needs, goals, and strengths, as identified with the Member;
- 8) Advance directive information; including education needs of the Member about advance directives, and obtaining any advance directive documentation and filing them in the Member's file. The status of advance directives must be reviewed at annual assessments and with a significant change in health or functional status and shall be included in the ICP. Also included is documentation of information regarding the inability to provide information regarding advance directives and the reasons why the advanced directives may not have been obtained;
- 9) Plans for transition coordination and services for Members in nursing facilities who wish to move to the community;
- 10) Addressing health, safety (including minimizing risk), and welfare of the Member.
- 11) Back up plans as appropriate for CCC Plus Waiver Members in the event that the primary caregiver is unable to provide care. If applicable, the use of skilled respite nursing, trained backup caregivers, and facility admission may be required. All technology

- dependent Members must have a trained primary caregiver who accepts responsibility for providing care whenever nursing is not in the home and, if applicable, Members must have a back-up plan if personal care services cannot be rendered as planned;
- 12) Crisis plans for Members with behavioral health needs. For crisis plans, describe how the Contractor will assist the Member to identify and select individuals or agencies that will provide support, crisis intervention, crisis stabilization or other services (including peer recovery support services) to assist the Member in managing the crisis and to minimize emergency room or inpatient needs;
 - 13) Plan to access needed and desired community resources and non-covered services;
 - 14) Member's choice of services (including model of service delivery for personal care and respite –consumer-directed vs. agency-directed when appropriate for CCC Plus Waiver Members who are eligible for consumer-directed services);
 - 15) MMHS responses;
 - 16) CCC Plus Waiver and other covered services to be provided until the next person-centered ICP review;
 - 17) Elements included in the Provider Plan of Care (DMAS-97AB; DMAS-7A) for CCC Plus Waiver Members receiving personal care services and the DMAS-301 for Members receiving ADHC;
 - 18) Elements included in the Home Health Plan of Care (CMS-485) for Members receiving Private Duty Nursing; and,
 - 19) Elements included in the IFSP for Members receiving early intervention.

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

The Contractor shall fully comply with 42 CFR § 441.301(c)(1) and (2) and to the CMS guidance documents located at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-10-14.pdf>.

5.4.3 ICP Completion Timeframes

Following completion of the HRA, the Contractor's Care Coordinator shall develop an initial ICP prior to the ICT meeting. The Member must agree to and sign revisions/updates to the ICP following the ICT as indicated above for initial ICP. The ICP is considered complete upon Member signature. The Care Coordinator can develop the initial ICP during the HRA process and obtain the Member's signature at that time. The Care Coordinator is not required to wait until after the ICT meeting to complete the ICP. Electronic signatures are acceptable within federal requirements and when developed with the Member's agreement, when obtained over the phone (for non-LTSS Members). Refer to Attachment 11 [MOC Assessment (HRA) Individualized Care Plan (ICP) Requirements by Population].

5.4.3.1 ICPs for CCC Plus Waiver and EPSDT Populations

- 1) For CCC Plus Waiver Members who receive Private Duty Nursing Services, the Contractor shall ensure that the initial ICP is completed within thirty (30) calendar days of plan enrollment;

- 2) For CCC Plus Waiver Members who do not receive Private Duty Nursing Services, the Contractor shall ensure that the initial ICP is completed within sixty (60) calendar days of plan enrollment.

5.4.3.2 ICPs for Nursing Facility CCC Plus Populations

For those Members identified as part of the Nursing Facility population, the Contractor shall complete the initial ICP within one hundred twenty (120) calendar days of plan enrollment. Refer to Section 5.3.4.2 *Initial HRAs for Nursing Facility Populations*.

5.4.3.3 ICPs for High Risk Populations

For those Members identified as part of a high risk population, the Contractor shall complete the initial ICP within thirty (30) calendar days from completion of the MMHS. Refer to Section 5.3.4.3 *Initial HRAs for High Risk Populations*.

5.4.3.4 ICPs for Moderate Risk Populations

For those Members identified as part of a moderate risk population, the Contractor shall complete the initial ICP within sixty (60) calendar days from the completion of the MMHS. Refer to Section 5.3.4.4 *Initial HRAs for Moderate Risk Populations*.

5.4.3.5 Initial ICPs for Low Risk Populations

For those individuals who are Aged, Blind, or Disabled, are not in a Medicaid expansion aid category, and do not meet the moderate or high risk category, the Contractor shall ensure that ICPs are completed within ninety (90) calendar days of completion of the MMHS. Refer to Section 5.3.4.5 *Initial HRAs for Low Risk Populations*.

5.4.3.6 ICPs for Minimal Risk Populations

If an HRA is completed for a Member of the minimal risk population, the Contractor must complete the ICP at the same time the HRA is completed.

If a Member of the minimal risk population is re-categorized, the Contractor is responsible for completing the ICP within the required timeframes noted above. Refer to Section 5.3.4.6, *Initial HRAs for Minimal Risk Populations*.

5.4.4 ICP Review Completion Timeframes

Following completion of the initial ICP, the Contractor's Care Coordinator shall ensure the revised ICPs are conducted according to the following timeframes set forth below.

5.4.4.1 Revised ICP for CCC Plus Waiver and EPSDT Populations

- 1) For CCC Plus Waiver or EPSDT Members who receive Private Duty Nursing Services, the Contractor shall ensure that ICP revisions are completed face-to-face every six (6) months following the initial ICP,

- 2) For CCC Plus Waiver or EPSDT Members who do not receive Private Duty Nursing Services, the Contractor shall ensure that ICP revisions are completed face-to-face every six (6) months following the initial ICP.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4.4.2 Revised ICP for Nursing Facility CCC Plus Populations

For CCC Plus Members who reside in a nursing facility, the Contractor shall ensure that ICP revisions are completed face-to-face every six (6) months following the initial ICP.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4.4.3 Revised ICP for Other Vulnerable Populations

For CCC Plus Members who are categorized as “other vulnerable” populations for ongoing care coordination purposes, the Contractor shall ensure that ICP revisions are completed annually. The Contractor shall ensure that for those Members with SMI, the ICP revision is completed face-to-face. For those Members without SMI, the ICP revision may be done telephonically.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4.4.4 Revised ICP for Emerging Vulnerable Subpopulations

For CCC Plus Members who are categorized as “emerging vulnerable” populations for ongoing care coordination purposes, the Contractor shall ensure that ICP revisions are completed annually. The Contractor shall ensure that for those Members with SMI, the ICP revision is completed face-to-face. For those Members without SMI, the ICP revision may be done telephonically.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4.4.5 Revised ICP for Minimal Need Subpopulations

For individuals categorized as “minimal need” subpopulation, the Contractor shall not be required to ensure that an ICP or ICP revision is completed. An HRA, ICP, and required reassessments and revisions shall be completed if the Member is re-categorized.

Refer to Attachment 11, *Individualized Care Plan, HRA Reassessments, and Level of Care Reviews*.

5.4.4.6 Revised ICP for Triggering Events

The Contractor shall ensure that the revised ICP for each CCC Plus Member is conducted within thirty (30) days upon a triggering event such as a hospitalization or significant change in health or functional status (or as expeditiously as the Member’s condition requires).

5.5 INTERDISCIPLINARY CARE TEAM (ICT)

The Contractor shall arrange for each Member, in a manner that respects the needs and preferences of the Member, the formation and operation of an interdisciplinary care team (ICT). The Contractor shall ensure that each Member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention and social needs) is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to his/her licensure and relationship with the Member. The Member shall be encouraged to identify individuals that he/she would like to participate on the ICT. The ICT shall be person-centered, built on the Member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The Care Coordinator shall lead the ICT. For those who qualify as "minimal risk" as described in Section 5.3.4.6, *Initial HRAs for Minimal Risk Populations*, and therefore do not receive an HRA, the Contractor may but is not required to arrange an ICT as described in this section.

5.5.1 ICT Meeting Timeframes

The Contractor shall conduct initial ICT meetings within timeframes that are consistent with the Member's needs and ensure completion of the ICPs within the Department's contractual standards. At a minimum, the Contractor shall conduct initial ICT meetings within thirty (30) calendar days of completion of the HRA or no later than the next scheduled ICT in conjunction with the service provider, whichever is later. If a triggering event occurs before the nursing facility scheduled ICT, the Care Coordinator must schedule an ICT prior to the NF ICT.

5.5.1.1 ICT Completion Upon Triggering Events for Non-Nursing Facility Members and Non-ADHC Participants

The Care Coordinator shall complete an ICT for Non-Nursing Facility and Non-ADHC in the following circumstances:

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

5.5.2 Required ICT Members

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

- 1) Care Coordinator
- 2) PCP
- 3) Behavioral health clinician, if indicated
- 4) LTSS provider(s) when the Member is receiving LTSS

- 5) Targeted case manager, if applicable (if the Member is receiving TCM services, the Contractor shall include the targeted case manager on the Member's ICT.) TCM includes ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high risk prenatal and infant case management services.
- 6) Pharmacist, if indicated

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

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

5.5.3 ICT Documentation Requirements

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

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

5.6 REASSESSMENTS

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

5.6.1 Routine Re-Assessment Completion Timeframes

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

- 1) For Members residing in a NF, reassessments shall be completed at least every six (6) months, consistent with MDS guidelines;

- 2) For CCC Plus Waiver participants and Members receiving EPSDT Private Duty Nursing services reassessments shall be completed at least every six (6) months;
- 3) For Other Vulnerable and Emerging Vulnerable Members, reassessments shall be completed by the HRA anniversary, not to exceed 365 calendar days;
- 4) The Contractor is not required to complete an HRA for Minimal Risk Members or re-assessment for Minimal Need Members.

5.6.2 Reassessments Upon Triggering Events

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

- 1) Within thirty (30) days of the Member experiencing a triggering event such as a hospitalization or significant change in health or functional status (or as expeditiously as the Member's condition requires); and,
- 2) To determine changes in the Member's status and needs, utilizing a standardized re-assessment tool. The re-assessment tool must be approved by DMAS prior to implementation.

5.6.3 Annual LOC Review

The Contractor shall conduct an annual LOC review for Members enrolled in the CCC Plus Waiver within 365 days of the enrollment date or within 365 days of the last annual LOC review. See Section 4.7.2.3.1, *Level of Care (LOC) Reviews* of this Contract.

5.6.4 ICT Related to Reassessments

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

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

5.7 CARE COORDINATION STAFFING

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

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

reserves the right to train to the Contractor's care coordination staff in relation to the CCC Program requirements.

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

5.7.1 Care Coordinator Qualifications

The Contractor's Care Coordinators assigned to CCC Plus Members shall have at least a bachelor's degree in a [health or human services field](#) or be a Registered Nurse or Licensed Practical Nurse (LPN). All Care Coordinators shall have at least one year of experience directly working with individuals who meet the CCC Plus target population criteria. Licensed or Certified Care Coordinators must be licensed or certified in Virginia or hold a RN/LPN license with multi-state privilege recognized by Virginia in accordance with §54.1-3040.1 et. seq., of the *Code of Virginia*.

Members who have been determined to be unable to contact and are considered Minimal Need may be assigned to a Care Coordinator that does not meet the specified qualification above. Once the member is able to be contacted they shall be reassigned to a Care Coordinator that meets the minimum qualifications above within one week. CCC Plus Waiver and Nursing Facility Residents cannot be considered unable to be contacted. See Section 23.1, *Definitions* for the definition of "Unable to Contact (UTC) for the HRA".

Assignment of the Care Coordinator shall be based on the assessment of the Member's needs and condition, as well as the qualifications of the Care Coordinator. All Care Coordinators shall complete a comprehensive training curriculum that includes CCC Plus Members' various medical/behavioral health needs, including training in specialized areas (e.g., dementia, substance use disorders); person-centered, culturally competent care; and, standards of care. The Contractor's Care Coordinators shall also be trained and knowledgeable about the CCC Plus program and services described in the *CCC Plus Covered Services Chart*. Care Coordinators shall also be knowledgeable of involuntary psychiatric admissions related to emergency custody orders and temporary detention orders. Care coordination staff shall also be trained in providing assistance to Members in crisis. Care coordination staff shall have demonstrated ability to communicate with Members who have complex medical needs and who may have communication barriers.

For Members receiving Private Duty Nursing services, the Care Coordinator shall be a registered nurse who is licensed in Virginia or holds a RN license with multi-state privilege recognized by Virginia and has at least one year of related clinical nursing experience with medically complex Members dependent on life sustaining equipment.

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

5.7.2 Care Coordinator Supervisor

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

5.7.3 Use of Community Based Organizations or Subcontractors for Care Coordination Services

The Contractor may subcontract with Community Based Organizations (CBOs) including, but not limited to, Centers for Independent Living (CILs), Community Services Boards (CSBs), and Area Agencies on Aging (AAAs) for the provision of care coordination as long as the Contractor ensures that CBO care coordination staff and supervisors meet all contractual standards and Federal conflict of interest requirements particularly in the area of functional eligibility assessments. Administrative firewalls should exist to ensure that staff within the contracted CBOs who perform direct care services, such as personal care, are not the same staff who provide care coordination services. CMS and DMAS do not consider case management to be a direct care service and therefore, case managers are not prohibited from performing care coordination functions. Reference additional guidance provided by CMS at: <https://www.medicaid.gov/medicaid/hcbs/downloads/conflict-of-interest-in-medicaid-authorities-january-2016.pdf>. Also reference Section 5.8, *Care Coordination Partnerships* below.

5.7.4 Regional Dedicated Transition Care Coordinator

The Contractor shall have at least one (1) dedicated transition Care Coordinator in each region without a caseload (other than individuals in transition) to assist individuals with care transitions. Care transitions include transitioning individuals from NFs, hospitals, inpatient rehabilitation, or other institutional settings into the community, and assisting individuals who desire to remain in their community setting. Transition Care Coordinators shall meet the qualifications of a Care Coordinator as described in Section 5.7.1, *Care Coordinator Qualifications* above. Also reference Section 5.11, *Care Coordination with Transitions of Care*.

5.7.5 Formal Referral and Assistance Process for Homeless Members

The Contractor shall develop formal referral and assistance processes and procedures in its existing case management programs that identify homeless Members enrolled in the Contractor's managed care program and provide them with information and referrals to local shelters and other community based homeless aid programs services provided in every region of the state. The Contractor shall submit a report to DMAS within one hundred twenty (120) days of the effective date of this Contract and annually, that identifies these community based homeless support services by city/county, details of the formal referral relationships established, and how the Contractor will make face-to-face contact with its homeless Members. Refer to the *CCC Plus Technical Manual*.

5.8 CARE COORDINATION PARTNERSHIPS

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

5.9 CARE COORDINATOR STAFFING RATIOS

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

CCC Plus Care Coordination Staffing Ratios by Population				
CCC Plus Waiver Subpopulation	Nursing Facility Subpopulation	Other Vulnerable Subpopulation	Emerging Vulnerable Subpopulation	Minimal Need Subpopulation
1:75	1:200	1:150	1:400	1:1,000
See Section 5.1.1 and Section 23.1 for definitions of “Other Vulnerable Subpopulation,” “Emerging Vulnerable Subpopulation,” and “Minimal Need Subpopulation.”				

Care Coordinators may have a “blended” caseload, comprised of Members in more than one subpopulation to meet business operational needs or provide continuity of care for Members as long as the standard ratio thresholds are met. For Technology Assisted or Benefit Level A populations, to reach the standard threshold, special consideration should be given to blend the caseload with comparable subpopulations to allow for optimal availability of the Care Coordinator. For example Care Coordinator A is assigned CCC Plus Waiver Members, residing in NF, and other emerging vulnerable populations. The Contractor must identify the FTE percentage the Care Coordinator works, and must provide the FTE percentage allocated to CCC Plus Waiver Members, residing in NF, and other emerging vulnerable subpopulation Members. If the Care Coordinator is allocated 30% time for CCC Plus Waiver Members, 30% time for NF Members, and 40% time for other emerging vulnerable population Members, the Care Coordinator must have no more than 22 CCC Plus Waiver Members, 60 NF, and 160 other

Members with emerging vulnerables. Caseloads must be adjusted according to employment status of full or part-time hours per week i.e. a .5 staff position would equate to .5 of the standard ratio. Multiple percentage split variations may occur to make up a total 100% caseload among various populations but the case assignments must not exceed the total combined established ratio.

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

5.9.1 Ongoing Care Coordination – CCC Plus Waiver Subpopulation

The CCC Plus Waiver Subpopulation includes Members in the CCC Plus Waiver including Technology Assisted and Standard levels of care. Refer to Section 5.1.1(a), *CCC Plus Vulnerable and Emerging Vulnerable Populations*. All individuals will require an HRA reassessment to be completed by the Contractor in accordance with the reassessment timeframes defined in Section 5.6.1, *Routine Re-assessment Completion Timeframes*.

5.9.2 Ongoing Care Coordination – Nursing Facility Subpopulation

The Nursing Facility Subpopulation includes Members in Nursing Facilities and in Specialized Care and Long-Stay Hospital. Refer to Section 5.1.1(b), *CCC Plus Vulnerable and Emerging Vulnerable Populations*. All individuals will require an HRA reassessment to be completed by the Contractor in accordance with the reassessment timeframes defined in Section 5.6.1, *Routine Re-assessment Completion Timeframes*.

5.9.3 Ongoing Care Coordination – Other Vulnerable Subpopulation

The Other Vulnerable Subpopulation includes:

- 1) Individuals with Serious Mental Illness (SMI), including all former GAP enrollees.
- 2) Individuals (duals and non-duals) with complex or multiple conditions as identified in Section 5.1.1 a-1, who are identified by the plan or self-identified as having conditions that are not well managed based on the criteria listed in Section 5.3.4.3, *Initial HRAs for High Risk Populations* e.g. multiple ED visits, multiple inpatient admits, have a lack of medication adherence, etc. All individuals will require an HRA reassessment to be completed by the Contractor in accordance with the reassessment timeframes defined in Section 5.6.1, *Routine Re-assessment Completion Timeframes*. See Section 23.1 *Definitions* for “Other Vulnerable Subpopulation”.

5.9.4 Ongoing Care Coordination – Emerging Vulnerable Subpopulation

The Emerging Vulnerable Subpopulation includes all individuals (duals and non-duals) who do not meet the criteria for any other subpopulation. The Emerging Vulnerable Subpopulation

includes populations (duals and non-duals) with complex or multiple conditions, as defined in Section 5.1.1, a-m, *CCC Plus Vulnerable and Emerging Vulnerable Populations* who are well managed. All individuals will require an HRA reassessment to be completed by the Contractor in accordance with the reassessment timeframes defined in Section 5.6.1, *Routine Re-assessment Completion Timeframes*. See Section 23.1, *Definitions* for “Minimal Need Subpopulations”.

5.9.5 Ongoing Care Coordination – Minimal Need Subpopulation

A Member is considered minimal need if he or she meets all of the following criteria:

- 1) Is a CCC Plus ABD or expansion Member;
- 2) Is not a CCC Plus Waiver or Nursing Facility Member;
- 3) Is an Other Vulnerable or Emerging Vulnerable population Member who is unable to be contacted by the Contractor to conduct the HRA reassessment.

All individuals will require an HRA reassessment to be completed by the Contractor in accordance with the reassessment timeframes defined in Section 5.6.1, *Routine Re-assessment Completion Timeframes*. See Section 23.1, *Definitions* for “Minimal Need Populations”.

5.10 CARE COORDINATION REQUIREMENTS

5.10.1 Care Coordination

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

The Member shall be assigned a Care Coordinator on or before the Member’s enrollment effective date. The Contractor shall send a notice to the Member within 14 days of enrollment providing the name and contact information for their assigned Care Coordinator. Upon request by the Department, the Contractor shall provide the name and contact number of the Care Coordinator assigned to a particular Member.

In addition, Care Coordinators shall:

- 1) Meet face-to-face requirements as outlined in this Contract.
- 2) Act as the primary point of contact for Members and the Interdisciplinary Care Team (ICT).
- 3) Ensure that Members have access (e.g., a telephone number, e-mail address) to their Care Coordinator.
- 4) Engage Members in care coordination activities.

- 5) Communicate with Members about their ongoing or newly identified needs on at least a quarterly basis for the CCC Plus, Nursing Facility and Minimal Need subpopulations and at least every six (6) months for the Other Vulnerable and Emerging Vulnerable populations (or a frequency as requested by the Member), to include a phone call or face-to-face meeting, depending on the Member's needs and preferences. For Members in nursing facilities or receiving HCBS Waiver services, contact with Members shall be at a frequency of at least every ninety (90) calendar days, even if the Member requests less frequent contact.
- 6) Notify Members if there is a change in their assigned Care Coordinators.
- 7) When possible, ensure continuity of care when Care Coordinator changes are made whether initiated by the Member or by the Contractor.

As the leader of ICTs, Care Coordinators must execute the following responsibilities:

- 1) Participate in HRAs for care planning;
- 2) Ensure that ICT meetings and conference calls are held periodically;
- 3) Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and facilitating referrals for the Member;
- 4) Ensure the ICP is developed updated as necessary;
- 5) Ensure that appropriate mechanisms are in place to receive Member input, complaints and grievances, and secure communication among relevant parties;
- 6) Incorporate but not duplicate Targeted Case Management (TCM) for applicable Members; and
- 7) Solicit and comply with the Member's wishes (e.g., advance directive about wishes for future treatment and health care decisions, prioritization of needs and implementation of strategies, etc.).

5.10.2 Enhanced Care Coordination for Other Vulnerable Subpopulations

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

Enhanced Care Coordination for these Members includes:

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

Coordinator shall ensure that services are transitioned to non- early intervention providers (PT, OT, speech, etc.);

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

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

5.11 CARE COORDINATION WITH TRANSITIONS OF CARE

5.11.1 Regional Transition Care Coordinator Roles and Responsibilities

5.11.1.1 Transition from Nursing Facility to the Community

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

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

5.11.1.2 Transition between Levels of Care

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

- 1) Participate in discharge planning for Members transitioning from acute institutional settings to lower levels of care, including Long Stay Hospitals, Nursing Facilities, and the community. Single, non-recurrent (within 30 calendar days) medical stays of two nights

or less do not require the participation of the Transition Care Coordinator unless indicated by the Member's needs and circumstances;

- 2) Coordinate with the assigned Care Coordinator in discharge planning activities to ensure a safe transition that meets the Member's needs and preferences;
- 3) Coordinate with Utilization Management staff, as indicated regarding discharge planning;
- 4) Coordinate with Nursing Facility staff, the Member's assigned Care Coordinator, and the Member when it is identified that the Member wishes to transition from NF care to the community;
- 5) Provide support to Care Coordinators to maintain Members in the community in lieu of transitioning to institutional settings, as needed; and,
- 6) For Dual eligible Members enrolled in a DSNP, the Regional Transition Coordinator shall also work with the DSNP Care Coordinator upon approval of the Member, to coordinate the above activities.

5.11.2 Transition Coordinator and Care Coordinator Activities

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

- 1) Work closely with the Transition Coordinator to ensure the Member's needs and preferences are met;
- 2) Ensure the completion of the reassessment and updating the ICP for triggering events, to include detailed care coordination interventions and strategies to provide seamless transitions and avoid delays in services and supports
- 3) Upon notification of a hospital or nursing facility admission or discharge, work closely with the Transition Care Coordinator to ensure that communication of the hospital or nursing facility admission or discharge will be conveyed to the PCP and community based providers within 24 hours;
- 4) Upon notification of a hospital admission or discharge, communicate with providers of waiver services that an admission has occurred immediately upon notification of admission and as soon as a tentative discharge date is known;
- 5) Ensure that admissions and lengths of stay are appropriate to the Member's needs;
- 6) Ensure that there is timely and adequate discharge planning and medication reconciliation;
- 7) Work to reduce the need for hospital transfers and emergency room use;
- 8) Use HRA information and work with nursing facility staff (including obtaining MDS Section Q data), hospital staff, community care providers, screening teams, and the state Long-Term Care Ombudsman to facilitate transitions to the community. This includes utilizing local contact agencies in order to facilitate transitions and linking with other community resources that provide support (including housing and employment options) to individuals and their families/caregivers, such as CILs, CSBs, and local AAAs;
- 9) Ensure services are provided in the least restrictive environment;
- 10) Utilize community resources and work with staff (e.g., community LTSS providers, hospital staff, and the state Long-Term Care Ombudsman) to facilitate transitions when Members need a higher level of care (e.g., an emerging vulnerable Member needs to transition to LTSS). This includes when the need for the transition to a higher level of care is communicated to internal staff and to the Members or families/caregivers how

individuals are referred to community resources in order to facilitate transitions. Transitions include linking with other community resources that provide support to individuals and their families/caregivers, such as CILs, CSBs, and local AAAs. This also includes necessary referrals for screening activities being completed prior to transition when required;

- 11) Utilize and partner with community resources (e.g. CILs, CSBs, AAAs, etc.) and works with staff to facilitate transitions when a Member transitions to a lower or less restrictive level of care (e.g., a NF Member wishes to transition to the community, a Member in inpatient hospital (medical or psychiatric) transfers to a NF or the community, a CCC Plus Waiver Member no longer meets NF criteria, etc.). The description shall include strategies to be put in place to ensure successful and seamless transitions. It shall also include a description of how the Contractor will ensure necessary screening activities are completed prior to transition when required;
- 12) Ensure the ICT is scheduled and held as required;
- 13) For dual-eligible Members, coordinate with the DSNP Care Coordinator upon the approval of the Member, when the Member is enrolled in a DSNP;
- 14) Provide education to Members, authorized representatives, family/caregivers, and providers regarding importance of notification of inpatient admissions in order to effectuate successful transitions;
- 15) Provide outreach to providers of Medicare services regarding the role of the Care Coordinator related to transitions of care and the model of care; and,
- 16) Coordinate with providers of inpatient services to incorporate transition needs as identified above, into the ICP.

5.11.3 Discharge Planning Interventions

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

- 1) Identification and assignment of a facility based Care Coordinator for the Member if different than the community Care Coordinator for planned transitions to a NF. This Care Coordinator shall be involved in the establishment and implementation of treatment and discharge planning;
- 2) Notification and participation of the Member's ICT in discharge planning, coordination, and re-assessment as needed;
- 3) Identification of non-clinical supports and the role they serve in the Member's treatment and after care plans;
- 4) Assistance with scheduling of discharge/aftercare appointments in accordance with the access and availability standards;
- 5) Identification of barriers to aftercare, and the strategies developed to address such barriers;
- 6) Assurance that the appropriate behavioral health providers provide a discharge plan following any behavioral health admission to ICT Members;
- 7) Activities that ensure that Members who require medication monitoring will have access to such services within fourteen (14) calendar days of discharge from a behavioral health inpatient setting or as medically advised;
- 8) Best efforts to ensure a smooth transition to the next service or to the community, and
- 9) Documentation of all efforts related to these activities, including the Member's active participation in discharge planning; and,

10) Within the continuity of care provisions described in Section 5.15, *Continuity of Care*.

5.12 VIRGINIA EMERGENCY DEPARTMENT CARE COORDINATION PROGRAM

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

The Contractor shall participate in the statewide program as required by state law for Medicaid health plans by June 30, 2018 when the technology solution is required to be implemented. Participation will require the Contractor to sign the ConnectVirginia Exchange Trust Agreement.

The Contractor shall work with DMAS and hospital and physician representatives on any workgroup established by DMAS, VDH, and/or ConnectVirginia to develop shared care coordination models to leverage this new statewide technology solution to improve outcomes for high risk and high cost CCC Plus Members with high utilization of EDs or other high need, priority populations.

The Contractor shall describe activities supporting appropriate utilization of hospital emergency room services, to include incentives the Contractor provides for primary care practices that provide night and weekend hours and same-day appointments, and advanced levels of care management for those exhibiting high utilization of emergency services; and use of the ED Care Coordination encounter alerts and care coordination plans by MCO Care Coordinators to identify frequent ED utilizers and address their needs. Refer to the *CCC Plus Technical Manual*.

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

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

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

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

For services provided to dual eligible Members by a Federally Qualified Health Center (FQHC), the Contractor shall pay the full copayment and deductible that DMAS would pay. The Medicaid allowed amount for FQHCs and RHCs is equal to the Medicare allowed amount.

Refer to Attachment 14 (July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo) and Attachment 15 (MCO COB Resource Chart) for the Department's expectations during the coordination of benefits process.

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

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

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

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

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

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

1. Train network providers on available D-SNP and CCC Plus program benefits and services as requested by provider and/or provider associations.
2. Establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CCC Plus Members, that Care Coordinators are notified/engaged as appropriate.
3. Maintain daily reports for audit to determine appropriate and timely engagement in discharge planning.
4. Coordinate with a Member's D-SNP or MA Plan or other primary MCO regarding CCC Plus program services that may be needed by the Member; however, the D-SNP or MA Plan or primary MCO carrier shall remain responsible for ensuring access to all benefits covered by the Member's primary payer, including nursing facilities and home health,

and shall not supplant such medically necessary covered services with services available only through the CCC Plus program.

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

5.14 CLINICAL WORKGROUP MEETINGS

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

5.15 CONTINUITY OF CARE

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

In accordance with 42 CFR § 438.62, the Contractor's strategic processes shall include: the Contractor's compliance with requests for historical utilization data when the Member is enrolled in a new MCO; the ability for the Member to retain the access to services consistent with the access they previously had and is permitted to retain their current provider during the continuity of care period (refer to Section 5.15.1, *General Provisions*) if that provider is not in the network; the Contractor refers the Member to appropriate providers of service that are in the network; and, the Member's new providers are able to obtain copies of the Member's medical records.

The Contractor must have systems and operational processes in place for sharing data to/from DMAS, reviewing the data for potential high risk Member needs, and utilizing the data to support the transition process. Transition data shall include but not be limited to Member's claims and service authorizations. The process shall require the Contractor to, at a minimum:

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

5.15.1 General Provisions

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

The continuity of care period is as follows: Within the first thirty (30) calendar days of a Member's enrollment, the Contractor shall allow a Member to maintain his or her current providers (including out-of-network providers). The Contractor shall extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the Contractor or the Member's safe and effective transition to a contracted provider. The Department has sole discretion to extend the continuity of care period time frame.

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

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

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

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

5.15.2 Members With Service Authorizations (SA)

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

If the authorized service is an inpatient stay, the financial responsibility shall be allocated as follows: For per diem provider contracts, reimbursement will be shared between the Contractor and either the Department or the new MCO. In the absence of a written agreement otherwise, the Contractor and the Department or the new MCO shall each pay for the period during which the Member is enrolled with the entity. For DRG provider contracts, in accordance with the Section 3.2.4, *Enrollment Process for Individuals Hospitalized at Time of Enrollment*, the Contractor is responsible to pay for the full inpatient hospitalization (admission to discharge), including for any Member actively enrolled in the MCO on the date of admission, regardless of the Members' disenrollment from the MCO during the course of the inpatient hospitalization.

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

5.15.3 Members In Nursing Facilities

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

If an individual residing in a continuing care retirement facility becomes eligible for CCC Plus and subsequently qualifies for nursing facility level of care, the Contractor shall make every reasonable effort to contract with the NF provider at rates equitable to other contracted Nursing Facilities, or reimburse the NF at the fee-for-service rate for this Member. The continuing care nursing facility must accept the agreed upon reimbursement as payment in full for this provider. If the provider refuses to contract with the Contractor or accept the fee-for-service rate, only then may the Contractor move the Member to a network facility.

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

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

In the event of a NF closure, or as necessary to protect the health and safety of residents, the Contractor shall arrange for the safe and orderly transfer of all Members and their personal effects to another facility. In addition to any notices provided by the facility, the Contractor shall provide timely written notice inclusive of the required elements in 42 CFR § 483.75 (r) and work cooperatively with the Department for Aging and Rehabilitation, including the local Departments of Social Services, the Long Term Care Ombudsman and other state agencies in arranging the safe relocation of residents. The Contractor's Care Coordinator shall coordinate the relocation plan and act as a resource manager to other agencies and as a central point of contact for Member relocations.

5.15.4 Members Who Transition Between Contractors

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

5.15.5 Medicaid Expansion Population

The Contractor shall provide a continuity of care period of thirty (30) days for new populations such as the Medicaid expansion populations, including those receiving services with out of network providers in accordance with the requirements in this Contract.

The Medicaid expansion population shall maintain their MCO enrollment when they transition between the CCC Plus Program and the Medallion 4.0 program without being enrolled in Fee-For-Service Medicaid. As described in Section 5.15.1, *General Provisions*, continuity of care for transitions between Fee-For-Service and MCO's or between MCO's is thirty (30) days.

The Contractor must honor any Fee-For-Service authorizations, including those for the GAP population transitioning on January 1, 2019 (as described in *GAP Transition Special Provisions*), and other populations who will have Fee-For-Service coverage briefly before enrolling in the Contractor.

5.15.6 Services for Justice Involved Members

The Contractor shall collaborate with the Department to develop policies and procedures for the screening and provision of care for Medicaid Members who have been identified as recently released from a correctional facility or local/regional jail. These policies and procedures should address the following: 1) assisting the Member with accessing care and/or community supports as needed; 2) partnering with community resources to facilitate referral networks; and 3) developing reports that include methods for identifying and removing barriers to care and addressing additional needs expressed by the Member. Plans, policies, and procedures will be submitted annually to DMAS for approval according to specifications in the *CCC Plus Technical Manual*.

5.16 CARE DELIVERY MODEL POLICY AND PROCEDURES

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

5.16.1 Model of Care

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

5.16.2 HRA and Reassessments

The Contractor shall submit its HRA policies and procedures and HRA tool to the Department for approval prior to implementation, at revision, or upon request. The Contractor shall also include its policies and procedures related to the reassessment tool and the reassessment tool (if different than the HRA) that will be used to identify the specialized needs of its Members upon a triggering event and at specified timeframes. The Contractor's HRA and reassessment processes and tools shall describe all of the following required elements.

- 1) The identification strategy, including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information that are used to prioritize the timeframes for when and how initial HRAs and reassessments and annual ICP reviews are conducted for each Member (e.g., initial assessment upon enrollment, reassessments and ICP reviews within prescribed timeframe of last assessment; conducted by phone interview (for the emerging vulnerable population), face-to-face, written form completed by Member, etc.).
- 2) When the stratification is conducted (e.g., how far in advance of effective date).
- 3) How the results of the HRAs are used to confirm the appropriate stratification level.
- 4) The personnel who review, analyze, and stratify health care needs (e.g., professionally knowledgeable and credentialed such as physicians, nurses, restorative therapist, pharmacist, psychologist, etc.).
- 5) How the Contractor involves Members, authorized representatives, family Members and caregivers in the HRA process, including the Contractor's efforts to obtain documentation, including signatures, to signify that Members, authorized representatives, and family Members and caregivers understand and consent to the HRA process.

- 6) Describes efforts the Contractor will use for completing the HRAs for the different populations, including Members residing in nursing facilities, Members enrolled in the waivers, and best efforts for the community well population.
- 7) A description of triggering events and the reassessment process.

5.16.3 MCO Member Health Screening (MMHS)

The Contractor shall submit its MMHS policies and procedures to the Department for approval within ninety (90) days of the effective date of this contract and, upon revision, or upon request. The Contractor's MMHS policies and procedures shall describe all of the following required elements:

- 1) The identification strategy, administrative claims data when available, and other sources of information that are used to prioritize the timeframes for when and how initial MMHS's are conducted for each Member.
- 2) When the stratification is conducted.
- 3) The qualifications of the personnel conducting the MMHS.
- 4) How the Contractor determines if Members, are capable of participating in the MMHS process and how authorized representatives, family Members and caregivers are involved in the MMHS process when appropriate.
- 5) How the Contractor will provide Communication/Interpreter Services as described in *Communication / Interpreter Assistance*.

Refer to the *CCC Plus Technical Manual*.

5.16.4 ICP

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

- 1) The method of stratification, the person centered and culturally competent ICP development process, and how the ICP development process will incorporate and not duplicate Targeted Case Management (if applicable).
- 2) How the Contractor will ensure the Member and family/preferred support system is engaged in the initial and ongoing development of their ICP and receives any assistance and accommodations to prepare for and fully participate in the care planning process and ICP development.
- 3) How the Care Coordinator will obtain the Member's signature on the initial ICP and any subsequent updates and revisions by the ICT or during other contacts with the Member.
- 4) How the ICT will be involved in the ICP ongoing development and how the Care Coordinator leads the development of the comprehensive, person-centered, culturally competent, individualized ICP that is tailored to the Member's needs and preferences.
- 5) The personnel who review the person-centered ICP and how frequently the ICP is reviewed and revised (e.g., initially developed by the Member and Care Coordinator and reviewed/revised by the ICT, including the Member and family/preferred support system

whenever feasible, and other pertinent specialists required by the Member's health needs; reviewed and revised at least annually and as otherwise required, etc.).

- 6) How the person-centered ICP is documented and where the documentation is maintained (e.g., accessible to interdisciplinary team, provider network, and Member either in original form or copies; maintained in accordance with industry practices such as preserved from destruction, secured for privacy and confidentiality, etc.).
- 7) How services included during the continuity of care period are incorporated into the ICP and how Medically Necessary services will be continued after the continuity of care period is over.
- 8) Assurances that the Contractor shall explain the service authorization process to the Member and that there may be a change in the services provided based upon the HRA completion.
- 9) How information from the UAI, when available, will be incorporated into the ICP for individuals in the CCC Plus Waiver.
- 10) How information from the MMHS will be incorporated in the ICP.
- 11) The Contractor's process for obtaining nursing facility MDS data and how it will be incorporated into the ICP.
- 12) How the Contractor will incorporate and leverage external existing plans of care (e.g. NF, Personal Care, ADHC, TCM, etc.)
- 13) How the ICP is developed, maintained, and monitored to ensure all treatment needs are met and that all changes and updates are reflected accurately and timely.

5.16.5 ICT

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

- 1) The method used to facilitate the participation of the Member, the Member's authorized representative, and other required participants whenever feasible.
- 2) How the Contractor will accommodate the Member's needs and preferences related to location of ICT meetings (e.g., in the home/facility for LTSS Members, transportation to other locations, etc.).
- 3) How the Contractor will coordinate with other existing ICT meetings, including but not limited to, those held in NFs, ADHC, CSB, etc. Include provider outreach and education regarding ICT requirements and expectations.
- 4) How the scheduled ICTs will operate, document, and communicate (e.g., frequency of meetings, process for documenting proceedings in a Member's medical records and retention of records, notifications and invitations about ICT meetings, dissemination of ICT reports to all ICT participants and invitees, etc.).
- 5) Description of the advanced notice that will be provided to the Member and other required attendees in order to maximize participation (for planned ICT meetings, notice must be provided at least one (1) week in advance) and how documentation will be maintained if an invitee cannot attend.
- 6) Description of how the ICT will solicit input from required participants who are unable to participate in the ICT meeting and how these participants will be informed of information discussed and outcomes of the ICT meeting.
- 7) The communication mechanism the Contractor institutes to notify the ICT, provider network, Members, etc. about the HRA and stratification results (e.g., written notification, secure electronic record, etc.).

- 8) Description how the provider network coordinates with the ICT and the Member to deliver specialized services (e.g., how care needs are communicated to all stakeholders, which personnel assures follow-up is scheduled and performed, how it assures that specialized services are delivered to the Member in a timely and quality way, how reports on services delivered are shared with the Contractor and ICT for maintenance of a complete Member record and incorporation into the care plan, how services are delivered across care settings and providers, etc.).
- 9) How the ICT process will be used to empower and support the ICT in proactively recognizing signs of emerging issues (e.g., depression, fall risk, etc.) and mechanism for follow-up on identified risks.
- 10) Description how the ICT process will interface with the ongoing development of a comprehensive ICP.

5.16.6 Care Coordination Partnerships

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

5.16.7 Care Coordination

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

- 1) How all Members shall have access to the following supports: (i) a single, toll-free point of contact for assistance; (ii) assurance that referrals result in timely appointments; (iii) communication and education regarding available services and community resources in a mode and manner that is culturally, developmentally appropriate and that considers the Member's physical and cognitive abilities and level of literacy; and, (iv) assistance with developing self-management skills to effectively access and use services.
- 2) How Members are notified of the name of their assigned Care Coordinators and how to contact them.
- 3) In addition to the required HRAs, re-assessments, ICTs, and ICPs, the policy and procedures shall describe how Care Coordinators will work with all Members to ensure their ongoing care coordination needs are identified and met, using a person-centered planning approach. The policy and procedures must also describe how the Contractor will incorporate chronic condition management and disease management into the care coordination approach for all Members. The Contractor shall design programs to proactively provide the support needed to maintain current health status and avoid functional decline.
- 4) If the Care Coordinator is not available to the Member, how the Care Coordinator shall be notified by the next business day of any issues/changes/concerns of the Member (this includes contacts from the Member or the Member's authorized representative or caregiver made through a Member support line, 24-hour clinical triage line that offers

nurse advice and behavioral health crisis response. Should the Care Coordinator not be available for an extended period of time, back-up coverage shall be identified and made available by the Contractor's staff.

- 5) How the Care Coordinator is made aware of grievances and appeals filed by Members or by providers (when providers file an appeal based on a denial of service)
- 6) How the Contractor will ensure continuity of care when Care Coordinator changes are made whether initiated by the Member or by the Contractor.
- 7) How providers, including nursing facilities, are notified of the name and contact information of their clients' or residents' assigned Care Coordinators and any changes to this assignment.
- 8) Describe strategies to: (1) outreach to and engage Members who are hard to contact/locate (e.g., incorrect address information, missing or incorrect phone number, Members who are homeless); and (2) re-engage Members who previously refused to engage in care coordination activities.
- 9) Members enrolled in a Waiver or residing in a NF shall not be classified as "Unable to Contact" (UTC) for reporting and care coordination purposes until after documented attempts to engage existing LTSS service providers (prior providers if not currently receiving services) in attempts to reach the Member. Detailed documentation must be maintained regarding provider contacts.
- 10) Describe the strategies the Contractor shall use to document attempted contacts. "Robocalls" or automated telephone calls that deliver recorded messages will not be an acceptable form of contacting Members. Upon request, the Contractor shall provide DMAS with detailed documentation of efforts taken (dates, times, type of attempts made, etc.) to reach specific Members and with an explanation of the reason why they were unable to successfully reach Members and complete contract deliverables (including HRAs, ICPs, etc.).
- 11) Describe strategies the Contractor shall use to assist Members who are determined to have high risk behaviors. Safety plans for Members and Contractor staff shall be included in the Contractor's policies and procedures.
- 12) How training of Care Coordinators is confirmed and verifying that training or any certifications remain current. Training shall include the process for involuntary admissions.
- 13) Describe how the Contractor will address non-compliance with training by Care Coordinators.
- 14) Annually, at the Department's request, prior to implementation, or if revised, the Contractor shall identify the types of training, including the frequency and modes of training the Contractor will provide to its Care Coordinators.

5.16.8 Enhanced Care Coordination

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

- 1) The identification strategy, including predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information that are used to identify Members meeting criteria for enhanced care coordination.
- 2) How the ICP will be developed and how the ICT will engage the Member to provide enhanced care coordination.
- 3) The Contractor shall have documented procedures to ensure the interface with the BHSA is conducive to open communication and collaboration in the best interest of the Member's integrated care needs,
- 4) The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures on discharge planning. The Contractor shall implement policies and procedures that (1) ensure timely and effective treatment and discharge planning; (2) establish the associated documentation standards; (3) involve the Member; and (4) begin on the day of admission.
- 5) The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures for its care transition programs. The policy and procedures should include partnerships with community-based organizations, the metrics used to measure outcomes associated with transitions (e.g., hospital re-admission rates), and outcomes data. The Contractor's policies and procedures shall describe the processes, systems, and goals.

5.16.9 Care Coordination and Transitions of Care

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

5.16.10 Coordination with Member's Medicare Plan

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

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

5.16.11 Continuity of Care Policy and Procedures

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

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

SECTION 6.0 UTILIZATION MANAGEMENT REQUIREMENTS

6.1 GENERAL UTILIZATION MANAGEMENT REQUIREMENTS

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

At initial contract, annually, upon revision (if any) and upon request, the Contractor shall submit all applicable policies and procedures to the Department for review and approval regarding its utilization management (UM) program. The policies and procedures shall include procedures to evaluate medical necessity, criteria used, information source, and the process used to review and approve or deny the provision of services. In accordance with 42 CFR § 438.210, the Contractor's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting provider when appropriate.

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

6.2 SERVICE AUTHORIZATION

The Contractor shall authorize, arrange, coordinate, and provide to Members all medically necessary covered services as specified in this Contract in accordance with amount, duration, and scope of coverage rules described in the Attached *CCC Plus Coverage Chart*.

The Contractor shall ensure that its utilization management policies and procedures meet NCQA standards. In accordance with UM 4: Factor 2, the Contractor shall use licensed health care professionals to make UM decisions. For Behavioral Health Services, including Community Mental Health Rehabilitation Services (CMHRS), a clinical interpretation and clinical judgement from a mental health professional is required for service authorization approvals or denials. The

Contractor may employ UM reviewers of behavioral health services and CMHRS who are licensed health care professionals in a state other than Virginia, however those individuals must be licensed in a state in the United States, the license must be in good standing, and he/she must report to a mental health professional who is licensed in Virginia. See Section 23.1, *Definitions* for the definition of Mental Health Professional.

For ARTS, see Section 4.2.4.1.2, *Appropriate Standards of Care*.

6.2.1 Service Authorization Policy and Procedures

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

6.2.2 Medical Necessity Criteria

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

The Contractor's medical necessity criteria shall not be more restrictive than the Medicaid FFS Medicaid program criteria, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy manuals. For ARTS, reference Section 4.2.4.1, *Critical Elements of the Contractor's ARTS System of Care*.

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

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

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

The Contractor shall ensure that coverage decisions are based upon medical necessity and are in accordance with 42 CFR § 438.210.

- 1) The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member.
- 2) The Contractor may place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.

- 3) The Contractor shall ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the Member's ongoing need for such services and supports and considers the Member's functional limitations by providing services and supports to promote independence and enhance the Member's ability to live in the community;
- 4) The Contractor shall ensure that coverage decisions for family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.
- 5) The Contractor shall ensure that services are authorized in a manner that supports:
 - a. the prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder, health impairments and/or disability,
 - b. ability for a Member to achieve age-appropriate growth and development,
 - c. ability for a Member to attain, maintain, or regain functional capacity,
 - d. in the case of EPSDT, correct, maintain or ameliorate a condition.
 - e. opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

6.2.3 Members with Service Authorizations (SA)

The Contractor (the Member's current MCO) shall assume responsibility for all managed care contract covered services and shall honor authorizations by either the Department or a previous MCO, which are rendered after the enrollment effective date, in accordance with provisions described in this Contract. No service (including CCC Plus Waiver services) can be reduced during the continuity of care period of a Member's enrollment with the Contractor. The Contractor shall honor SAs issued by the Department or its Contractors as provided through DMAS transition reports and DMAS' contracted entities for the duration of the Service Authorization or during the continuity of care period, whichever comes first. If the authorization ends before the initial HRA is completed, the continuity of care period continues until after the HRA is completed and a new person-centered Individualized Care Plan has been implemented. Reference the Section 5.15, *Continuity of Care* of this Contract.

6.2.4 EPSDT Provisions for Service Authorizations

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

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

6.2.5 Behavioral Health Services

6.2.5.1 Traditional Behavioral Health Services

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

6.2.5.2 Community Mental Health Rehabilitation Services

The Contractor shall follow the service authorization or registration requirements in accordance with the CMHRS authorizations grid. “Register” or “Registration” means the provider notifying the Contractor that an individual will be receiving services that do not require service authorization. Discretion with the utilization management requirements described below is allowed by the Contractor with DMAS approval, per provider payment related provisions in Section 12.4.2, *Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS, and Early Intervention* and value based payment provisions described in Section 13.5, *DMAS Approval of VBP for Certain Services*.

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

6.2.6 LTSS

The Contractor’s authorization process for LTSS shall be based on a Member's current needs assessment and consistent with the Member’s person-centered service plan. Coverage decisions for LTSS shall be provided in a manner that supports a participant in their ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The

Contractor shall cover appropriate LTSS based on needs identified through the initial LTSS Screening Instrument, other comprehensive assessments, and subsequent level of care reviews.

The Contractor has the discretion to authorize LTSS more broadly in terms of criteria, amount, duration and scope, if the ICP determines that such authorization would provide sufficient value to the Member's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Member in the least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS.

6.2.7 Emergency and Family Planning Services

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

6.2.8 Early Intervention Services

Service authorizations shall not be required for Early Intervention Services. The Contractor shall not deny the EI services authorized in the IFSP, unless the child does not meet EI criteria or the billing provider is not a certified EI provider. Reference Section 4.5, *Early Intervention (EI) for additional information*.

6.2.9 Pharmacy Utilization Management

Reference Section 4.8.5, *Utilization Management For Pharmacy Services*.

6.2.10 Service Authorization Timeframes

6.2.10.1 Standard Authorization

Beginning February 1, 2020, for standard authorization decisions, the Contractor shall, unless otherwise specified in this contract (i.e., ARTS or Pharmacy specifics requirements), provide written notice as expeditiously as the Member's 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 State agency upon request) that the need for additional information is in the Member's interest.

A service authorization is not required for hospice services, however the Contractor shall enter hospice admissions and discharges into the Virginia Medicaid Web Portal no later than two (2) business days of notification of admission/discharge. Refer to Section 4.7.9.2, *Hospice* of this Contract.

6.2.10.2 Expedited Authorization Decision Timeframe

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

days if the Member requests an extension, or if the Contractor justifies (to the State agency upon request) that the need for additional information is in the Member's interest.

6.2.10.3 Extending Timeframe for Service Authorization Decision

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

- Give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and,
- Issue and carry out its determination as expeditiously as the Member’s health condition requires and no later than the date the extension expires.

6.2.10.4 NCQA Service Authorization Standards

Beginning February 1, 2020, the Contractor shall ensure that its service authorization policies and procedures meet NCQA standards. The Contractor is responsible for determining the classification (i.e., urgent versus non-urgent) and type (i.e., concurrent versus preservice). This however does not preclude a provider from indicating the need for an expedited review as described in 6.2.10.2 Expedited Authorization Decision Timeframe and 42 CFR § 438.210(d)(2).

There will be no extensions to the timeframes below due to weekends or holidays.

Current NCQA service authorization timeliness standards are as follows:

Physical/Non-behavioral Health			
Classification	Type	Timeliness	Extension
Urgent	Concurrent	72 hours (3 calendar days)	14 calendar days
	Preservice	72 hours (3 calendar days)	14 calendar days
Non-urgent	Preservice	14 calendar days	14 calendar days
PostsERVICE	N/A	30 calendar days	14 calendar days
Behavioral Health			
Classification	Type	Timeliness	Extension
Urgent	Concurrent	72 hours (3 calendar days)	14 calendar days
	Preservice	72 hours (3 calendar days)	14 calendar days
Non-urgent	Preservice	14 calendar days	14 calendar days
PostsERVICE	N/A	30 calendar days	14 calendar days

Urgent requests are requests for medical care or services where application of the timeframe for making non-urgent or non-life threatening care determinations could:

- Seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function, based on a prudent layperson’s judgment, or
- Seriously jeopardize the life, health or safety of the Member or others, due to the Member’s psychological state, or

- In the opinion of a practitioner with knowledge of the Member’s medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Physical/Non-Behavioral Health and Behavioral Health, care or services to accommodate transitions between inpatient or institutional setting to home/community shall be considered urgent preservice requests.

In accordance with Item 317 E., Chapter 1289, 2020 Virginia Acts of Assembly in any case where a service authorization or reauthorization for community mental health and rehabilitation services, is not approved or denied within NCQA response time standard, the provider shall assume to have approval to provide the service and receive payment until date of denial.

The Contractor shall comply with all NCQA UM standards related to determining if a request meets urgent or non-urgent criteria. This includes but is not limited to: *UM 2: Clinical Criteria for UM Decisions* and *UM 4: Appropriate Professionals*. The Contractor must be able to accept all requests from a provider for expedited review as described in *6.2.10.2 Expedited Authorization Decision Timeframe* and 42 CFR § 438.210(d)(2). The Contractor’s UM policies and procedures must include a description of the standards used to determine if a request meets urgent or non-urgent criteria.

Non-urgent requests are requests for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member’s ability to regain maximum function and would not subject the Member to severe pain.

The Contractor will be required to report to the Department on compliance with NCQA Service Authorization standards. At a minimum, this reporting will include the items required in Item 317 E., Chapter 1289, 2020 Virginia Acts of Assembly. The frequency and format of such reports will be provided in the *CCC Plus Technical Manual* or through other separate guidance.

6.2.11 Covered Outpatient Drug Decisions

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

6.2.12 Adverse Benefit Determination

In accordance with 42 CFR § 438.210, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member’s condition or disease. Additionally, the Contractor and its subcontractors are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the UM staff or entity to deny, limit, or discontinue medically necessary services to any Member. All adverse determinations shall be reviewed by the Contractor’s Medical Director or physician designee.

In accordance with 42 CFR § 438.210(c), the Contractor shall notify the requesting provider, and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

The Contractor shall provide a written *Notice of Adverse Benefit Determination* to the requesting provider, and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Contractor's notice shall include the reason for denial, a list of titles and qualifications, including specialties, of individuals participating in the authorization review, and shall meet the requirements of 42 CFR § 438.404 and *Code of Virginia* § 32.1-137.13. See Section 15.4.1, *Notice of Adverse Benefit Determination* of this Contract.

6.2.12.1 Timing of Notice

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

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

6.2.13 Appeal Determinations

Decisions to provide authorized medical services required by this Contract shall be based solely on medical necessity and appropriateness (and the application of EPSDT criteria for those under age 21). Disputes between the Contractor and Members about medical necessity may be appealed in accordance with Section 15.0, *Member and Provider Grievances and Appeals*.

The Contractor shall authorize and provide services ordered by the Department pursuant to an appeal from the Contractor's internal appeal process or an appeal directly to the Department by a Member or for emergency services as defined in this Contract.

6.2.14 LTSS Service Reductions and Denials

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

6.3 PATIENT UTILIZATION MANAGEMENT & SAFETY (PUMS) PROGRAM

The Contractor must have a Patient Utilization Management & Safety Program (PUMS) intended to coordinate care and ensure that Members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the Member's placement in the PUMS, the Contractor must refer Members to appropriate services based upon the Member's unique situation. Note that Members with an active cancer diagnosis are excluded from the PUMS program.

6.3.1 PUMS Program Placement

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

- The Contractor's specific utilization review of the Member's past twelve (12) months of medical and/or billing histories indicates the Member may be accessing or utilizing health care services inappropriately, or in excess of what is normally medically necessary, including the minimum specifications as noted below in 6.3.1.1 PUMS Placement Criteria. Note that Members with a cancer diagnosis are excluded.
- At the end of the twelve (12) month period, the Member must be re-evaluated by the Contractor to determine if the Member continues to display behavior or patterns that indicate the Member should remain in the PUMS program.
- The Contractor is encouraged to utilize the Prescription Monitoring Program (PMP), when evaluating PUMS Members.
- Medical providers or social service agencies provide direct referrals to the Department or the Contractor.

6.3.1.1 PUMS Placement Criteria

- (PUMS1) Opioid Use Disorder (OUD) Case Management: The Contractor may review any Members receiving OUD and provide case management.
 - Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three (3) years; pregnant women with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate;
 - Clinical expertise and judgment shall be used to identify and manage any Members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").
- **(PUMS2) High Average Daily Dose:** \geq ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,
- **(PUMS3) Opioids and Benzodiazepines concurrent use** – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order),
- **(PUMS4) Doctor and/or Pharmacy Shopping:** \geq three (3) prescribers OR \geq three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,
- **(PUMS5) Use of a Controlled Substance with a History of Dependence, Misuse, or Poisoning/Overdose:** Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Misuse or Dependence in the past three hundred and sixty-five (365) days,
- **(PUMS6) History of Substance Use, Use or Dependence or Poisoning/Overdose:** Any Member with a diagnosis of substance use, substance misuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

6.3.1.2 Temporary Change to PUMS Status

At the discretion of DMAS or its Contractor, Members identified as eligible for the PUMS program may be required to use one pharmacy of their choice. If they are referred to an ARTS Residential Treatment Facility, and need to continue medication management via a single pharmacy, the Residential provider shall contact the MCO to request the pharmacy be updated to one that the Residential provider utilizes, so that the Member may continue the current medical regimen. The provider may contact the health plans and the Contractor to update the Member's preferred pharmacy while the Member is in the residential treatment program.

Upon discharge from the Residential Treatment Facility, the provider shall notify the Member's MCO of the discharge so that the Member's pharmacy provider may be updated based on the Member's choice and proximity to their place of discharge. This task shall be included in the discharge planning process.

6.3.2 PUMS Program Details

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

Contractor shall submit the PUMS report using the specifications as outlined in the *ARTS Technical Manual*.

If the Member changes from another health plan to the Contractor's health plan while the Member is enrolled in a PUMS, the Contractor must re-evaluate the Member for the PUMS program within thirty (30) days to ensure the Member meets the minimum criteria above for continued placement in the Contractor's PUMS.

6.3.3 PUMS Member Rights Notifications and Requirements

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

- 1) A brief explanation of the PUMS program;
- 2) A statement that the Member was selected for placement into the program;
- 3) An explanation that the decision is appealable;
- 4) A statement that the Contractor shall provide appeals rights to Members placed in the PUMS Program, information regarding how the Member may submit an appeal request to the Contractor, the Member's right to directly request a State Fair Hearing after first exhausting the Contractor's appeals process, and information regarding how the Member qualified for the PUMS based on the minimum criteria;
- 5) A statement clearly outlining the provisions for emergency after hours prescriptions if the Member's selected pharmacy does not have 24-hour access; and,
- 6) A statement indicating the opportunity and mechanisms by which the Member may choose a pharmacy, primary care provider, controlled substance provider, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types. The language must clearly state that if the Member does not select the relevant providers within fifteen (15) calendar days of enrollment into the PUMS program, the Contractor may select one for the Member.

6.3.4 PUMS Reporting Requirements

- **Annual PUMS Plan**
At initial contract, annually, upon revision (if any) and upon request, the Contractor shall submit all applicable policies and procedures to the Department for review, including clinical protocols used to determine appropriate interventions and referrals to other services that may be needed (such as substance abuse treatment services, etc.).
- **Monthly Reporting**
The Contractor must report a detailed summary of Members enrolled in its PUMS program on a Monthly basis.

Refer to the *ARTS Technical Manual* for reporting requirements.

6.4 ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM

Effective October 1, 2019, The Contractor shall require agency-directed providers that bill for personal care and respite care services to use an EVV system that will electronically verify and collect data that meets the requirements consistent with the 21st Century Cures Act, Section 12006, 42 U.S.C. § 1396(b). At a minimum, the EVV shall capture in real-time the following data elements for agency-directed personal care and respite services.

- 1) Type of service performed
- 2) The Member receiving the service
- 3) Date of service
- 4) Time the service begins and ends
- 5) The location of service delivery at the beginning and the end of the service
- 6) Employee providing the service

The Contractor must ensure that the provider's EVV systems shall:

- 1) Securely transmit all EVV raw data elements to the Contractor.
- 2) Limit authority to modify changes and modifications to service entries. In the event the time of service delivery needs to be adjusted, the start or end time may be modified by someone who has the provider's authority to adjust the attendant's hours. For agency-directed providers, this may be a supervisor or the agency owner or designee who has authority to make independent verifications.
- 3) Support real time access to Members (if Member authentication is used) and providers.
- 4) Be compliant with the requirements of the ADA (as amended, 42 USC § 12101 et seq.) and HIPAA (P.L. 104-191).
- 5) Retain EVV data for at least six years from the last date of service or as provided by applicable federal and state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved. Policies regarding retention of records shall apply even if the provider discontinues operation.

The Contractor's claim processing system shall have edits in place that prevent claims for services that are not electronically verified and documented using an EVV system.

The Contractor shall submit EVV encounter data to the Department in a format as defined by the Department. For technical assistance on submission of EVV encounters refer to the Encounter Processing System (EPS) Medicaid Enterprise Encounter (MES) Companion guide (<https://eps.dmas.virginia.gov/epsportal/#/guides>) For 837 Professional Health Care and Transportation Encounter Transactions.

6.5 NOTIFICATION TO THE DEPARTMENT OF SENTINEL EVENTS

A sentinel event is an unexpected occurrence involving death (not primarily related to the natural course of the patient's illness or underlying condition) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "Sentinel" because they signal the need for immediate investigation and response. The Contractor shall maintain a system for identifying and recording any Member's sentinel event. The Contractor shall provide the Department with reports of sentinel events within one (1) business day of discovery. See the *CCC Plus Technical Manual* for details.

SECTION 7.0 SUBCONTRACTOR DELEGATION AND MONITORING REQUIREMENTS

7.1 GENERAL REQUIREMENTS FOR SUBCONTRACTORS

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

The Contractor shall submit a list of all such subcontractors and the services each provides annually to the Department, or upon request, making note of any changes to subcontracts or subcontractors. See the *CCC Plus Technical Manual* for details.

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

The Contractor shall ensure that subcontractors have received proper certification or training to perform the specific services for which they are contracted. The Contractor shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs.

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

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

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

The Contractor shall give the Department at least thirty (30) calendar days advanced written notice prior to the termination of any subcontractor agreement. At a minimum, such notice shall include the Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, and any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan upon request, which shall include, at a minimum, information regarding how continuity of the project shall be maintained. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted provider(s).

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

7.2 DELEGATION REQUIREMENTS

- 1) All subcontracts shall be in writing;
- 2) Subcontracts shall fulfill the requirements of this Contract and applicable Federal and State laws and regulations;
- 3) Shall require the Subcontractor to require its provider contracts to comply with all provider provisions of this Contract and applicable Federal and State laws and regulations;
- 4) Subcontracts shall specify the activities and reporting responsibilities delegated to the subcontractor;
- 5) Subcontracts shall provide that the Department may evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract;
- 6) Subcontracts shall clearly state that the subcontractor shall comply with Member privacy protections described in HIPAA regulations and in Title 45 CFR parts 160 and 164, subparts A and E; and
- 7) Subcontracts shall provide provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate, and ensure all information necessary for the reimbursement of any outstanding Medicaid claims is supplied promptly.
- 8) Subcontracts shall provide that the State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor's subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for (ten) 10

years from the final date of the contract period or from the date of completion of any audit, whichever is later.

7.3 MONITORING REQUIREMENTS

- 1) The Contractor shall perform on-going monitoring of all subcontractors and shall assure compliance with subcontract requirements.
- 2) The Contractor shall perform a formal performance review of all subcontractors at least annually.
- 3) The Contractor shall monitor encounter data of its subcontractor before the data is submitted to the Department. The Contractor shall apply certain key edits to the data to ensure accuracy and completeness. These edits shall include, but not be limited to, Member and provider identification numbers, dates of service, diagnosis and procedure codes, etc.
- 4) The Contractor shall monitor the subcontractor's provider enrollment, credentialing, and re-credentialing policies and procedures to assure compliance with Federal disclosure requirements described in this Contract, with respect to disclosure of information regarding ownership and control, business transactions, and criminal convictions for crimes against federally funded health care programs. Additionally, the Contractor shall monitor to assure that the subcontractor complies with requirements or prohibited affiliations with individuals or entities excluded from participating in Federal health care programs as described in this Contract.
- 5) As a result of monitoring activities conducted by the Contractor (through on-going monitoring and/or annual review), the Contractor shall identify to the subcontractor deficiencies or areas for improvement, and shall require the subcontractor to take appropriate corrective action.
- 6) The Contractor shall perform an annual review on all subcontractors to assure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this contract.

7.4 DATA SHARING CAPABILITIES

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

7.5 BEHAVIORAL HEALTH SERVICES ADMINISTRATOR

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

The Contractor shall ensure that coordination efforts occur for Members as needed and on a frequent and on-going basis with the BHSA for Members in need of or receiving those services currently carved out of managed care. Care coordination activities between the Contractor's Care Coordinator and the BHSA shall ensure:

- 1) Comprehensive care planning;

- 2) Necessary crisis services;
- 3) Provider collaboration; and,
- 4) On-going monitoring.

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

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

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

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

SECTION 8.0 PROVIDER NETWORK MANAGEMENT

8.1 GENERAL NETWORK PROVISIONS

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

The Contractor shall develop and maintain a list of referral sources which includes community agencies, State agencies, “safety net” providers, teaching institutions and facilities that are needed to assure that the Members are able to access and receive the full continuum of treatment and rehabilitative medical, behavioral health, ARTS, Nursing Facility, hospice, and waiver services and supports needed.

8.1.1 Network Elements

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

- 1) The anticipated CCC Plus enrollment;
- 2) The expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated CCC Plus program population to be served and the existing patterns of utilization, including in localities that fall adjacent to another region and localities that border with other States;
- 3) The number and types (in terms of network training status, experience, and specialization) of network providers required to furnish the services covered under this Contract;
- 4) The number of network providers who are not accepting new membership from the Contractor;
- 5) The geographic location of network providers and CCC Plus Members, considering distance, travel time, the means of transportation ordinarily used by CCC Plus Members;
- 6) The ability of network providers to communicate with limited English proficient enrollees in their preferred language;
- 7) The ability of network providers who have the demonstrated capacity to actively deliver services within the model of care, ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for CCC Plus Members with physical or mental disabilities;
- 8) The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions;
- 9) Elements that support a Member's choice of provider;
- 10) Strategies that ensure the health and welfare of the Member and support community integration of the enrollee;
- 11) Other considerations that are in the best interest of the Members that need LTSS; and
- 12) Other considerations that are in the best interest of Medicaid expansion Members including but not limited to the below directives.
- 13) That, in accordance with 42 CFR 438.206(b)(7), its network includes sufficient family planning providers to ensure timely access to covered services.

The Contractor is not required to contract with all willing providers; however, its network must meet the access to care standards described in Section 9.0, *Access to Care Standards* of this Contract.

8.1.1.1 Network Development for Medicaid Expansion Population

The Contractor shall enroll and credential primary care providers, large and small physician groups, and providers who practice in a specialty that has been designated by The Department as insufficient to meet enrolled population needs and who do not participate in the Virginia Medicaid program. These providers shall include urgent care centers, free clinics, Federally designated rural health clinics, Federally Qualified Health Centers, providers who participate in the Ryan White Program, providers who participate in VCU's Virginia Coordinated Care Program, local health departments who provide direct patient care, providers who participate in the INOVA program for the uninsured and other non-participating providers.

The Contractor shall work cooperatively with the Department on initiatives for provider recruitment and retention. The Contractor is encouraged to work with Virginia's academic medical centers, other State colleges and universities that place students pursuing degrees in the allied health professions that have preceptor programs and residencies in practice sites and with the state and local area health education centers and evaluate practices. The Department will not supercede the Virginia Department of Health Professions or NCQA. The Department has the discretion to require that the Contractor submit network development project plans, recruitment strategies, geo-mapping of target areas and areas of need, etc. in the future.

8.2 SPECIALIZED NETWORK PROVISIONS

8.2.1 DD Waiver Providers

Individuals enrolled in the HCBS waivers that serve the DD populations (Building Independence (BI), Community Living (CL), and the Family and Individual Supports (FIS) waivers) will be enrolled in CCC Plus program only for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). The Contractor shall ensure that it develops and maintains adequate network of qualified providers to meet the non-waiver integrated care needs of the DD subpopulation through a person centered delivery model. See Section 5.0, *CCC Plus Model of Care*.

8.2.2 Inpatient Admission Privileges

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

8.2.3 Urgent Care

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

8.2.4 Health Homes

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

8.2.5 Behavioral Health Homes

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

As DBHDS implements System Transformation, Excellence, and Performance in Virginia (STEP VA), the Contractor shall develop, implement and modify BHHs reflecting the elements of STEP VA in accordance with § 37.2-500 and as additional phases of STEP-VA services are implemented over the next two biennia. Goals of the BHHs align with the CCC Plus program and include:

- 1) Improving health and behavioral health outcomes and opportunities for community integration for BHH Members using evidence-based practices;
- 2) Empowering medical and behavioral health providers to collaborate and exchange information for aligned care planning to provide person-centered care at the right time in the least restrictive environment/mode;
- 3) Improving the experience of care, quality of life and consumer satisfaction and promote a seamless and timely experience for enrolled individuals;
- 4) Improving access to primary and urgent care services, lowering the rates of hospital emergency department (ED) use, reducing hospital admissions and re-admissions and decreasing reliance on long term care facilities and other high cost services; and,
- 5) Providing Member education for medical, behavioral health, pharmacy and other community services, supports and needs, including principles of recovery and resiliency as defined by SAMHSA.

8.2.6 Behavioral Health (Including ARTS and CMHRS)

The Contractor shall develop a network of behavioral health providers, including inpatient, outpatient, and community based treatment providers sufficient to cover the full scope of behavioral health services as defined in Attachment 5, *CCC Plus Coverage Chart* attached to this Contract. The Contractor shall monitor and assure that the Contractor's behavioral health network is adequate (in terms of service capacity and specialization) to serve child, adolescent, and adult populations timely and efficiently for all behavioral health and ARTS services covered by the Contractor. The Department will assess the MCO's inpatient, community based and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

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

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

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

The Contractor shall provide monthly updates to the Department by the 15th of each month, all ARTS credentialed provider organizations by ASAM Level of Care and by region in the Contractor's network as defined in Section 10.16, *ARTS Specific Measurement and Reporting* of this Contract. The report must include ASAM Levels 1.0, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, and 4.0 as well as Opioid Treatment Programs and Office-Based Opioid Treatment providers.

The Contractor must have appropriate Residential Treatment Providers at all ASAM Levels of Care (including ASAM Level 3.1, 3.3, 3.5 and 3.7) in each region. The Contractor shall ensure that its provider network meets access to timely care for services, including where the provider travels to the Member's home to provide services as set forth in the Section 9.0, *Access to Care Standards* of this Contract.

The Department recognizes that challenges may exist with achieving complete network adequacy across all continuums of care within certain regions for certain provider types, including providers that provide ARTS services. The Department will not consider plans to be in violation of this Contract if they do not have a specific provider type in all regions due to a lack of appropriately licensed providers and if they have exhausted all efforts to contract with existing providers in the State, both in and out of their networks.

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

Refer to Section 7.0, *Subcontractor Delegation and Monitoring Requirements* of this Contract.

8.2.7 Long Term Services And Supports (LTSS)

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

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

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

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

Within ten (10) calendar days of establishing or changing such an arrangement, the Contractor shall notify the Department in writing about the type of FQHC payment arrangement it has established.

For services provided to dual eligible Members by an FQHC, the Contractor shall also comply with 42 USC § 1396a(a)(10)E and § 1396d(p)(3).

8.2.9 Physical/Mental Abuse, Neglect, and Domestic Violence

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

8.2.10 Early Intervention Providers

The Contractor shall develop and maintain a network of early intervention providers, certified by DBHDS, with sufficient capacity to serve its CCC Plus Members in need of early intervention services. Early intervention providers shall be reflected in the Contractor's networks. Provider qualification requirements for early intervention are described at 12VAC30-50-131 and 12VAC35-225 et seq, in Appendix G of the DMAS *Early Intervention Services Manual*, and the DBHDS Practice Manual. Early intervention providers must be contracted with or have memorandum of agreement with the local lead agency for the catchment area in which the Member resides. In order to ensure adequate early intervention provider participation, the Contractor shall adhere to the Department's early intervention coverage rules and shall comply with special payment provisions described in Section 12.4.2, *Exceptional Processing and Payment Rules*.

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

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

8.3 CERTIFICATION OF NETWORK ADEQUACY

The Contractor's network shall meet or exceed Federal network adequacy standards at 42 CFR § 438.68 and the full scope of access standards as described in Section 9.0, *Access to Care Standards*, of this Contract and as described in the *CCC Plus Network Submission Requirements Manual (NSRM)*. In accordance with 42 CFR § 438.206(b), the Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. The Contractor shall assess and certify the adequacy of its provider networks monthly and when there is a substantial change to the program design (e.g., new populations, benefits, etc.). Refer to the *CCC Plus Technical Manual* for network reporting format requirements.

When identified, the Contractor shall report any network deficiencies as soon as possible and no later than within five (5) business days and request an exemption to the DMAS network standards for any circumstance whereby the Contractor is unable to meet the Department's network time and distance standards. Such a request may be granted only in circumstances where there exists a shortage of the number of providers in a specialty practicing in the region (i.e., provider shortage area). The Contractor's request for exemption shall also identify the Contractor's strategy (for its enrolled Members) for ensuring timely access to care for all contract covered services.

The Department will review and reserves the right to request changes to the provider network, which must be completed within specified timeframes. The Contractor shall contract with a broad range of providers to meet the complex needs of its Members. Services shall be delivered in the most integrated setting possible while offering opportunities for active community living and workforce participation.

The Department shall be the sole determiner of Contractor network sufficiency. Network sufficiency for new population group expansions will be set forth by the Department as part of the program development cycle. These standards shall be considered as operational guidelines. Reference Section 9.0, *Access to Care Standards*.

8.4 PROVIDER CREDENTIALING STANDARDS

8.4.1 General Requirements

The Contractor shall utilize credentialing and re-credentialing standards outlined by NCQA for network development and maintenance. The Contractor shall implement written policies and procedures for credentialing and recredentialing of acute, primary, behavioral, ARTS, and LTSS network providers and those policies and procedures shall comply with Federal standards at 42 CFR § 438.214, the most recent NCQA standards, and State standards described in 12 VAC 5-408-170. In addition, consistent with §438.12, the Contractor's credentialing standards shall not discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment.

In accordance with NCQA credentialing and re-credentialing requirements, the Contractor shall have the proper provisions to determine whether physicians and other health care professionals are licensed by the Commonwealth and are qualified to perform the services in accordance the provisions required in this Contract. The Contractor's re-credentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and Member satisfaction surveys.

The Contractor shall ensure all orders, prescriptions or referrals for items, or services for Members originate from appropriately licensed practitioners. The Contractor shall credential and enroll all ordering, referring and prescribing physicians or other professionals providing services to Medicaid Members.

The Contractor's re-credentialing process shall include the consideration of performance indicators obtained through the QIP, utilization management program, grievance and appeals system, and Member satisfaction surveys.

8.4.2 Provider Accessibility

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

8.4.3 Prohibition Against Discrimination

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

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

8.4.4 Network Provider Licensing and Certification Standards

The Contractor shall verify that providers are appropriately licensed by the State and have received proper certification or training to perform medical and clinical services contracted for this Contract. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements with its network providers which must be secured by current subcontracts or employment contracts.

8.4.5 Credentialing of Behavioral Health Providers

The Contractor's Behavioral Health providers, Community Based Mental Health and ARTS providers (public and private) shall meet any applicable DBHDS certification and licensing standards. Behavioral health providers shall meet the Department's qualifications as outlined in 12VAC30-50-226, 12VAC30-60-143, 12VAC30-50-130, 12VAC30-60-61, and 12VAC30-130-5000, et.al. Behavioral Health providers shall meet the requirements in the Department's most current behavioral health provider manuals, including the ARTS, community mental health rehabilitative services, and psychiatric services provider manuals found at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>.

8.4.6 Credentialing of CCC Plus Waiver Providers

The Contractor shall monitor and ensure that network providers providing services to CCC Plus Waiver Members comply with the provider requirements as established in the DMAS provider manuals available at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal> and the following regulations: 12VAC30-120-900 through 12VAC30-120-995.

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

As part of the annual assessment and plan of care review, the Contractor's Care Coordinator or another entity as approved by the Department shall conduct, in a format prescribed by the Department, an Individual Experience Survey in order to ensure that the Member's services and supports are provided in a manner that comports with the setting provisions of the HCBS

regulations in 42 CFR § 441.301(c)(4)-(5). DMAS will develop the survey in collaboration with the CCC Plus health plans.

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

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

8.4.7 Credentialing of Early Intervention Providers

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

8.4.8 Excluded Entities/Service Providers

The Contractor shall require its providers and subcontractors to fully comply with Federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 CFR § 455 Subpart B.

The Contractor shall comply with the requirements detailed at 42 CFR § 455.436, requiring the Contractor to, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE) and other Federal databases; (1) at least monthly for its non-Medicaid enrolled providers, (2) before contracting with providers, and (3) at the time of a provider's credentialing and re-credentialing consistent with requirements described in Sections 2.10, *Disclosure of Ownership and Control Interest* – 2.12, *Excluded Entities* of this Contract.

The Contractor shall obtain Federally required disclosures from all non-Medicaid enrolled network providers and applicants in accordance with 42 CFR § 455 Subpart B and 42 CFR § 1002.3, as related to ownership and control, business transactions, and criminal conviction for offenses against Federally related health care programs including Medicare, Medicaid, or CHIP programs. The Contractor shall screen all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc. The information shall be obtained through provider enrollment forms and credentialing and re-credentialing packages. The Contractor shall maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DMAS in accordance with this Contract and relevant state and Federal laws and regulations.

The Contractor shall conduct monthly checks and shall require subcontractors to conduct monthly checks to screen non-Medicaid enrolled providers for exclusion, using the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. The Contractor shall also check the DMAS provider file or conduct its own checks against the Federal exclusion files (named above) to ensure that any of its network providers who are "Medicaid enrolled" providers remain enrolled with DMAS.

The Contractor's screening process shall also include: verifying licenses, conducting revalidations at least every five (5) years, site visits for providers categorized under federal and state program integrity rules and plans at moderate or high risk, criminal background checks as required by state law, federal database checks for excluded providers at least monthly, and reviewing all ownership and control disclosures submitted by subcontractors and providers.

The Contractor/Subcontractor shall terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled. The Contractor shall immediately notify the Department of any action taken by the Contractor to exclude, based on the provisions of this section, an entity currently participating.

The Contractor shall inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov/>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered.

8.4.9 Provider Monitoring

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

8.4.10 Credentialing Related Reporting

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

8.5 PROVIDER AGREEMENTS

In accordance with 42 CFR § 438.206, the Contractor's network shall be supported by written agreements. Prior to CCC Plus program Contract signing, the Contractor shall submit to the

Department each type of provider agreement template for services covered under this Contract, including any attachments applicable to the template. Ongoing, the Contractor shall submit for review any new or revised network provider agreement template at least thirty (30) calendar days prior to the effective date of use, and upon request thereafter.

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

The Department will approve or disapprove any new or revised template within thirty (30) calendar days after its receipt from the Contractor. The Department may extend this period by providing written notification to the Contractor if, in the Department's sole opinion, additional review or clarification is needed. Network provider agreements shall be deemed approved if the Department fails to provide notice of extension or disapproval within thirty (30) calendar days.

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

8.5.1 Provider Enrollment into Medicaid

In order to comply with 42 CFR 438.602(b)(1) and (b)(2), 42 CFR § 438.608(b), and 42 CFR § 455.100-106, 42 CFR § 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, all providers furnishing services to Virginia Medicaid Members, including providers participating in a managed care organization (MCO) provider network, are required to be screened and enrolled with DMAS (including signing a DMAS provider participation agreement) by December 1, 2019, or at the time MES is implemented. The Provider Enrollment Wizard, managed by the contracted modular vendor, is Virginia's web-based Medicaid provider enrollment system. This requirement applies to all individuals and entities who provide services of any type to CCC Plus Members, including but not limited to: health care providers; pharmacies; ordering, referring, or prescribing providers; and providers who do not participate in Medicaid fee-for-service (FFS) but are network providers through a CCC Plus MCO.

The Contractor must require all providers to be registered in the Virginia's provider enrollment system prior to finalizing the contracting and credentialing process with the provider. This requirement is regulated by Title 42 Code of Federal Regulations (CFR) §438.602(b) (1). This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

8.5.2 National Provider Identifier (NPI)

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

8.5.3 Elements That Shall Not Be Included in Provider Agreements

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

8.5.4 Elements That Shall Be Required in Provider Agreements

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

8.5.4.1 Elements Required in All Provider Agreements

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

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

preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.

- 15) Provider agreements shall include claim processing and payment provisions as described in Section 12.4, *Provider Payment System*.
- 16) Under 42 CFR § 434.6(a)12(i) the Contractor is prohibited from making a payment to the Provider for provider-preventable conditions (PPC) that meet the criteria outlined in 42 CFR § 447.26(b). The Provider shall report to the Contractor all PPCs or health care-acquired conditions (HCACs) associated with claims. No reduction in payment for a PPC shall be imposed on the Provider when the condition defined as a PPC or that meets the definition of a HCAC for a particular covered member that existed prior to the initiation of treatment for that covered member by the Provider.

8.5.4.2 Special Provisions For Certain Provider Agreements

- 1) LTSS, ARTS, CMHRS and Early Intervention provider agreements shall include provisions requiring the use of the DMAS established billing codes as described in the CCC Plus Coverage Chart.
- 2) LTSS Providers agreements shall include provisions for compliance with the CMS HCBS Settings Rule detailed in 42 CFR § 441.301(c)(4)(5).
- 3) Nursing Facility, LTSS, ARTS, and Early Intervention provider agreements shall include special claim processing and payment provisions as described in Section 12.4, *Provider Payment System*.
- 4) Provider agreements with private providers of Community Mental Health Rehabilitative Services- the CMHRS providers are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.
- 5) Provider agreements with Virginia Community Services Boards (CSBs) shall include provisions that allow the CSB to bill under the facility NPI for qualifying practitioners in accordance with DMAS guidelines. Such guidelines apply to:
 - a. Psychiatric services CSBs can provide outpatient services as described under the Psychiatric Services Manual, Chapter 2, where qualifying providers are not required to operate under the physician-directed model for all services. CSBs have the option to bill as a mental health clinic in a physician-directed model. The specific requirements for physician-directed services are described in the Psychiatric Services manual, Chapter 2.
 - b. Community Mental Health Rehabilitative Services- the CSBs are enrolled as an agency and can bill with their agency NPI. These requirements can be found in the Community Mental Health Rehabilitative Services manual, Chapter 2.

8.5.5 Network Provider Contract Supplement

The Department recognizes that the Contractor may use a Provider Manual as a supplement to the Network Provider Contract. Under that condition, it must be understood that the Contract takes precedence over any language in the Provider manual. The Contract must reference the Provider Manual and identify it as part of the Network Provider Contract. The Manual must contain language that states the Manual revisions, and amendments to it are part of the Network Provider Contract.

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

8.5.6 Termination of a Contracted Provider

8.5.6.1 Policies and Procedures

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

- 1) Procedures to provide a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. [42 CFR § 438.10(f)(1)]
- 2) Procedures to provide a good faith effort to transition Members to a new PCP or specialist at least thirty (30) calendar days prior to the effective date of provider termination;
- 3) Procedures for the reassessment of the provider network to ensure it meets access standards established in this Contract per Sections 8.3 (*Certification of Network Adequacy*) and 9.18 (*Native American Health Care Providers*); and,
- 4) Procedures for notifying the Department within the time frames set forth in this Contract and the *CCC Plus Technical Manual* including but not limited to Sections 8.3, *Certification of Network Adequacy*, 8.4.10, *Credentialing Related Reporting*, 9.4, *Exceptions to Access Standards*, 9.17, *Assurances that Access Standards are being met*, 14.2, *Program Integrity Plan, Policies, and Procedures*, and 14.10, *Quarterly Fraud/Waste/Abuse Report*.

8.5.6.2 Notice to the Department

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

- 1) At least thirty (30) business days in advance (when possible) of a contract termination that could reduce Member access to care, and no later than within thirty (30) business days of implementing any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider where the termination, pending termination, or pending modification could reduce Member access to care;
- 2) In advance of, as soon as possible, and within five (5) business days where the provider termination would create any network deficiencies whereby the Contractor is unable to meet the Department's network time and distance standards, see Section 8.3, *Certification of Network Adequacy* of this Contract;
- 3) As soon as possible and within forty-eight (48) hours for suspected or actual fraud or abuse per Section 14.10, *Quarterly Fraud/Waste/Abuse Report* of this Contract;
- 4) Immediately, including notice to the appropriate authorities for any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license see Section 8.4.10, *Credentialing Related Reporting* of this Contract.

The Contractor shall also notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems. This written notice must occur in advance of the formal notification of hospital's termination from the Contractor's network.

Reference Section 16.9 *Data Quality Requirements* for provider file Submission requirements and the *CCC Plus Technical Manual*.

SECTION 9.0 ACCESS TO CARE STANDARDS

9.1 GENERAL STANDARDS

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

The Contractor's network shall meet or exceed Federal network adequacy standards at 42 CFR §438.68 and shall have sufficient types and numbers of traditional and LTSS providers in their networks to meet historical need and must be able to add providers to meet increased Member needs in specific geographic areas. Adequacy will be assessed along a number of dimensions, including: number of providers, mix of providers, hours of operation, providers not accepting new patients, accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); and geographic proximity to beneficiaries (provider to Members or Members to provider). See Section 8.0, *Provider Network Management* of this Contract.

9.2 CHOICE OF PROVIDER STANDARDS

9.2.1 Providers Requiring Member Travel

The Contractor shall provide Members with a choice of at least two (2) providers for each type of service listed below in accordance with time and distance standards specified in Section 9.3, *Member Travel Time and Distance Standards* of this Contract or where an exception is granted by the Department as described in Section 9.4, *Exceptions to Access Standards* of this Contract.

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

The Contractor shall provide Members with at least one (1) provider for each type of service listed below in accordance with time and distance standards specified in Section 9.3, *Member Travel Time and Distance Standards* below or where an exception is granted by the Department as described in Section 9.4, *Exceptions to Access Standards* of this Contract.

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

9.2.2 Providers that Travel to the Member

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

- Home Health
- LTSS – Personal Care, Respite Care and Respite Care LPN
- LTSS – Skilled Nursing, Congregate Nursing, and Congregate Respite Nursing
- LTSS – Service Facilitation
- CMHRS – Crisis Stabilization, Crisis Intervention, Intensive In-Home, Mental Health Skill Building, Peer Recovery Support Services, Behavioral Therapy, Intensive Community Treatment

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

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

- LTSS - Assistive Technology Only
- LTSS – Personal emergency response systems (PERS)
- LTSS – Environmental Modification,
- Durable Medical Equipment (DME) and Supplies

The Contractor may need to submit more than the minimum number of required providers within a given locality to ensure that Members have access within the contractually required time and distance standards described in this section.

9.2.3 Individuals With Special Health Care Needs

When a Member with special health care needs has been identified through an assessment to need a course of treatment or regular care monitoring, and in compliance with 42 CFR § 438.208(c)(4), the Contractor shall have a mechanism in place to allow the Member to directly access a specialist, as appropriate for the Member's condition and identified needs.

9.3 MEMBER TRAVEL TIME AND DISTANCE STANDARDS

The Contractor shall ensure that the travel time and distance standards described in this section are met for services in which the Member travels to receive care, as described in Section 9.2.1, *Providers Requiring Member Travel* of this Contract. Travel time shall be determined based on driving during normal traffic conditions (i.e., not during commuting hours). Travel time and distance standards do not apply to providers who travel to provide a service (e.g., PERS, home health, personal care, respite, etc.).

The Contractor shall contract with a sufficient number of providers and facilities to ensure that at least 80 percent of its Members within a county can access primary care within the time and distance services described below. In addition, travel time and distance for all other providers in

which the Member travels to receive covered benefits shall not exceed the standards below for at least 75 percent of its enrolled Members.

Member Time & Distance Standards Tidewater, Central, Charlottesville/Western & Northern/Winchester Regions		
Standard	Distance	Time
Urban		
• PCPs	15 Miles	30 Minutes
• Other Providers including Specialists*	30 Miles	45 Minutes
Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes
Member Time & Distance Standards Roanoke/Alleghany & Southwest Regions		
Standard	Distance	Time
Urban and Rural		
• PCPs	30 Miles	45 Minutes
• Other Providers including Specialists*	60 Miles	75 Minutes

9.4 EXCEPTIONS TO ACCESS STANDARDS

In accordance with 42 CFR §438.68 (d), the Contractor may request an exception to the standards described in this section where there is a shortage of the provider type(s) practicing in a given locality and/or region; for example, certain ARTS provider types, urgent care facilities, hospital facilities, Adult Day Health Care facilities, etc. The Contractor’s exception request shall include a detailed action plan for network improvement with actionable and measurable goals, and related milestones for coming into compliance. The Contractor’s action plan shall also explain how the Contractor will ensure that Members receive timely access to care including in any instance where an exception is granted by the Department. The Contractor shall monitor and work to improve access to any provider types in which the Department grants an exception on an ongoing basis and shall report findings to DMAS per the action plan approved by DMAS. DMAS also reserves the right to establish different time and distance standards in future Contract revisions. Also refer to Section 8.3, *Certification of Network Adequacy*.

9.5 TWENTY-FOUR HOUR COVERAGE

The Contractor shall maintain adequate provider network coverage to serve its enrolled Members twenty-four (24) hours per day, seven (7) days a week. The Contractor shall make arrangements to refer Members seeking care after regular business hours to an appropriate physician within twenty-four (24) hours per the standard set in 9.10.2, *Urgent Medical and Symptomatic Office Visits*. The Contractor may direct the Member to go to an emergency department for potentially emergent conditions and this may be done via a recorded message. Refer to *Warm Transfer to a Clinical Professional Staff* for more information.

9.6 URGENT CARE ACCESS

All CCC Plus enrolled Members must have access to at least one (1) urgent care facility (where available) to alleviate inappropriate use of hospital emergency rooms. These facilities must meet time and distance standards for care. Urgent care transportation must be provided for medically necessary care.

9.7 EMERGENCY SERVICES COVERAGE

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

The Contractor shall negotiate provider agreements with emergency care providers to ensure prompt and appropriate payment for emergency services. Such network provider agreements shall provide a process for determining the medical necessity of an emergency.

9.8 INPATIENT HOSPITAL ACCESS

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

9.9 MEMBER PRIMARY CARE ACCESS (ADULT AND PEDIATRIC)

The Contractor shall offer each Member covered under this Contract the opportunity to choose a PCP affiliated with the Contractor to the extent that open panel slots are available pursuant to travel time and distance standards described in this Contract. Except for dual eligible Members, the Contractor shall ensure that each Member has an assigned Primary Care Provider (PCP) at the date of enrollment. Members shall be allowed to select or be assigned a new PCP when requested by the individual, when the Contractor has terminated a PCP, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding.

9.9.1 Primary Care Physician (PCP) Assignment for Members

The Contractor shall have written policies and procedures for assigning a PCP for each of its non-Medicare enrolled Members. The Contractor shall also have an established mechanism to identify the PCP of all Members (including dual eligible) and incorporate the information into the Members' medical records to improve care coordination, including maintaining current PCP contact information. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Department at least thirty (30) calendar days prior to implementation and must be approved by the Department.

9.9.2 Member-To-PCP Ratios

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

Each contract between the Contractor and any of its network providers who are willing to act as a PCP must indicate the number of open panel slots available to the Contractor for Members under this Contract. This standard refers to the total CCC Plus program Members under enrollment by the Contractor. If necessary to meet or maintain appointment availability standards

set forth in this Contract, the Contractor shall decrease the number of Members assigned to a PCP. When specialists act as PCPs, the duties they perform must be within the scope of their specialist's license.

9.9.3 Providers qualifying as PCPs

- 1) Pediatricians;
- 2) Family and General Practitioners;
- 3) Internists;
- 4) Obstetrician/Gynecologists;
- 5) Specialists who perform primary care functions within certain provider classes, care settings, or facilities including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or,
- 6) Other providers approved by the Department.

9.9.4 Nursing Facility PCP

The Contractor shall work closely with nursing facility providers to ensure that physicians who are credentialed with a Nursing Facility to serve as a PCP are also credentialed with the Contractor. Refer to Section 4.7.3, *Nursing Facility and Long Stay Hospital Services* for more information.

9.9.5 Default Assignment of PCP

If the Member does not request an available PCP prior to the twenty-fifth (25th) day of the month prior to the enrollment effective date, then the Contractor may assign the new Member (without Medicare) to a PCP within its network, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), age and sex, and area of residence. The Contractor shall notify the Member in writing, on or before the effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

9.9.6 Timing of PCP Assignment

The Contractor shall ensure its Members have an assigned PCP from the date of enrollment with the plan. (Except for Members who have Medicare coverage.)

9.9.7 Change in PCP

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

CCC Plus Program Members may request that their PCP be a specialist. The Contractor shall make a good faith effort to ensure that children whose PCP is a specialist receive scheduled EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these Members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

9.10 TIMELINESS ACCESS STANDARDS

The Contractor shall arrange to provide care as expeditiously as the Member's health condition requires and according to the Department's requirements.

9.10.1 Emergency Services

Appointments for emergency services shall be made available immediately upon the Member's request.

9.10.2 Urgent Medical and Symptomatic Office Visits

All urgent care and symptomatic office visits shall be available within no more than twenty-four (24) hours of the Member's request; however, as quickly as the symptoms demand. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring care in an emergency room setting. Transportation to these services shall be provided by the Contractor.

9.10.3 Routine Primary Care Services

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

9.10.4 Maternity Care Appointment Standards

For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant Members as follows:

- 1) First trimester - Within fourteen (14) calendar days of request.
- 2) Second trimester - Within seven (7) calendar days of request.
- 3) Third trimester - Within five (5) business days of request.
- 4) High Risk Pregnancy - Within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.

9.10.5 Behavioral Health Services

The Contractor shall ensure that Members are able to receive behavioral health appointments as expeditiously as the Member's condition requires and within no more than five (5) business days from the Contractor's determination that coverage criteria is met. See Section 6.2.10, *Service Authorization Timeframes*.

9.10.6 LTSS

The Contractor shall ensure that Members are able to receive LTSS as expeditiously as the Member's condition requires and within no more than 5 business days from the Contractor's determination that coverage criteria is met. See *Service Authorization Timeframes* in Section 6.2.10.

9.11 SECOND OPINIONS

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

9.12 OUT-OF-NETWORK SERVICES

The Contractor shall provide services out-of-network in all of the following circumstances:

- 1) When the Contractor has pre-authorized out of its established network;
- 2) When emergency and family planning services are rendered to a Member by a non-participating provider or facility, as set forth in this Contract;
- 3) When the Member is given emergency treatment by such providers outside of the service area, subject to the conditions set forth elsewhere in this Contract;
- 4) When the needed medical services or necessary supplementary resources or services furnished in facilities or by practitioners outside the Contractor's network are not available in the Contractor's network;
- 5) When the Contractor cannot provide the needed specialist, as specialist is defined in this contract, within the contract distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas;
- 6) When the type of provider needed and available in the Contractor's network does not, because of moral or religious objections, furnish the service the Member seeks;
- 7) During the Member's continuity of care period and the Member's provider is not part of the Contractor's network, has an existing relationship with the Member, and has not accepted an offer to participate in the MCOs network;
- 8) In accordance with Section 5.15.3, *Members in Nursing Facilities*, of this contract for Members in nursing facilities; and,
- 9) When DMAS determines that the circumstance warrants out-of-network treatment.

In accordance with 42 CFR § 438.206(b)(5), when the Contractor is unable to provide necessary services in-network, in addition to paying out of network, the Contractor must coordinate with the provider for payment and ensure that the cost to the Member is no greater than it would be if the services were furnished within the Contractor's network.

9.13 OUT-OF-STATE SERVICES

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

- 1) Necessary emergency or post-stabilization services;
- 2) Where it is a general practice for Members in a particular locality to use medical resources in another State; and,
- 3) The required services are medically necessary and not available in-network and within the Commonwealth.
- 4) While the Contractor is honoring a transition of care plan authorized by the Contractor, another MCO, or the Department until services can be safely and effectively transitioned to a provider in the MCO's network within the Commonwealth.

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

9.14 PROVIDER TRAVEL CONSIDERATIONS

Many CCC Plus program services are provided in the Member's home. The Contractor shall ensure that CCC Plus providers who are not located in the city/county of the Member's residence are willing and able to service residents of that city/county.

Recruiting and retaining agency- and community-based LTSS providers may be challenging due to low pay, limited benefits, and transportation costs. Urban areas generally have the advantage of public transportation systems. However, the distances workers have to travel, variable gas prices, other costs associated with automobile ownership, seasonal road and weather conditions, and serving fewer individuals per day due to travel time can present challenges in rural areas. Therefore, the Contractor should consider implementing creative solutions such as: carpooling, scheduling based on geography, reimbursing workers for mileage expenses, arranging with rental companies to rent fuel-efficient cars for workers to use, etc., in these rural areas.

9.15 POLICY OF NONDISCRIMINATION

The Contractor shall ensure that its providers provide contract services to Members under this Contract in the same manner as they provide those services to all non-Medicaid Members. Additionally, in accordance with 42 CFR § 438.206, the Contractor shall ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial Members or other Virginia Medicaid programs, if the provider serves only Medicaid Members.

9.16 ACCOMMODATING PERSONS WITH DISABILITIES

The Contractor shall provide at contract implementation, at revision, or upon request, written policies and procedures to assure that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all covered services from the Contractor.

The Contractor shall accommodate all Members and ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. The Contractor and its network providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Members by:

- 1) Providing flexibility in scheduling to accommodate the needs of the Members;
- 2) Providing interpreters or translators for Members who are deaf and hard of hearing;
- 3) Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to:
 - a. Ensuring safe and appropriate physical and communication access to buildings, services and equipment;
 - b. Ensuring providers allow extra time for Members to dress and undress, transfer to examination tables, and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information; and,

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

9.17 ASSURANCES THAT ACCESS STANDARDS ARE BEING MET

The Contractor shall establish a system to monitor its provider network to ensure that the access standards set forth in this Contract are met, must monitor regularly to determine compliance, taking corrective action when there is a failure to comply, and must provide a quarterly report by provider type that demonstrates to the Department that these access standards are being continuously monitored by the Contractor and that standards have been met.

9.18 NATIVE AMERICAN HEALTH CARE PROVIDERS

In accordance with Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (ARRA), the Contractor shall provide the following for its Native American Members:

- 1) Provide coverage for services from an Indian Health Service or Tribal provider, including out-of-network Indian Health Service (HIS) or Tribal providers, in accordance with the State Health Official Letter (SHO #16-002)(available at <https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf>). In accordance with 42 CFR §438.14(c)(2), when an Indian Health Care Provider (IHCP) is not enrolled in Medicaid regardless of whether it participates in the network of a contracted health plan, the IHCP has the right to receive its applicable encounter rate published by the HIS, or in the absence of a published rate, the amount it would receive if the services were provided under the state plan's fee-for-service payment methodology;
- 2) Offer Native American Members the option to choose an Indian Health Care Provider as a PCP if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services;
- 3) Demonstrate that there are sufficient Indian Health Care Providers in the network to ensure access to Covered Services;
- 4) Reimburse both network and non-network Indian Health Care Providers who provide covered services to Native American Members a negotiated rate which shall be no lower than the Department's fee-for-service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the covered service by a non-Indian Health Care Provider;
- 5) Reimburse non-network Indian Health Care Providers that are FQHCs for the provision of services to an Native American Member at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider; and,
- 6) Not impose enrollment fees, premiums, or similar charges on Native Americans served by an Indian Health Care Provider.

SECTION 10.0 QUALITY MANAGEMENT AND IMPROVEMENT

10.1 QUALITY DEFINITION AND DOMAINS

As defined by Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Guided by this definition, the Contractor shall deliver quality care that enables its Members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

- 1) Quality of physical health care, including primary and specialty care;
- 2) Quality of behavioral health care focused on recovery, resiliency and rehabilitation;
- 3) Quality of LTSS;
- 4) Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS providers and services;
- 5) Continuity and coordination of care across all care and services settings, and for smooth transitions in care and maximum care continuum; and,
- 6) Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

10.2 CONTINUOUS QUALITY IMPROVEMENT PRINCIPLES AND EXPECTATIONS

The Contractor shall apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

- 1) Most current state endorsed healthcare quality improvement methodology and techniques;
- 2) Align with Virginia Medicaid Quality Strategy (located at <http://www.dmas.virginia.gov/files/links/416/DMAS%202017-2019%20Quality%20Strategy.pdf>) and Annual CCC Plus Quality Work Plan;
- 3) Quantitative and qualitative data collection and data-driven decision-making;
- 4) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
- 5) Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities;
- 6) Issues identified by the Contractor, and the Agency;
- 7) Ensure that the quality management and improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health, LTSS, and care coordination; and
- 8) Ensure that the quality strategy for the Medicaid expansion population shall follow the Quality Strategy described in this section.

10.3 QUALITY INFRASTRUCTURE

The Contractor shall structure its QI program for CCC Plus separately from any of its existing Medicaid, Medicare, or commercial lines of business. Specifically, required measures and reports for the CCC Plus Contract must reflect information only on the CCC Plus population

according to the specifications provided by the Department, and shall not include data from the CCC Demonstration, Medallion, and FAMIS programs.

The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 CFR § 438, including Subpart E, Quality Measurement and Improvement and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements. The Contractor shall:

- 1) Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;
- 2) Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;
- 3) Seek the input of providers and medical professionals representing the composition of the Contractor's Provider Network in developing functions and activities;
- 4) Establish internal processes to ensure that the QM activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the activities in this section of this Contract and, in addition, the following elements:
 - a. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the merged Member Experience and Quality of Life Survey, network provider and Member satisfaction survey, and other measurement results in designing QI activities;
 - b. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 CFR Part 456 or corresponding section in the Medicaid managed care final rule once in effect. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to the Department;
 - c. A process to measure clinical reviewer consistency in applying clinical criteria to Utilization Management activities, using inter-rater reliability measures;
 - d. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in consumer advisory boards; and
 - e. In collaboration with and as further directed by the Department, develop a customized medical record review process to monitor the assessment for and provision of Behavioral Health and LTSS.
- 5) Keep written minutes of all quality committee, key workgroup meetings, and Member advisory boards. A copy of the signed and dated written minutes for each meeting above shall be available on-file after the completion of these meetings. These minutes shall be available for review upon request by the Department, its contractor (such as EQRO) or

other entities (such as NCQA accreditation review). The Contractor shall provide advance notice to the Department about any of the meetings listed above. To the extent allowed by law, the Department or its designee, may attend any of these meeting at his/her option.

10.4 ANNUAL EVALUATION OF THE QAPI/QI PROGRAM

Pursuant to 42 CFR § 438.330, the comprehensive QAPI must include a mechanism to detect underutilization and overutilization of services; and, to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State Quality Strategy. The Standards for Quality Management and Improvement are from the most recent version of the NCQA's Standards and Guidelines for the Accreditation of Health Plans. The Contractor shall conduct an annual written evaluation of the QI program that includes the following information:

1. The evaluation of the QAPI shall address quality studies and other activities completed; and ongoing QI activities that address quality and safety of clinical care and quality of services;
2. Trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and
3. An analysis and evaluation of the overall effectiveness of the QAPI program to include its progress toward influencing network wide safe clinical practices.

The Contractor shall provide its Quality Improvement Plan (QIP) consistent with the requirements in the *CCC Plus Technical Manual*. Health Plans new to Virginia Medicaid shall provide their 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 the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's CCC Plus website.

10.5 QI STAFFING

The Contractor shall employ and maintain sufficient and qualified staff to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:

- 1) Key Contractor and subcontractor staff who can represent all major areas of the Contractor's CCC Plus line of business;
- 2) At least one designated physician who shall be a Medical Director or Associate Medical Director; at least one designated behavioral health clinician; ARTS Care Coordinator as

defined in 12 VAC 30-130-5020 (if different from the designated behavioral health clinician who should have oversight of all behavioral health services); and, a professional with expertise in the assessment and delivery of long term services and supports with substantial involvement in the QI program;

- 3) A qualified individual dedicated to serve as the QI Director who will be directly accountable to the Contractor's Project Manager or Medical Director/Chief Medical Officer and, in addition, if the Contractor offers multiple products or services in multiple states, will have access to the Contractor's executive leadership team. This individual shall be responsible for:
 - a. Overseeing all QI activities related to Members, ensuring compliance with all quality activities, and maintaining accountability for the execution of, and performance in, all such activities;
 - b. Maintaining an active role in the Contractor's and subcontractor's overall QI structure; and,
 - c. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:
 - i. Physical;
 - ii. Behavioral health;
 - iii. Pharmacy management;
 - iv. Care management;
 - v. LTSS;
 - vi. Financial;
 - vii. Statistical/analytical;
 - viii. Information systems;
 - ix. Marketing, publications;
 - x. Enrollment;
 - xi. Network;
 - xii. Utilization Management;
 - xiii. Grievance and appeal;
 - xiv. Operations management; and
 - xv. Subcontractor Oversight;
 - d. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by the Department, or its designee, and that may be attended by representatives of the Department, a Department contractor, or other entities, as appropriate; and,
 - e. Serve as liaison to, and maintaining regular communication with, Virginia QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

10.6 PERFORMANCE MEASUREMENT

The Contractor's reporting of quality performance measures shall at minimum cover the following four (4) domains:

- 1) Enhance Member experience and engagement in person-centered care;
- 2) Improve quality of care;
- 3) Improve population health; and,

4) Reduce per capita costs.

Within these four (4) domains, the Department has identified five (5) priority areas and selected measures that align with Federal, State and CCC Plus quality improvement aims and priorities. These measures are listed in the *CCC Plus Core Performance Measures List* and their reporting requirement specifications are outlined in the *CCC Plus Performance Measure Reporting Requirements* included in the *CCC Plus Technical Manual*. As required in the *CCC Plus Technical Manual*, the Contractor's HEDIS measure reporting must be done through a certified vendor/auditor. The Department reserves the right to add, delete, or update this document on a quarterly basis. The Contractor shall report on all of these measures according to the specifications listed in the *CCC Plus Performance Measure Reporting Requirements* document. The Contractor shall have an internal reporting data quality review and compliance process to ensure performance measure data is complete, accurate and timely. The Department will implement a performance measure reporting compliance program. Its results will impact the Contractor's score and rating in the CCC Plus Quality Incentive program and overall Annual Contract Evaluation and Compliance program.

A subset of the CCC Plus performance measures are designated as *CCC Plus Key Performance Indicators* as listed in the *CCC Plus Key Indicators List*, which will also be noted in the *CCC Plus Performance Measure Reporting Requirements* document. Key Performance Indicators represent CCC Plus performance measures and quality improvement priority areas. The Department reserves the rights to add, delete and modify any *CCC Plus Key Performance Indicators* list on a quarterly basis at the Department's discretion. *CCC Plus Key Performance Indicators* will require more frequent and early reporting requirements. The Contractor shall ensure full compliance with the *Key Performance Indicators* rigorous reporting requirements.

The Department will require certain measures to be reported based on a specific member population. For example, for the ARTS services, certain measures will be required to be reported based on Members receiving these services. The Department reserves the rights to add, delete and change such specific performance measure reporting designation on a quarterly basis at its own discretion. These performance measure requirements will be noted in the *CCC Plus Performance Measure Reporting Requirements* document. The Contractor shall be able to report these designated specific program performance measures at the specific program level according the specifications in the *CCC Plus Performance Measure Reporting Requirement* document.

In addition, the Contractor shall not modify the reporting specifications methodology prescribed by the Department without first obtaining the Department's written approval. The Contractor must have policies and procedures in place to ensure accurate and timely performance measure reporting to the Department. Department (or its designee) will evaluate these policies and procedures and will perform an independent validation on at least a sample of the Contractor's performance measures. The Contractor shall collect performance data and contribute to all QI-related initiatives as follows:

- 1) Collect and submit to the Department, in a timely manner, according to the Department's specifications, data for the measures specified in the *CCC Plus Performance Measure Reporting Requirements*;

- 2) Contribute to all Department data quality assurance processes, which shall include, but not be limited to, responding in a timely manner, to data quality inadequacies identified by Department, and rectifying those inadequacies as directed by the Department;
- 3) Contribute to the Department's data regarding the individual and aggregate performance of the Contractor with respect to the noted measures;
- 4) Contribute to the Department's processes culminating in the publication of any technical or other reports related to the noted measures; and,
- 5) Demonstrate how to utilize results of the measures specified in *CCC Plus Performance Measure Reporting Requirements* in designing future QI initiatives.

Annually, the Contractor shall conduct Member experience and Provider survey activities, as follows:

- 1) Conduct an annual CAHPS survey. The Contractor shall enter into agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The Contractor's vendor shall perform the CAHPS Adult Version Medicaid survey, CAHPS Child Version, Children with Chronic Conditions Medicaid survey using the most current CAHPS version specified by NCQA. Survey results shall be reported on the CCC Plus program separately for each required CAHPS surveys listed above with results specifically for the CCC Plus program. Composite scores should also be reported. Performance on CAHPS surveys may also be publicized as described above. The Contractor is required to identify Spanish speaking Members through administrative data and ensure those Members who are included in the CAHPS sample receive the Spanish version of the survey rather than the English version. Survey results shall be submitted to the Department, NCQA, and Agency for Healthcare Research and Quality (AHRQ) for inclusion in the National CAHPS Benchmarking Database if the option is available through AHRQ. CAHPS Surveys are due annually by June 15 of each calendar year beginning in 2019.
- 2) Conduct, as directed by the Department, the HCBS Experience survey for Members utilizing LTSS. Survey methodology and tools will be jointly developed via a collaborative effort between the Department and the CCC Plus program Contractors. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;
- 3) Conduct, as directed by the Department, a merged Member satisfaction survey on care management, ARTS Member experience, and quality of life. Survey methodology and tools will be jointly developed via a collaborative effort between the Department and the CCC Plus program Contractors;
- 4) Design and administer network providers and Member satisfaction surveys regarding their satisfaction with the Contractor. The Contractor can use the merged Member satisfaction, ARTS Member experience, and quality of life survey as the Members satisfaction survey, or administer a separate Member satisfaction survey. The Contractor shall submit a survey plan and all related survey materials to the Department for approval at least 60 calendar days before survey administration and shall submit the results of the survey to the Department within the required timeline;
- 5) Conduct any other surveys as deemed necessary by the Department. The Contractor shall also assist with any Department CCC Plus Member survey, if any;
- 6) If not required specifically, the Contractor shall prepare detailed reports summarizing the survey results for submission to the Department per required timelines. The Department

may require the Contractor to present individual survey results to various groups of audiences. The Contractor shall also prepare and conduct presentations, if requested by the Department, for each survey. These presentations shall include survey background, methodology, timeline, results, best practices, lessons learned, and how the Contractor utilizes the results for QI initiatives and system/process changes; and,

- 7) The Contractor shall demonstrate best efforts to utilize Member experience survey results in designing QI initiatives and implement system and process changes.

The Contractor shall contribute to data quality assurance processes, including responding in a timely manner to data quality inadequacies identified by the Department and rectifying those inadequacies, as directed by the Department. The Contractor shall contribute, as directed by the Department, to processes culminating in the development of CCC Plus quality reports regarding CCC Plus quality of care and performance.

10.7 PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

The Contractor shall perform at least one (1) clinical and one (1) non-clinical PIP. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, behavioral health, long term services and supports, high-volume services, high risk services, and/or high-cost services. Non-clinical PIPs include projects focusing on availability, accessibility, cultural competency of services, interpersonal aspects of care, appeals, grievances, complaints, care transition and continuity, coordination of care and care management, and/or Member satisfaction.

The Department will require the two (2) above mentioned mandatory PIPs to address specific topic areas and use specific performance measures with input from the CCC Plus Quality Collaborative. If not specified by the Department, the duration of each PIP should be three (3) years starting from the approval of the PIP work plan by the Department. Within 30 days after initial signing of the CCC Plus program Contract, the Contractor shall identify at least two (2) qualified representatives with leadership responsibilities of the PIPs to serve on a CCC Plus Quality Collaborative with the Department. These representatives shall include at least the Contractor's QI Director and Chief Medical Officer or Medical Director with responsibility for clinical oversight of the PIPs.

This Collaborative shall brainstorm and propose PIP topic areas for the two (2) mandatory PIPs above and key PIPs performance measures (based on the CCC Plus Core Performance Measure set) as recommendations to the Department. The Department will make the final decision regarding the specific topics for each of the two (2) mandatory PIPs and the key performance measures for each PIP.

The one (1) clinical PIP shall include one (1) in the area of a major chronic condition medical management (such as cardiovascular disease, diabetes, pulmonary disease, and mental health) or in the area of behavioral health that is relevant to ARTS.

The one (1) non-clinical PIP shall be in the area of long-term care and LTSS diversion; or in the area of care management, care coordination, and/or care transitions.

The Contractor can plan and implement additional PIPs outside the required two (2) mandatory PIPs above. For all PIPs, including the two (2) mandatory PIPs and any additional PIPs proposed by the Contractor, the Contractor shall submit a PIP project plan to the Department according to the times and template provided by the Department for review and approval before implementation.

The Contractor shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for performance improvement projects are documented using the format and submission guidelines specified by Department in annual guidance provided for the upcoming contract year.

The Contractor shall identify benchmarks and set achievable performance goals for each of its PIPs which will be submitted to the Department for review and approval. The Contractor shall collect information and data in accordance with PIPs' specifications for its Members. For any PIPs, if performance measures are not selected by the Department, the Contractor should consider the *CCC Plus Core Performance Measure* set in selecting PIP performance measures. The Contractor shall implement PIPs in a culturally competent manner, to achieve their objectives using the Plan Do Study Act (PDSA) improvement model defined by the Institute for Health Care Improvement. The Contractor shall identify and implement intervention and improvement strategies for achieving the performance goals set for each PIP and promote sustained improvements.

Using the submission guidelines specified by the Department, the Contractor shall develop comprehensive written PIP reports on a semi-annual basis. Such reports shall include information regarding PDSAs, progress on QI Project Requirements, performance on key PIP performance measures and progress toward achieving performance goals, barriers encountered and new knowledge gained. As directed by the Department, the Contractor shall present this information to the Department upon receipt of requirements by the Department; The Contractor shall evaluate the effectiveness of the PIP continuously based on implementation of PDSA results and plan and initiate processes to sustain achievements, and encourage best practices to continue improvements. The Department will review PIP progress reports and provide feedback. The Contractor shall address any questions, concerns, and direct guidance from the Department regarding PIP plan and implementation.

After the initial PIPs' implementation period, the Contractor shall evaluate to determine if any specific PIPs should be continued. Prior to discontinuing a PIP, the Contractor shall identify a new PIP and submit a new PIP project plan to the Department for approval. The new PIP focus areas will be mandated by the Department after gathering recommendations from the Quality Collaborative. The Contractor must receive the Department's approval to discontinue the previous PIP and perform the new PIP.

The Contractor shall conduct additional PIPs, special projects, focus studies, and research outside of the two (2) mandatory PIPs if mandated by the Department.

10.8 EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by the Department, in accordance with 42 CFR § 438.358 or

corresponding section in the Medicaid managed care final rule. EQR activities shall include, but are not limited to:

- 1) Annual validation of performance measures reported to the Department, as directed by the Department, or calculated by the Department;
- 2) Annual validation of quality improvement projects required by the Department;
- 3) At least once every three (3) years, review of compliance with standards mandated by 42 CFR Part 438, or corresponding section in the Medicaid managed care final rule, and at the direction of the Department, regarding access, care coordination, structure and operations, scope and quality of care and services furnished to Members, and other standards;
- 4) Annual validation of the Contractor's provider network adequacy;
- 5) Any other optional EQRO activities the Department may contract with the EQRO to conduct including validation of encounter data, administration or validation of consumer or provider surveys of quality of care, calculation of performance measures in addition to those reported by health plans, conduct PIPs in addition to those mandated to be conducted by health plans, focus studies, and assistance with the health plan quality rating system development required by CMS; and,
- 6) The Contractor shall take all steps necessary to support the EQRO in conducting EQR activities including, but not limited to:
 - a. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:
 - i. Oversee and be accountable for compliance with all aspects of the EQR activity;
 - ii. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO or the Department in a timely manner;
 - iii. Serve as the liaison to the EQRO and the Department and answer questions or coordinate responses to questions from the EQRO or the Department in a timely manner; and
 - iv. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR activity and as requested by the EQRO or the Department.
 - b. Maintaining data and other documentation necessary for completion of EQR activities specified above. The Contractor shall maintain such documentation for a minimum of ten (10) years;
 - c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or the Department;
 - d. Participating in health plan-specific and cross-health plan meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and the Department;
 - e. Implementing actions, as directed by Department, to address recommendations for QI made by the EQRO, and sharing outcomes and results of such activities with the EQRO or the Department in subsequent years; and
 - f. Participating in any other activities deemed necessary by the EQRO and approved by Department.

10.9 WAIVER ASSURANCES

The Department must meet Federal requirements for all Medicaid Waivers that provide the Department with authority to implement the CCC Plus program and any component of the CCC Plus program such as ARTS. The Contractor shall fully comply and implement to the Department's satisfaction any delegated activities by the Department for any Federal waiver requirements. An example of these requirements is the HCBS waiver assurances under the following domains: 1) Level of Care; 2) Service Plan; 3) Qualified Providers; 4) Health and Welfare; 5) Financial Accountability; and 6) Administrative Authority. Delegated by the Department, the Contractor shall conduct quality management reviews for the HCBS waivers and programs. Quality management reviews (QMRs) focus on the creation and implementation of the plan of care (POC). Reviewers determine if the plan is person centered, based on the assessment, addresses the individual's needs and personal goals. Provider documentation of services is reviewed to determine if services were delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. QMR details are discussed with the provider at an exit conference during the review and are further explained in a letter sent to the provider. These reviews will be monitored by the Department in accordance with parameters required through the Department's waiver application and related policies and procedures. The Contractor shall follow all of these quality assurances procedures and protocols which will be provided by the Department.

The Contractor shall report on the Waiver assurance measures according to the requirements and timelines described in the *CCC Plus Technical Manual*.

10.10 QI FOR UTILIZATION MANAGEMENT ACTIVITIES

The Contractor shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.

The QI activities for the UM program shall include:

- 1) Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
- 2) At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of long term services and supports representative of the Contractor or subcontractor, with substantial involvement in the UM program; and
- 3) A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

10.11 CLINICAL PRACTICE GUIDELINES

The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

- 1) Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of long term

- services and supports in the relevant field, community-based support services or the Contractor's approved behavioral health performance specifications and clinical criteria;
- 2) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of LTSS;
 - 3) Do not contradict existing Virginia-promulgated regulations or requirements as published by the Departments of Social Services, Health, Health Professions, Behavioral Health and Developmental Services, Virginia Department of Health or other State agencies;
 - 4) Prior to adoption, have been reviewed by the Contractor's medical director, as well as other Contractor practitioners and network providers, as appropriate;
 - 5) Are reviewed and updated, as appropriate, or at least every two (2) years;
 - 6) Are reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;
 - 7) For guidelines that have been in effect two (2) years or longer, the Contractor must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;
 - 8) Disseminate, in a timely manner, the clinical guidelines to all new network providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's web site. The Contractor shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made;
 - 9) Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services; and,
 - 10) Submit to the Department a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

10.12 QUALITY COLLABORATIVE AND OTHER WORKGROUPS

As directed by the Department, the Contractor shall actively participate in the CCC Plus Quality Collaborative, including attendance at all meetings by the QI Director and the Contractor's Chief Medical Officer or Medical Director. The Contractor shall also actively participate in all other workgroups that are led by the Department, including any quality management workgroups or activities that are designed to support QI activities and to provide a forum for discussing relevant issues.

Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup. The Contractor shall also serve as a liaison to, and maintain regular communication with, the Department or its designated QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or promptly sharing data relevant to all QI activities. These QI activities may include ongoing health plan quality monitoring, sharing quality data and best practices through the Quality Collaborative, coordinating performance improvement projects, and participating in a quality workgroup for survey planning and CCC Plus Health Plan Rating System development, etc.

These workgroups will be attended by representatives of the Department, the Department's contractors, and other entities, as appropriate. The Contractor will identify qualified representatives, including the QI Director and senior physicians such as medical directors or associate medical directors and clinicians who are actively working on quality activities, to participate in these workgroups.

10.13 MEMBER INCENTIVES

The Contractor may offer non-cash incentives or discounts to their enrolled Members for the purpose of rewarding healthy behaviors (e.g., immunizations [EPSDT, flu, shingles, pneumonia, etc.], prenatal visits, provider visits, or participating in disease management, HEDIS or HEDIS related measures/activities, etc.).

The Contractor shall also ensure that incentives are made available in equal amount, duration, and scope to the Contractor's Membership in all localities served. Incentives shall be limited to a value of no more than \$50.00 for each medical goal, unless otherwise approved by the Department.

Incentives over \$50 per medical goal must be approved by the Department prior to implementation; DMAS reserves the right to deny healthy incentive initiatives that do not align with DMAS or CMS policy. Non-cash incentives may include gift cards or discounts for services. The Contractor shall have assurances that gift cards cannot be redeemed by the business (Wal-Mart, Target, etc.) for cash; cash incentives are not permitted.

Annually the Contractor shall report its healthy incentives plan, including the various incentives that will be offered to its Members. The report must describe how the Contractor will measure the success of the incentives offered and shall provide anticipated outcomes and return on investment. The Contractor shall describe the activities supporting health and wellness initiatives to include healthy behavior incentives to encourage Members to take an active role in their health. Examples of healthy behavior activities include engagement in disease management programs, performance of best-practice preventive measures such as flu shots, participating in smoking cessation programs, etc. Refer to the *CCC Plus Technical Manual*. The Contractor shall maintain a database and track incentives by individual and must provide information to the Department upon request. Additionally, as part of the Contractor's annual report to DMAS, the Contractor shall report regarding the value/impact of the Contractor's healthy incentive initiatives on Member health outcomes.

10.14 SOCIAL DETERMINANTS OF HEALTH

The Contractor shall develop programs and establish partnerships to address social factors that affect health outcomes, also called social determinants of health (SDOH), which contribute significantly to the cost of care and the Member's health care experience. The Contractor shall provide care coordination efforts that identify and address Member access to employment, food security, housing stability, education, social cohesion or resources that support Member connection to social supports, health and health care, as well as environmental needs identified by the Member. These social determinants are encompassed in five key areas as shown below

(Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment.)

By February 15, 2019, the Contractor shall complete the following reporting requirements as specified in the *CCC Plus Technical Manual*: A) The Contractor shall submit its policies and procedures related to the programs and partnerships established to address the following three (3) determinants belonging to the SDOH areas described as Economic Stability; B) The Contractor shall submit Care Coordination Training Materials for both the CCC Plus and Medicaid Expansion Populations; C) The Contractor shall submit its policies and procedures related to identifying, addressing, and tracking how the Contractor is addressing the following three (3) determinants belonging to the SDOH areas described as Economic Stability:

- Employment
- Food security
- Housing stability

The Contractor shall utilize the pdf templates for submission of its policies and procedures and other reporting requirements in the format(s) specified in the *CCC Plus Technical Manual*.

The Department has the discretion to expand the SDOH reporting criteria throughout future Contract years, to include specific data for the areas noted above or additional areas as necessary. Additional SDOH include, but may not be limited to, the following:

- Education (high school graduation, enrollment in higher education, language and literacy, early childhood education and development);
- Social and Community Context (perceptions of discrimination and equity, incarceration/institutionalization);
- Health and Health Care (access to health care, access to primary care, health literacy);
- Neighborhood and Built Environment (access to foods that support healthy eating patterns, crime and violence, environmental conditions, quality of housing).

Effective July 1, 2019, the Department encourages the Contractor to focus SDOH programs and partnerships on addressing the following priority populations.

- Transitions of care – Members transitioning from the hospital to the community, from the nursing facility/ICF/IID to the community, and from incarceration to the community;
- High Risk populations – Members who are considered high emergency department (ED) utilizers; Children with asthma.
- Substance use / Opioid Use Disorders – Members with SUD and/or OUD especially pregnant mothers with SUD and/or OUD.

The five determinant areas noted in this section (Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment) were developed by the Office of Disease Prevention and Health Promotion, Healthy People 2020. For more details, see <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

10.15 BEHAVIORAL HEALTH SERVICES OUTCOMES

- 1) The behavioral health outcome measures will help to assess the standards of care and adherence to best practices within behavioral health. The goals are to increase the overall health of the population, improve the care for Members and to gain efficiencies in health care delivery leading to reduced care costs.
- 2) The Contractor shall require behavioral health providers to collect clinical outcomes data as determined by the Contractor and approved by the Department.
- 3) The Contractor's behavioral health provider contracts shall require the provider to make available behavioral health clinical assessment, treatment planning and outcomes data for quality, utilization and network management purposes;
- 4) The Contractor shall use outcome measures based on best practices within behavioral health care. As directed by the Department, the Contractor shall collaborate with DBHDS, other state agencies, CSBs/BHAs and behavioral health providers to develop outcome measures that are specific to each covered behavioral health service.
- 5) Outcome measures may include and are not limited to:
 - a. Recidivism;
 - b. Adverse occurrences;
 - c. Treatment terminations or discharges against medical advice;
 - d. Community tenure;
 - e. Utilization measures such as access to care, hospital admissions and readmissions, emergency department visits and coordination with medical care;
 - f. Social determinants of health such as employment or school attendance, availability of housing, social connectedness and criminal justice;
 - g. Recovery oriented measures;
 - h. Member satisfaction; and,
 - i. Cost measures.

10.16 ARTS SPECIFIC MEASUREMENT AND REPORTING

DMAS will collect reliable and valid data from the Contractor to enable reporting of ARTS specific metrics to the Centers for Medicare and Medicaid Services (CMS). The Department has the authority to add and remove ARTS specific metrics. The Contractor shall also be able to report these measures, as identified in the *ARTS Technical Manual*. Details regarding reporting specifications are listed in the *ARTS Technical Manual*. The Contractor shall be given sixty (60) days from the date of any updates to the *ARTS Technical Manual* to make any changes.

10.17 MEDICAID EXPANSION POPULATION SPECIFIC MEASUREMENT AND REPORTING

The Contractor must be able to:

- 1) Refer Members to job training, education and job placement assistance (example: referrals by Care Coordinators to Career Work Centers to Work Force One-Stop centers);
- 2) Utilize current health and wellness programs or healthy behavior incentives to encourage Members to take an active role in their health. Examples of healthy behavior activities include engagement in disease management programs, performance of best-practice preventive measures such as flu shots, participation in smoking cessation programs, access to health-related services not covered by traditional medical practices, such as gym memberships and vision services, etc.;
- 3) Appropriate utilization of hospital emergency room services and use of the ED Care Coordination encounter alerts and shared care coordination plans by MCO Care Coordinators to identify frequent ED utilizers and address their needs, and;
- 4) Work with the Department on enhanced fraud prevention efforts, in addition to the complying with requirements in Section 14.0, *Program Integrity (PI) and Oversight*. The Contractor shall advocate for and support enhanced fraud prevention efforts. Protecting the integrity of all Members has heightened urgency as the Medicaid population increases in number. The Department's Program Integrity Division will collaborate with the Contractor on enhanced Program Integrity efforts. The Contractor shall send an enhanced fraud prevention effort report by April 1, 2019. Refer to the *CCC Plus Technical Manual* for reporting criteria specific to the Medicaid expansion Populations.

10.18 QUALITY SYSTEM

The Contractor's quality information system or core systems shall support all quality related activities as described in this Contract. The system shall accurately track and report all the QI performance measures at the frequency and timeframe required by the Department. The system must be flexible with creating and customizing performance measures to support the full scope of QI initiatives performed under this Contract.

10.18.1 Consumer Decision Support Tool

As required by CMS per 42 CFR § 438.334 to publish a quality rating system (QRS), the Department will publish a consumer decision support tool, comprised of performance measurement data collected from the Contractor. This data will include performance measures identified by CMS and stakeholders and will be published once a year and posted on the Department's website. The consumer decision support tool will be available by May of each year.

10.19 NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

The Contractor shall obtain and retain Medicaid health plan accreditation by the National Committee for Quality Assurance (NCQA). When the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) calendar days of receiving the report. The Department must also be notified in writing within ten (10) calendar days of any change to the Contractor's accreditation level. Denial or revocation of

NCQA accreditation or a status of “Provisional” may be cause for the Department to impose remedies or sanctions as described in Section 18.0, *Enforcement, Remedies, and Compliance* of this Contract to include suspension, depending upon the reasons for denial by NCQA.

Beginning January 1, 2019, Contractors with existing NCQA accreditation shall obtain NCQA LTSS Distinction at their next health plan accreditation (HPA) renewal.

If the Contractor is seeking NCQA New Health Plan accreditation for its Virginia Medicaid line of business, it must adhere to the following timeline of milestones for NCQA Accreditation set forth by the Department and provide documentation upon completion of each milestone:

- 1) Participate in EQRO comprehensive onsite reviews at dates to be determined by the Department.
- 2) Attain Interim Accreditation Status from NCQA by the end of the eighteenth (18th) month of operations (onset of delivering care to CCC Plus Members).
- 3) Obtain NCQA accreditation with LTSS distinction status of at least “Accredited” within 36 months of the onset of delivering care to CCC Plus Members.

The Contractor shall adhere to all requirements based on the most current version of NCQA Standards and Guidelines for the Accreditation of MCOs. The standards categories include: Quality Management and Improvement, Standards for Utilization Management, Standards for Credentialing and Re-credentialing, Standards for Members’ Rights and Responsibilities, Healthcare Effectiveness Data and Information Set (HEDIS) measures required for credentialing (Medicaid products), and CAHPS survey.

If the Contractor provides coverage for more than one product line for the Department (e.g., Medallion, Commonwealth Coordinated Care, Commonwealth Coordinated Care Plus), the Contractor shall report its HEDIS and CAHPS separately for each product line.

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

SECTION 11.0 MEMBER SERVICES AND COMMUNICATIONS

11.1 MEMBER CALL CENTERS

The Contractor shall operate adequately staffed toll-free telephone lines to respond to the various Member concerns, health crises, inquiries (e.g., covered services, provider network), complaints and questions regarding the Virginia CCC Plus program. The calls may be generated from a CCC Plus program Member, the Member's family, or the Member's provider.

The Contractor's call centers shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues. Further, the Contractor's call centers shall be adequately staffed with qualified personnel who are trained to accurately respond to Members.

The Contractor shall develop Member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, monitoring of calls via recording or other means, and compliance with standards. The Contractor shall measure and monitor the accuracy of responses and phone etiquette, taking corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

11.1.1 Staffing Requirements

The Contractor shall ensure that the Member customer service line is staffed adequately to respond to Members' questions and concerns that are specific to the Virginia CCC Plus program during the required hours of operation. The Member customer service call center shall be staffed with qualified clinicians to triage crisis, urgent, and emergency calls from Members and to facilitate the transfer of calls to clinical triage personnel or Care Coordinators from or on behalf of a Member that requires immediate attention.

The Contractor's customer service staff shall be trained to apply a low threshold in identifying crisis calls; that is, they only need to suspect a crisis to initiate crisis call procedures including assessing eminent risk and immediately engaging a licensed care manager. When the staff hear verbal cues or other indications that suggest an emergency, he or she shall immediately pass the call "live" to a clinical triage crisis care manager.

The Contractor's call centers' staff shall be trained to respond to the unique needs of the CCC Plus program populations including calls from Members with cognitive, physical, or mental disabilities, or from Members with limited English proficiency (including access to interpreter and translation services as necessary).

The Contractor may have a separate clinical triage line that meets all of the operating requirements detailed herein.

11.1.2 Member Clinical Triage Line

The Clinical Triage line shall be dedicated to providing the management of all crisis calls (e.g., behavioral health, ARTS, medical), nurse advice, and care coordination support. The Clinical Triage line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified clinicians to triage behavioral health, ARTS, urgent care and emergency calls from Members.

The Clinical Triage line shall facilitate the transfer of calls to a Care Coordinator from or on behalf of a CCC Plus program Member that requires immediate attention. Through the Clinical Triage line, clinical staff will work with Members to determine their needs, discuss behavioral health/ARTS service options and assist them in identifying an appropriate provider. If at any time, a caller is in distress or appears to have complex needs or a complicating condition, a clinical care manager shall provide the appropriate triage and referral.

The Contractor shall implement policies and procedures, subject to approval by the Department, that describe how calls to the clinical triage line from CCC Plus Members will be handled and how the Member's Care Coordinator is made aware of all calls in order to ensure appropriate follow-up, continuity of care, etc. The Contractor shall have policies and procedures, subject to approval by the Department, to identify and assist callers in crisis. Procedures must include established network resources for immediate referrals as clinically assessed to be warranted to protect the safety of the Member and community.

11.1.3 Warm Transfer to Clinical Professional Staff

The Contractor shall ensure that all calls from CCC Plus program Members that require immediate attention are transferred via a "warm transfer" when necessary to a medical, behavioral, or ARTS professional with appropriate clinical expertise to assist the Member, and to connect the Member with their assigned Care Coordinator. These "warm transfer" calls shall be delineated separately in reports and metrics from other call center contacts.

At a minimum, behavioral health crisis call reporting shall include:

- 1) Date of call, Member name and ID, Member FIPS, and contact information
- 2) Call reason,
- 3) Assessment and referral,
- 4) Member status,
- 5) Identified treating provider(s),
- 6) Outcomes, and
- 7) Follow-up treatment and monitoring activities.

11.1.4 Appropriate Call Transfers

The Contractor shall implement protocols, subject to the Department's approval, to ensure that calls to the Member services information line that should be transferred/referred to other Contractor staff, including but not limited to a Member services supervisor, a Care Coordinator, or to an external entity (including but not limited to the F/EA) are transferred/referred appropriately.

11.1.5 Communication /Interpreter Assistance

The Contractor shall provide language assistance services and auxiliary aids, including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, large print or Braille, free of charge to Members and/or the Member's representative.

11.1.6 Monitoring By The Department

The Contractor shall provide the capability for the Department to monitor calls remotely from DMAS offices at no cost to the Department.

11.1.7 Member Services Hours Of Operation

- 1) General customer service helpline (available 8:00 am-8:00 pm, seven (7) days a week). Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays (see Definitions);
- 2) Clinical triage line, (available 24 hours per day; 7 days per week) shall include:
 - a. behavioral health/ ARTS crisis line;
 - b. care coordination support; and,
 - c. clinical/nurse advice.

The Contractor may use an interactive voice response (IVR) system to route calls to the appropriate support outside of the general customer service hours (as opposed to a customer service representative needing to be available 24/7 to answer and route the call). Outside of general customer service hours, the Contractor must employ a clinical triage line (behavioral health/ARTS crisis line, care coordination support, and clinical/nurse advice), and a Pharmacy Technical Support line available 24 hours per day, 7 days per week. Refer to *Hours of Operation*. Also refer to *Hospital Emergency Department Assistance*.

11.1.8 Interactive Voice Response (IVR)

For the initial call to the call center(s), the Contractor may employ an answering service or use an interactive voice response (IVR) system to route calls. The Contractor's IVR system shall provide an option for crisis or emergency calls and direct the caller immediately to an appropriate representative. These calls, when transferred from the initial IVR, shall not go to another answering service or IVR.

The Contractor shall ensure that any line that receives crisis or emergency calls must be staffed by appropriate clinical staff. If the Contractor determines that the call is not an emergency, the caller may be informed the line is reserved for emergencies only and the caller may be transferred back through the standard phone line for assistance from the next available representative.

11.1.9 Performance Standards

The Contractor's call centers shall:

- 1) Answer 85% of all calls within 30 seconds or less;
- 2) Limit the average hold time to less than two (2) minutes (defined as the time spent on hold by the caller after the IVR system/touch tone response system/recorded greeting and before reaching a live person);
- 3) Limit the disconnect (abandonment) rate of all incoming calls to five (5) percent). *Calls abandoned are the number of calls where the caller disconnects while on hold waiting for an agent. An abandoned call is one that hangs up after 60 seconds. If the caller hangs up before 60 seconds, it's not considered abandoned;*
- 4) Have a process to measure the time from which the call is answered to the point at which a Member reaches an Enrollee Service Representative (ESR) capable of responding to the

Member's question in a manner that is sensitive to the Member's language and cultural needs;

- 5) Record 100% of incoming calls from the Member helplines using up-to-date call recording technology. Call recordings shall be searchable by provider NPI, Member ID # (if available), phone number (when identified), and date and time of the call. Recordings shall be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call;
- 6) Measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff;
- 7) Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance;
- 8) Report on CCC Plus program calls separately from other Virginia lines of business, if any; and,
- 9) Report by region and by service area (i.e., ARTS, Mental Health, LTSS, Nursing Facility, Primary and Medical Services, Transportation Services). The Contractor's call system shall also track and report the number of mental health and ARTS crisis calls received.

11.2 MEMBER INQUIRIES

The Contractor shall provide a timely response to all inquiries received from Members or on behalf of Members while ensuring HIPAA compliance. Additionally, in any instance where the Contractor receives a claim for payment filed by the Member, the Contractor shall respond to the Member, in writing, and at the time of any action affecting the claim. This response to the Member is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the Member regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

11.3 MEMBER RIGHTS AND PROTECTIONS

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

The Contractor shall comply with requirements for Member rights. At a minimum such Member rights include the right to:

1. Receive information in accordance with 42 CFR § 438.10.
2. Be treated with respect and with due consideration for his or her dignity and privacy.
3. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.
4. Participate in decisions regarding his or her health care, including the right to refuse treatment.
5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

6. Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.
7. Have free exercise of rights and the exercise of those rights does not adversely affect the way the Contractor and its providers treat the Member.
8. Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210 as described in this Contract.

11.4 ADVANCED DIRECTIVES

In accordance with 42 CFR §438.3(j)(1) and (2); the Contractor shall educate staff concerning their policies and procedures on advance directives.

Members must be provided information about advance directives (at a minimum those required in 42 CFR §§ 438.3.(j), 489.102 and 422.128), including:

1. Member rights under the law of the Commonwealth of Virginia, including any changes in State law as soon as possible, but no later than 90 days after the effective date of the change;
2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
3. That complaints concerning noncompliance with the advance directive requirements may be filed with DMAS; and,
4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Member.

Nothing in this Contract shall be interpreted to require a Member to execute an advanced directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicaid program.

11.5 CULTURAL COMPETENCY

The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Members including those with limited English proficiency, differing abilities, and diverse cultural and ethnic backgrounds. The Contractor shall demonstrate cultural competency in all forms of communication. Furthermore, the Contractor shall ensure that cultural differences between providers and Members do not impede access and quality health care.

11.6 COST-SHARING

The Contractor shall not impose any cost sharing obligations on Members for covered and non-covered services. The Contractor may not impose co-payments on prescription drugs covered under this Contract. CCC Plus program Members will be exempt from cost sharing other than for any Patient Pay established by DSS towards LTSS services, including skilled and custodial nursing facility and CCC Plus Waiver services. (Refer to Section 4.7.5, *Patient Pay* of this Contract for more information.)

11.7 PROTECTING MEMBER FROM LIABILITY FOR PAYMENT

In accordance with 42 CFR § 438.106 and 42 CFR § 447.15, the Contractor, shall ensure that its Members are not held liable for payment for any services provided under this Contract other than

for any Patient Pay established by DSS towards LTSS services. The Contractor shall assure that all in-network provider agreements include requirements whereby the Member shall not be charged for any Medicaid covered service. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions. Refer to Attachment 14 (July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo) and Attachment 15 (MCO COB Resource Chart) for the Department's expectations during the coordination of benefits process.

The Contractor shall not deny and shall ensure that its providers and subcontractors do not deny any service covered under this Contract to any Member for failure or inability to pay any applicable charge or where the Member, who, prior to becoming CCC Plus program eligible, incurred a bill that has not been paid.

The Contractor shall ensure Provider Network compliance with all Member payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any Member of the Contractor's Provider Network that does not comply with such provisions.

The Contractor and its subcontractors are subject to criminal penalties if providers knowingly and willfully charge, for any service provided to a Member under the State Plan or under this Contract, money or other consideration at a rate in excess of the rate established by the Department, as specified in Section 1128B (d)(1) of the Social Security Act (42 USC § 1320a-7b), as amended. This provision shall continue to be in effect even if the Contractor becomes insolvent until such time as Members are withdrawn from assignment to the Contractor.

Pursuant to Section 1932(b)(6), (42 USC § 1396u-2 (b)(6)), and in accordance with 42 CFR § 438.106 the Contractor and all of its subcontractors shall not hold a Member liable for:

1. Debts of the Contractor in the event of the Contractor's insolvency.
2. Covered services provided to the Member for whom the Contractor has not received payment from the Department for the services; or, the provider, under contract or other arrangement with the Contractor, fails to receive payment from the Department or the Contractor.
3. Payments in excess of the contracted amount
4. Payments to providers that furnish covered services under a contract or other arrangement with the Contractor that are in excess of the amount that normally would be paid by the Member if the service had been received directly from the Contractor.
5. Coinsurance, copayments, deductibles, financial penalties, or any other amount other than any Patient Pay established by DSS towards LTSS services.

11.8 MEMBER ADVISORY COMMITTEE

In accordance with 42 CFR §438.110, the Contractor shall establish a Member Advisory Committee that will provide regular feedback to the Contractor on issues related to CCC Plus program management and Member care. The Contractor shall ensure that the Member Advisory Committee (1) meets at least quarterly beginning the second quarter of CY 2018 and (2) is comprised of a reasonably representative sample of the LTSS Members, or other individuals representing Members including family Members, independent advocates and other caregivers

that reflect the diversity of the CCC Plus program population, including individuals with disabilities and individuals residing in NFs. The Contractor shall advise all Members of this Committee and provide a procedure for interested Members, family members, independent advocates, and other caregivers to participate on the Committee. The Department reserves the right to review and approve Committee Membership.

The Contractor shall include Ombudsman reports in quarterly updates to the Member Advisory Committee and shall participate in all statewide stakeholder and oversight meetings as requested by the Department.

11.9 PROTECTION OF CHILDREN AND AGED OR INCAPACITATED ADULTS

The Contractor shall report as follows:

Suspected or Known Child Abuse or Neglect

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

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

Suspected or Known Abuse of Aged or Incapacitated Adults

In accordance with Section 63.2-1606 of the *Code of Virginia*, the Contractor shall report immediately upon learning of any suspected or known abuse, neglect, or exploitation of adults to the local adult protective services office or to the Virginia Department of Social Services' toll-free Adult Protective Services hotline at: **(888) 832-3858**. The Contractor shall make available to the Department upon request information pertaining to these reports. All staff training must include policies and procedures regarding mandated reporting.

11.10 PROTECTION OF MEMBER-PROVIDER COMMUNICATIONS

In accordance with 42 USC §1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a provider from advising a Member about his/her health status or medical care or treatment options for the Member's condition or disease; information the Member needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Member's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the provider is acting within the lawful scope of practice.

11.11 MEMBER COMMUNICATIONS AND ENROLLMENT MATERIALS

11.11.1 Prior Approval Process

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

Medicaid Expansion Member materials must be pre-approved by the Department before being made accessible to the public. The Contractor must submit its Member materials to the Department for review and approval thirty (30) days prior to initial posting and thirty (30) days prior to any substantive changes being made.

11.11.2 Written Material Guidelines

In accordance with CFR § 438.10(c)(4)(i), the definitions provided in the Attached *Common Definitions For Managed Care Terminology* shall be used by the Contractor in all Member communications and materials. In accordance with 42 CFR § 438.10(c)(4)(ii), the Contractor shall utilize the DMAS Member notice templates as developed and directed by the Department.

The Contractor shall ensure that documents for its Membership, such as the Member handbook, are comprehensive and written to comply with readability requirements. All written material for Members shall be in a font size no smaller than 12 point. All information provided to Members or potential Members shall use easily understood language and formats, and shall meet the information requirements outlined in 42 CFR § 438.10. CMS published a health literacy tool kit that provides guidance for how to make written material clear and effective, available at: <https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html>. Part 7 of the Tool Kit provides cautionary information on using readability formulas and suggests alternative methods to make written material easier for individuals to understand. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

The Contractor shall make available information detailing how to access smartphone applications, social media platforms, member letters, enrollment packets and other communications electronically.

The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, Member handbooks, appeal and grievance notices, and denial and termination notices, in English and Spanish and shall include taglines in the top fifteen (15) other prevalent non-English languages spoken in Virginia. Reference: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15-non-english-by-state-MM-508_update12-20-16.pdf.

As outlined in 42 CFR § 438.10(d), written materials shall be made available in alternative languages and formats upon request of the Member at no cost. Auxiliary aids and services shall also be made available upon request of the Member at no cost. Written materials shall include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's Member/customer service unit. Materials shall also include information that indicates that the Member can access free interpreter services to answer any questions. Large print means printed in a font size no smaller than 18 point.

11.11.3 Distribution of Member Materials

11.11.3.1 Electronic Information

Except as specifically required by this contract, the Contractor must provide the required Member materials, described below, as outlined in 42 CFR § 438.10(g)(3). Further, if information is made available to the Member electronically, then the information provided must further meet the requirements as outlined in 42 CFR § 438.10(c)(6). Required Membership materials shall not be provided electronically by the Contractor unless all of the following are met:

- 1) The format is readily accessible; and,
- 2) The information is placed in a location on the Contractor's Web site that is prominent and readily accessible; and,
- 3) The information is provided in an electronic form which can be electronically retained and printed; and
- 4) The information is consistent with the content and language requirements described in 42 CFR §438.10; and
- 5) The Member is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

11.11.3.2 Required Membership Materials

The Contractor shall notify the Member of his or her enrollment in the Contractor's plan through a letter submitted simultaneously with the required membership materials.

At a minimum, the Member materials shall include:

- 1) Welcome/introduction Letter
- 2) Identification Card that Includes the Medicaid ID Number
- 3) Member Handbook. The Contractor shall provide the handbook to the Member using one of the following methods:
 - a) provides via a paper copy by mail; or,
 - b) provides by email, after obtaining the Member's agreement to receive the information by email; or
 - c) posts the handbook on the Contractor's web site, where the Contractor must advise the Member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address. This method must ensure that Members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
 - d) provides the information by any other method that can reasonably be expected to result in the Member receiving that information. This method must be documented in the Member's record. An example could include a paper copy hand-delivered by the Care Coordinator.
- 4) Provider Directory, or a separate notice on how to access this information online and how to request a hard copy
- 5) Formulary Information, or a separate notice on how to access this information online and how to request a hard copy
- 6) PCP assignment (for non-duals)
- 7) Care Coordinator Contact Information.

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

11.11.4 Member Identification (ID) Card

Based upon information provided by DMAS to the Contractor in the 834 enrollment file, the Contractor shall provide to each Member a Member Identification Card prior to the Member's enrollment effective date.

The Contractor shall mail all Member ID cards as expediently as possible but no later than five (5) business days from the Member's effective date, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase "Return Services Requested."

The Contractor shall utilize at least first class or priority mail delivery services as the medium for providing the Member identification cards.

The Contractor shall provide each Member an identification (ID) card that is recognizable and acceptable to the Contractor's network providers. The Contractor's ID card shall also serve as sufficient evidence of coverage for non-participating providers.

The Contractor's identification card will include, at a minimum:

- 1) CCC Plus program logo;
- 2) Name of the Member;
- 3) Member's Medicaid identification number;
- 4) Member's Contractor identification number;
- 5) Name and address of the Contractor;
- 6) Telephone number to be used to access after-hours non-emergency care;
- 7) Behavioral health and ARTS crisis line number (if different);
- 8) Instructions on what to do in an emergency;
- 9) Any other information needed to process claims;
- 10) Telephone contact information for the *Smiles For Children* program;
- 11) Telephone number for transportation services; and,
- 12) Telephone number for the Contractor's Care Coordination Department.

The Contractor shall submit and receive approval of the identification card from the Department prior to production of the cards.

11.11.5 Member Handbook

In accordance with 42 CFR § 438.10, the Contractor shall develop a Member handbook that includes all required elements as defined in the Department's CCC Plus program Model Member handbook, available on the CCC Plus web page at:
<http://www.dmas.virginia.gov/#/cccplushealthplans>.

The Contractor's handbook shall include information about the transitions of care policy, in accordance with 42 CFR 438.62(b)(1), and the amount, duration, and scope of benefits available under this contract in sufficient detail to ensure that Members understand the benefits to which

they are entitled. The Contractor shall revise its Member handbook to coincide with changes that DMAS makes to the handbook template and as directed by DMAS. Changes to the printed version of the handbook shall be revised to incorporate needed changes at least on an annual basis or as directed by DMAS. A revised red-lined version of the Member Handbook must be provided to the Department for review and approval at least sixty (60) days prior to planned printing or within ten (10) days of the Department's request. If a significant mid-year change is required, the plan may revise through the use of an insert. Changes to the on-line version of the handbook shall be revised to incorporate needed changes within thirty (30) calendar days receipt notice of the required change. The insert or internet on-line changes must be approved by the Department prior to use by the Contractor.

The Contractor shall modify the Member handbook utilizing the model handbook guidance provided by the Department that should include, but not be limited to the additional benefits provided to Medicaid expansion Members and the MMHS.

11.11.6 Provider Network Directory

The Contractor shall make available in paper form upon request and electronic form, a provider directory that includes the following information about its network providers, including physicians, specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers in accordance with all requirements described in 42 CFR § 438.10. The Department will periodically monitor the Contractor's provider directories to ensure compliance with these content requirements. See the Compliance Violations in Section 18.2.3, *Compliance Violation Types*.

11.11.6.1 Content of Provider Directory

The provider directory must include, at a minimum, the following information for all providers in the Contractor's provider network:

- 1) The names, addresses, and telephone numbers of all current network providers;
- 2) For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, office hours, including the names of any network provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;
- 3) As applicable, whether the health care professional or non-facility based network provider has completed cultural competence training;
- 4) For network providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based network providers, licensing information, such as license number or National Provider Identifier;
- 5) Whether the network provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam room(s) and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;
- 6) Whether the provider is accepting new patients as of the date of publication of the directory;
- 7) Provider website/URL, if available;
- 8) Whether the network provider is on a public transportation route;
- 9) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, or access to language line interpreters;

- 10) For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use;
- 11) Whether there are any restrictions on the Member's freedom of choice among network providers (e.g., providers that require a referral prior to receiving care).
- 12) For pharmacy providers, names, addresses, and telephone numbers of all current network pharmacies and instructions for the Member to contact the Contractor's toll-free Member Services telephone line for assistance in finding a convenient pharmacy.

11.11.6.2 Maintenance and Distribution

- 1) The Contractor shall maintain, update, and distribute the directory as follows:
 - Update information in its paper directory at least monthly;
 - Update information in its online and printed directories no later than thirty (30) calendar days after receipt of provider updates;
- 2) Provide either a copy, or a separate notice about how to access this information online or request a hard copy within five (5) business days at no charge, to all new Members and annually thereafter;
- 3) Provider directories must be made available on the Contractor's Web site in a machine readable file and format;
- 4) When there is a significant change to the network, the Contractor shall send a special mailing to Members;
- 5) Ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 CFR §438.10; Consistent with 42 CFR §438.10(f)(1) the Contractor shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated provider;
- 6) Include written and oral offers of such provider and pharmacy directories in its outreach and orientation sessions for new Members.
- 7) Make available on the Contractor's Web site in a machine readable file and format per 42CFR§438.10(h).

11.11.7 Prescription Drug Formulary

In accordance with 42 CFR §438.10(h), the Contractor shall make available in electronic or paper form, the following information about its formulary:

- 1) Which medications are covered (both generic and name brand).
- 2) What tier each medication is on.
- 3) The Contractor's formulary drug lists must be made available on the Contractor's Web site in a machine readable file and format.

11.11.8 Member Disenrollment

Upon disenrollment from the Contractor's plan, the Contractor shall notify the Member through a disenrollment notice that coverage in the Contractor's plan will no longer be effective. The disenrollment notice should identify the effective date of disenrollment and, whenever possible, should be mailed prior to the Member's actual date of disenrollment.

11.12 MARKETING REQUIREMENTS

For the purposes of this Contract, Marketing Materials and Services as defined shall apply to Members who may or may not be currently enrolled with the Contractor.

11.12.1 DMAS Review and Approval

The Contractor shall submit all marketing materials and information, including electronic outlet platforms, regarding planned activities to the Department for review and approval prior to their planned use and in accordance with the timeframes below.

11.12.1.1 Marketing Plan

The Contractor shall annually submit a complete marketing plan to the Department for informational purposes. Any changes to the marketing plan shall be submitted to the Department for approval prior to use.

11.12.1.2 Marketing Materials

The Contractor shall submit all new and/or revised marketing and informational materials to the Department before their planned distribution. The Contractor shall also provide the Department with a description of any efforts to reach Members through various social media platforms to include but not be limited to Facebook, Twitter, Instagram, and Snapchat. The Contractor shall submit to DMAS all electronic addresses of all social media platforms, smartphone applications, and other media such as “YouTube” used to provide information on the CCC Plus Program within 60 days of the effective date of the contract. The Department will approve, deny, or ask for modifications to the materials within thirty (30) calendar days of the date of receipt by the Department (42 CFR § 438.104).

11.12.1.3 Other Marketing Venues

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

DMAS may conduct additional types of review of Contractor marketing, outreach, and communications activities, including, but not limited to:

- 1) Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.
- 2) Random reviews of actual marketing, outreach, and communications pieces as they are used in the marketplace.
- 3) “For cause” review of materials and activities when complaints are made by any source, and DMAS determines it is appropriate to investigate.
- 4) “Secret shopper” activities where DMAS requests Contractor materials, such as Enrollment packets.

11.12.2 Federal and State Laws

Marketing and promotional activities (including provider promotional activities) shall comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to Members [42 CFR §438.104].

The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor or its subcontractor(s) knows or should know is likely to influence the Member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid.

The Contractor shall be prohibited from offering rebates or other cash inducements of any individuals.

The Contractor shall be subject to fines or other sanctions if it conducts any marketing activity that is not approved in writing by the Department [42 CFR § 438.700].

11.12.3 Use of Subcontractors

The Contractor may utilize subcontractors for marketing purposes; however, Contractors will be held responsible by the Department for the marketing activities and actions of subcontractors who market on their behalf.

11.12.4 Marketing Activities Prior to Effective Date

The Contractor may not begin marketing activities until the Contractor has entered into this Contract, passed the readiness review, had materials reviewed and approved by the Department, and is able to receive payment and enrollment files.

The Contractor may not begin Marketing, Outreach, and Member Communications activities to individuals more than ninety (90) calendar days prior to the effective date of Member enrollment.

11.12.5 Distribution of Marketing Materials

The Contractor shall distribute marketing materials to the Contractor's eligible population within its participating region. The Department must approve a request for a smaller distribution area on a city or countywide basis and also through the Contractor's website.

11.12.6 Marketing Material Formats

All information including marketing and informational materials provided to Members or potential Members shall use easily understood language and formats, and shall meet the information requirements outlined in 42 CFR § 438.10. CMS published a tool kit that provides guidance for how to make written material clear and effective, available at:

<https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html>.

The Contractor shall ensure that all information provided to enrolled Members and Eligible Members is provided in alternate manners and formats according to the needs of enrolled Members and eligible Members, taking into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternate Formats shall include, but not be limited to, Braille, large font, audio tape, oral interpretation services, ASL video tape, and information read aloud to a Member. Information should be written with cultural sensitivity and be provided in large print (at least 18-point font), if requested.

The Contractor shall update materials to reflect any changes in Federal or State law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.

11.12.7 Permitted Marketing and Outreach Activities

The Contractor may engage in the following promotional activities:

11.12.7.1 General Public

Notify the general public of the CCC Plus program in an appropriate manner through appropriate media, including social media, throughout its enrollment area.

11.12.7.2 Pre-Approved Mail Campaigns

For potential Members, pre-approved mail campaigns are handled through the Department or its mailing vendor and will be sent to all potential Members. Mail campaigns are only allowed during open enrollment. The Contractor shall pay the mailing vendor directly for the cost of the mail campaign. DMAS shall not be responsible for any costs related to the Contractor's mail campaign.

11.12.7.3 Pre-Approved Informational Materials

The Department must pre-approve informational materials prior to use via television, radio, and newspaper dissemination.

11.12.7.4 Potential Member Request

Fulfillment of potential Member requests to the Contractor for general information, brochures, and/or provider directories that will be mailed to the Member. Where appropriate, Member requests for general information may also be provided telephonically.

11.12.7.5 Home Visits for Marketing Purposes

The Contractor is prohibited from making unsolicited offers of individual appointments. However, to the extent a Contractor provides individual appointments, a Contractor can make an individual appointment to an Member, Potential Member, or his/her authorized representative if the Member/representative has contacted the Contractor to request assistance or information. The Contractor shall make reasonable efforts to conduct an appointment in the Member or Eligible Beneficiary's preferred location. The Contractor cannot require that an individual appointment occur in a Member or Potential Member's home. The appointment must be staffed by a trained Member service representative.

11.12.7.6 Community Sites

The Contractor shall convene all pre-approved educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Members or eligible Members, including persons with disabilities and persons using public transportation.

11.12.7.7 Health Awareness/Community Events

Hosting or participating in health awareness events, community events, and health fairs pre-approved by the Department where representatives from the Department, the enrollment broker and/or local Health Departments and/or Departments of Behavioral Health and Developmental Services may be present. The Contractor shall make available informational material that includes the enrollment comparison chart. The Contractor is allowed to collect names and

telephone numbers for marketing purposes; however, no Medicaid ID numbers may be collected at the event. DMAS will supply copies of comparison charts upon proper notification.

11.12.7.8 Health Screenings

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

11.12.7.9 Promotional Items or "Giveaways"

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

11.12.8 Marketing and Outreach Activities for Medicaid Expansion Population

The Contractor shall comply with all Department guidelines issued in relation to enhanced outreach activities for the expansion effort. Within sixty (60) days prior to open enrollment, the Contractor shall develop a specific outreach campaign for expansion enrollees which includes details on each of the following outreach activities for specific populations. Refer to the *CCC Plus Technical Manual* for report specifications.

11.12.8.1 Outreach to QHP Members Who Qualify for Medicaid Expansion

If the Contractor offers a qualified health plan (QHP) certified by the Federal Health Insurance Marketplace under the Affordable Care Act, by November 1, 2018, the Contractor shall develop procedures for identifying those Members who are currently enrolled in the Contractor's QHP and who may qualify for Medicaid expansion according to the marketing guidelines specified in this Contract. The Contractor shall inform these Members in writing approved by the Department 60 (sixty) days prior to open enrollment that they may qualify for Medicaid and direct them to the CoverVA call center or the local DSS to apply. The Contractor shall notify the Department by August 1, 2018, and annually thereafter the localities in which the Contractor offers a QHP. Refer to the *CCC Plus Technical Manual* for report specifications.

11.12.8.2 Outreach to Pregnant Members Who Qualify for Medicaid Expansion

The Contractor shall assist pregnant Members who are two months post partum and who are not in a Medicaid expansion aid category with assistance in transitioning to a Medicaid expansion aid category. The Contractor shall develop policies and procedures to assist Members to assure that their newborn child gets enrolled in Medicaid and submit it to DMAS. Refer to the *CCC Plus Technical Manual* for report specifications.

11.13 PROHIBITED MARKETING AND OUTREACH ACTIVITIES

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

11.13.1 Certain Informational Marketing Activities

Engaging in any informational or marketing activities which could mislead, confuse, or defraud Members or misrepresent the Department (42 CFR§438.104).

11.13.2 “Cold Call” Marketing Activities

Directly or indirectly, conducting door-to-door, telephonic, or other “cold call” marketing of enrollment at residences and provider sites (42 CFR § 438.104).

11.13.3 Direct Mailing

All mailings must be processed through the Department or its agent except mailings to CCC Plus program Members of the Contractor.

11.13.4 Home Visits/Direct Marketing or Enrollment

The Contractor is not permitted to conduct unsolicited personal/individual appointments. Making home visits for direct marketing or enrollment activities is allowed only when requested by the Member or his/her authorized representative.

11.13.5 Incentives

Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll in the Contractor’s plan.

11.13.6 Prospective Member Marketing

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

11.13.7 Improper Use of DMAS Eligibility Database

Using the DMAS eligibility database to identify and market its plan to prospective Members or any other violation of confidentiality involving sharing or selling Member lists or lists of eligible individuals with any other person or organization for any purpose other than the performance of the Contractor’s obligations under this Contract.

11.13.8 Targeting on Basis of Health Status

Engaging in marketing activities which target prospective Members on the basis of health status or future need for health care services, or which otherwise may discriminate against Members eligible for health care services. The Contractor may, however, direct marketing to its Members about its programs for specific health status.

11.13.9 Contacting Members After Disenrollment Date

Contacting Members who disenroll from the plan by choice after the effective disenrollment date except as required by this Contract, for care coordination purposes, or as part of a Department approved survey to determine reasons for disenrollment.

11.13.10 Marketing a Rebate or Discount

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

11.13.11 Marketing at DSS Offices

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

11.13.12 Statements of Endorsement (Government)

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

11.13.13 Enroll to Keep Benefits

No assertion or statement that the Member must enroll with the Contractor in order to keep from losing benefits (42 CFR § 438.104).

11.13.14 Renewal of Medicaid Benefits/Reason for Disenrollment

Health plans may not solicit reason for disenrollment from Members leaving the Contractor's plan.

SECTION 12.0 PROVIDER SERVICES AND CLAIMS PAYMENT

12.1 PROVIDER CALL CENTER

The Contractor shall operate a toll-free provider call center to respond to questions, concerns, inquiries, and complaints, in accordance with the requirements detailed in this Contract. The Contractor's provider call center shall work efficiently through quick and correct transfer of calls, accurate transfer of information, and effective resolution of issues.

The Contractor shall have written provider service line policies and procedures that address all areas of call center operations including staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

The provider call center shall be adequately staffed with representatives who are trained to accurately respond to questions regarding the CCC Plus program, covered services, Member enrollment, utilization management, referral requirements, care coordination, provider network contracting and credentialing, and claims payment.

The provider service line shall be adequately staffed to provide appropriate and timely responses regarding authorization requests. The Contractor may meet this requirement by having a separate utilization management line.

Consistent with requirements set forth in 42 CFR § 438.66 the Contractor shall maintain a log of provider complaints and shall report these to the Department as directed in the *CCC Plus Technical Manual*.

12.1.1 Dedicated Assistance for LTSS Providers

For all areas where the Contractor is operational, the Contractor shall maintain a dedicated queue to assist and support LTSS providers. The Contractor shall ensure that LTSS providers are appropriately notified regarding how to access the dedicated queue for assistance. The Department may extend the required dedicated assistance timeframe for additional years if necessary.

12.1.2 Hospital Emergency Department Assistance

For hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, the Contractor shall have a specific process in place whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for Members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The Contractor may use the 24/7 clinical triage line for this purpose or may use another line the Contractor designates. The Contractor shall track and report the total number of calls received pertaining to patients in emergency departments who need assistance in accessing care in an alternative setting.

12.1.3 Monitoring by the Contractor

The Contractor shall measure and monitor the accuracy of responses and phone etiquette and take corrective action as necessary to ensure the accuracy of responses and appropriate phone etiquette by staff.

The Contractor shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall include, at a minimum, a secured voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor shall return all messages on the next business day.

12.1.4 Monitoring by the Department

The Contractor shall provide the capability for the Department to monitor calls remotely from DMAS offices at no cost to the Department.

12.1.5 Hours of Operation

1. General customer service helpline (available 8:00 am-8:00 pm, seven (7) days a week). Alternative technologies may be used on Saturdays, Sundays, and State of Virginia holidays (see Definitions).
2. Provider services and coverage determinations (available 8:00 am-6:00 pm, Monday through Friday)
3. Pharmacy Technical Support Line (hours of operation cover all hours for which any network pharmacy is open, seven (7) days a week)

The Contractor may use an interactive voice response (IVR) system to route calls to the appropriate support outside of the general customer service hours (as opposed to a customer service representative needing to be available 24/7 to answer and route the call). Outside of general customer service hours, the Contractor must employ a Clinical triage line, 24 hours per day, 7 days per week (behavioral health/ARTS crisis line, care coordination support, and clinical/nurse advice). The Contractor must employ a Pharmacy Technical Support Line outside of general customer service hours, as noted above. Refer to Section 12.1.2, *Hospital Emergency Department Assistance*.

12.1.6 Performance Standards

The Contractor's call centers shall:

1. Answer 85% of all calls within 30 seconds or less;
2. Limit the average hold time to less than two (2) minutes (defined as the time spent on hold by the caller after the IVR system/touch tone response system/recorded greeting and before reaching a live person);
3. Limit the disconnect rate of all incoming calls to five (5) percent);
4. Record 100% of incoming calls from the provider helplines using up-to-date call recording technology. Call recordings shall be searchable by provider NPI, Member ID # (if available), phone number (when identified), call center representative, and date and time of the call. Recordings shall be made available to the Department within three (3) business days upon request, and stored for a period of no less than fifteen (15) months from the time of the call;

5. Provide reports on a monthly basis that detail the types of calls handled and regarding the Contractor's call center performance;
6. Report on CCC Plus program calls separately from other Virginia lines of business, if any; and,
7. Report by service area (primary, acute, behavioral health, and LTSS). The Contractor's systems shall also track and report on behavioral health crisis calls.

12.2 PROVIDER TECHNICAL ASSISTANCE

The Contractor shall provide adequate resources to support a provider relations function to effectively communicate with existing and potential network providers. The Contractor shall also establish and conduct ongoing provider education and trainings to assist in contracting with qualified providers that meet the Contractor's requirements and with whom mutually acceptable provider contract terms, including rates, are reached.

The Contractor shall offer technical assistance to all CCC Plus program providers (in and out-of-network) for its Members. Technical assistance shall include activities such as:

1. Needs assessments;
2. Trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Direct one-on-one support/assistance; and,
4. Facilitating sharing of best practices.

Prior to referring providers to DMAS helpline, internet, or any other state and/or local agencies for CCC Plus information, the Contractor shall receive approval from the Department unless already outlined within this Contract.

12.3 PROVIDER EDUCATION

The Contractor shall also conduct continuous on-going technical advice/guidance/trainings to the CCC Plus program provider community. Trainings should encompass all basic information regarding managed care (e.g., what is managed care, what health plans will do for the provider, where the provider goes for assistance, protected health information, etc.); how the provider bills for services, edit checks, appeals process; and, prior authorizations. Trainings shall be specific to the needs of the CCC Plus program providers (e.g., model of care elements, how to achieve program goals, promoting health and wellness, providing coordinated care, improving beneficiary experience, how to recognize and report signs of elder abuse/neglect and financial abuse, and promoting efficient use of services). The Department reserves the right to have representatives attend the Contractor's trainings for either staff and/or providers. In addition to its own training commitments, the Contractor shall ensure staff attendance at all meetings and/or trainings required by the Department. The Department may further require trainings in neutral settings with the Department and other contracted health plans in attendance and participating. These trainings will be especially numerous during program start-up by region and during annual open enrollments.

The Contractor shall conduct ongoing provider education and training activities regarding the CCC Plus program and all applicable Federal and State requirements as deemed necessary by the Contractor or the Department in order to ensure compliance with this Contract.

Provider education and training activities include but are not limited to:

- 1) CCC Plus program covered services, including enhanced and carved-out services;
- 2) Policies and procedures (e.g., claims submission, process, payment, service authorizations);
- 3) Eligibility criteria and eligibility verification;
- 4) The role of the enrollment broker as the beneficiary support system for enrollment and disenrollment;
- 5) Special needs of Members that may affect access to and delivery of services (e.g., transportation needs, physically accessible buildings and equipment, cultural competency, and other accommodations under the ADA such as sign language interpreter services, or large print materials);
- 6) Member's rights and responsibilities;
- 7) Grievance and appeals procedures;
- 8) Procedures for reporting fraud, waste and abuse;
- 9) References to Medicaid manuals, memoranda, and other related CCC Plus program documents;
- 10) Billing instructions which are in compliance with the Department's encounter data submission requirements; and,
- 11) Marketing practice guidelines and the responsibility of the provider when representing the Contractor.

The Contractor shall notify the Department of any planned provider training event at least two (2) weeks prior to the date of the event.

12.3.1 LTSS Provider Training

The Contractor shall conduct ongoing provider education. Training and technical assistance topics shall include person-centered supports and compliance with CMS HCBS setting provisions, billing, and other necessary processes as directed and/or approved by the Department. Refer to training in model of care as defined in Section 5.1, *General Requirements and Covered Populations*.

12.3.2 CMHRS Provider Training

The Contractor shall conduct ongoing education with community mental health and rehabilitation service providers. Training and technical assistance topics shall include CCC Plus model of care elements, person-centered treatment planning, culturally competent care, evidence based service planning/treatment planning methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning and strengths based treatment goal selection, as directed and/or approved by the Department. Refer to training in model of care as defined in Section 5.1, *General Requirements and Covered Populations*.

12.4 PROVIDER PAYMENT SYSTEM

12.4.1 General Processing and Payment Rules

In accordance with Section 1932(f) of the Social Security Act (42 USC § 1396a-2), the Contractor shall pay all in and out-of-network providers (including Native American Health Care Providers) on a timely basis, consistent with the claims payment procedure described in 42 CFR

§ 447.45 and 42 CFR § 447.46 and Section 1902 (a)(37), upon receipt of all clean claims, as defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

The Contractor's timely filing requirements for all providers (in and out of network) shall not be less than three (3) months and not more than twelve (12) months from the date of service. If the Member has other coverage, the timeframe for submission would begin on the date of payment from the primary payer.

In accordance with Section 1932(b)(2)(D) of the Social Security Act and State Medicaid Director Letter 06-010, the Contractor shall pay non-contracted providers for emergency services no more than the amount that would have been paid if the service had been provided under the State's fee-for-service (FFS) Medicaid program. The Contractor shall reimburse out-of-network, and providers of emergent or urgent care, as defined by 42 CFR § 424.101 and 42 CFR § 405.400 respectively, at the Medicaid FFS payment level for that service. In accordance with Section 1932(f) of the Social Security Act (42 U.S.C. § 1396a-2), the Contractor shall pay all in-and out-of-network providers on a timely basis, consistent with the claims payment procedure described in 42 CFR § 447.45 and Section 1902 (a)(37), upon receipt of all clean claims for covered services rendered to covered Members who are enrolled with the Contractor. 42 CFR § 447.45 defines timely processing of claims as:

- Adjudication (pay or deny) of ninety percent (90%) of all clean Virginia Medicaid claims within thirty (30) calendar days of the date of receipt.
- Adjudication (pay or deny) of ninety-nine percent (99%) of all Virginia Medicaid clean claims within ninety (90) calendar days of the date of receipt.
- Adjudication (pay or deny) all other claims within twelve (12) months of the date of receipt. (See 42 CFR § 447.45 for timeframe exceptions.) This requirement shall not apply to network providers who are not paid by the Contractor on a fee-for-service basis and will not override any existing negotiated payment scheduled between the Contractor and its providers.

See Section 12.4.2, *Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS and Early Intervention* for exceptional processing and payment rules for nursing facility, LTSS, ARTS, CMHRS and early intervention providers.

In compliance with Section 1903(i) of the Act (final sentence) and Section 1903(i)(17) of the Act, the Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or services not covered under the Medicaid State Plan.

In the absence of an agreement between the Contractor and the provider, the Contractor shall pay out-of-network providers, including out-of-state providers, at the prevailing DMAS rate in existence on the date of service. This reimbursement shall be considered payment in full to the provider or facility. Additionally, claims for emergency services shall be paid in accordance with the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109-171), Section 6085. Reference the CMS State Medicaid Director Letter SMDL #06-010. The Contractor shall ensure that Members

maintain balance billing protections. Reference *Protecting Member From Liability For Payment*.

In accordance with 42 CFR§ 457.1201, the Contractor shall guarantee that it will not avoid costs for services covered in this Contract by referring enrollees to publicly supported health care resources.

12.4.2 Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, CMHRS and Early Intervention

The Contractor shall ensure 100% of clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under EPSDT – See Section 23.1, *Definitions* of this Contract), ARTS, CMHRS and Early Intervention providers are adjudicated within fourteen (14) calendar days of receipt of the clean claim for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

Where the service is covered by Medicare, the fourteen (14) calendar day timeframe begins post Medicare adjudication, except if the Member is concurrently enrolled with the Contractor's D-SNP.

12.4.2.1 LTSS, Early Intervention, ARTS, and CMHRS Payments

The Contractor shall ensure LTSS (including when providing services covered under EPSDT), Early Intervention, ARTS, and CMHRS services are paid no less than the current Medicaid FFS rate. The Contractor shall have prior approval from DMAS before implementing an alternative payment arrangement or value-based payment that revise the payment method for CMHRS, LTSS, ARTS, and Early Intervention Services such that the payment rate could be less than the current Medicaid FFS rate, such as a shared risk arrangement. The Contractor does not require DMAS approval to implement arrangements that pay at least the current Medicaid FFS rate and are mutually agreed upon by the provider and the Contractor.

The Contractor's reimbursement for CCC Plus Waiver services shall include the Northern Virginia differential for qualifying localities, as described on the DMAS website, http://www.dmas.virginia.gov/files/links/141/NOVA%20Localities_HCBS.pdf. The Northern Virginia differential reimbursement for Waiver services is based upon the Member FIPS except for Adult Day Health Care (ADHC) services.

The Department will publish ARTS rates by level of care prior to the beginning of each fiscal year available on the Department's website at: <http://www.dmas.virginia.gov/#/arts>

CMHRS shall be paid in accordance with the DMAS rates for rural and urban rate localities. The CMS reference guide that identifies VA rural and urban localities can be found at: <http://www.dmas.virginia.gov/#/cccplushealthplans>.

12.4.2.2 Nursing Facility Payments

The Contractor shall pay NFs no less than the Medicaid Resource Utilization Groups (RUGS) adjusted per diem rate for Medicaid covered days, using DMAS' methodology. The Contractor shall pay Specialized Care Facilities and Long Stay Hospitals no less than the per diem rate for

Medicaid covered days, using DMAS' methodology. In the event that rates are revised for cost settlements, in response to appeals or for other reasons, the Contractor shall adjust payments including retroactively based on the Department's instructions to the revised rates for any contracts based on the minimum rates. If the RUGS adjusted reimbursement calculation exceeds the charges, the Contractor shall pay the RUGS adjusted payment rate. The lesser of billed charges payment rule shall not apply to RUGS Nursing Facility reimbursement payments. If the patient has a LTSS patient pay responsibility, the Contractor shall adjust the payment according to its Contract with the nursing facility provider. Reference guidance information at: [http://www.dmas.virginia.gov/files/links/1243/Nursing%20Facility%20Price-Based%20Payment%20Methodology%20and%20Hospice%20FAQs%20\(Updated\).pdf](http://www.dmas.virginia.gov/files/links/1243/Nursing%20Facility%20Price-Based%20Payment%20Methodology%20and%20Hospice%20FAQs%20(Updated).pdf).

The Contractor may reimburse based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the Contractor. The Contractor does not require DMAS approval prior to implementing such an arrangement if the rate paid is not less than the current Medicaid FFS rate. However, in the event the alternative payment methodology or value-based payment could result in a payment rate less than the current Medicaid FFS rate, such as a shared risk arrangement, the Contractor must obtain DMAS approval prior to implementation. This includes and is not limited to Specialized Care Nursing Facilities, where MCOs can negotiate the process to develop their own protocols for identifying specialized care for reimbursement purposes; this process can differ from the FFS process. For example, DMAS does not oppose the process agreed upon in meetings between Nursing Facility stakeholders and MCOs to use the recommended process of revenue code 199 with 65x modifier. DMAS will publish Medicaid rates by Nursing Facility prior to the beginning of each fiscal year.

For all Members admitted to a Nursing Facility (NF) on or after July 1, 2019, the Contractor shall not reimburse a NF for services until a screening has been completed for the Member by an appropriate screening team (described below), the screening has been entered into the ePAS system (also described below), and the individual is found to meet NF level of care criteria. Payment shall not be made to the NF until the Contractor receives a copy of the screening. Following the Department's policy, the Contractor shall receive a copy of the UAI for Members admitted to a NF on or after July 1, 2019 prior to payment to a NF for that admission. For Members in a NF prior to July 1, 2019, in the event that a UAI has not been completed, the Contractor shall accept the MDS, and may request the DMAS-80, Patient Intensity Rating System Review (PIRS) form.

12.4.2.3 Out of Network Provider Payment

The Contractor shall reimburse out of network providers at the fee-for-service rate in effect on the date of service. For CCC Plus Waiver and home health services, the rate shall include the Northern Virginia differential.

12.4.2.4 Hospice claims

Non-institutional hospice services shall be paid by the Contractor based on the Member FIPS. The DMAS hospice revenue codes and rates for non-institutional claims are available at: <http://www.dmas.virginia.gov/#/ratesetting>.

Beginning July 1, 2019, for Members that reside in a nursing facility and are enrolled in a Medicaid approved hospice program, the Contractor shall pay the nursing facilities their share of

payment directly rather than paying the hospice provider. Payments made to the nursing facility shall be the full amount that would be paid to the nursing facility if the Member was not receiving hospice services.

Refer to Attachment 5, *Summary of Covered Services, Part 4B, Long Term Services and Supports Community Based*.

12.4.3 Relocation of Claims Operations

The Contractor shall notify the Department forty-five (45) calendar days in advance of any proposal to modify claims operations and processing that shall include relocation of any claims processing operations (except for its back-up claims processing system). Any expenses incurred by the Department or its contractors to adapt to the Contractor's claims processing operational changes (including but not limited to costs for site visits) shall be borne by the Contractor.

12.4.4 Electronic Submission

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

12.4.5 Interest Payments

The Contractor shall pay interest charges on claims in compliance with requirements set forth in § 38.2-4306.1 of the *Code of Virginia*. Specifically, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty (30) calendar days from the Contractor's receipt of "proof of loss" to the date of claim payment. "Proof of loss" means the date on which the Contractor has received all necessary documentation reasonably required by the Contractor to make a determination of benefit coverage. This requirement does not apply to claims for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the managed care organization's obligation on such claims.

12.4.6 Legislative Mandated Rates

To the extent the Governor and/or General Assembly implement a specified rate increase or decrease for Medicaid services or service providers, these rate adjustments are incorporated into the CCC Plus program capitation payment rates and, required by DMAS and/or regulation, the Contractor is required to increase its reimbursement to providers at the same percentage as Medicaid's increase as reflected in the revised fee-for-service fees under the Medicaid fee schedule, beginning on the effective date of the rate adjustment, unless otherwise agreed upon by DMAS. The Department shall make every reasonable effort to provide at least thirty (30) 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 sixty (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 a Member, or a provider on behalf of such a Member, may challenge the Contractor's decisions including, but not limited to, the denial of payment for services.

12.4.7 Uniform Billing Practices

DMAS requires the Contractor to implement uniform billing practices and claims submissions processes for NFs, LTSS, early intervention, and community behavioral health providers. The Contractor shall participate in working sessions with the Department and other CCC Plus program Contractors to develop and implement such uniform billing practices. Consideration will be made towards the development of uniform billing procedures especially for small providers who are not familiar with electronic billing through managed care organizations. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected CCC Plus program Contractors.

12.4.8 Physician Incentive Plans

The Contractor may, at its discretion, operate a physician incentive plan only if:

- No single physician is put at financial risk for the costs of treating a Member that are outside the physician's direct control;
- No specific payment is made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Member; and,
- The applicable stop/loss protection, Member survey, and disclosure requirements of 42 CFR Part 417 are met.

The Contractor shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 422.208, 422.210 as well as compliance with Section 1903(m)(5)(B)(ii) of the Social Security Act; 42 CFR 438.700(b)(6); 42 CFR 438.726(b); 42 CFR 438.730(e)(1)(i) which requires DMAS to deny payments for new enrollees when, and for so long as, payment for those enrollees is denied by CMS based on the state's recommendation, when the MCP fails to comply with the requirements for PIPs. . The Contractor shall submit all information required to be disclosed in the manner and format specified by the Department. The Contractor shall submit all physician incentive plans upon request and when appropriate to enrollees in accordance with 42 CFR 438.10(f)(3).

The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by DMAS that results from the Contractor's or any of its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 434 and 1003; however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Members in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of the Department, that it has made a good faith effort to comply with the cited requirements.

12.4.9 Hospital Payment Using DRG Methodology

If the Contractor has a contract with a facility to reimburse the facility for services rendered to its Members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, the Contractor is responsible for the full inpatient medical hospitalization from time of admission to discharge. This will be effective for any Member who is actively enrolled with the Contractor on the date of admission regardless if the Member is disenrolled during the course of the inpatient hospitalization.

If the enrollee is a Fee-For-Service Member and is admitted to a facility that utilizes the DRG payment process, then DMAS Fee-For-Service is responsible for the full inpatient medical hospitalization from time of admission to discharge, even if the individual becomes enrolled with a CCC Plus MCO during the inpatient stay.

The Contractor shall provide coverage for payment of practitioner services rendered during the hospitalization for any dates in which the Member was enrolled with the Contractor on the related date of service. See Section 3.2.4, *Enrollment Process for Individuals Hospitalized at Time of Enrollment* for more information.

12.4.10 Nursing Facility Mutual Aid Agreements

The Contractor shall work collaboratively and proactively with its nursing facility providers to support the mutual aid agreement (MAA) process for its membership. The MAA is a voluntary agreement between the disaster struck facility and one or more receiving facilities for the purpose of providing mutual aid at the time of a disaster. The Long-Term Care Mutual Aid Plan is an acceptable mutual aid agreement between facilities. The MAA addresses the loan of medical personnel, pharmaceuticals, supplies and equipment, and temporary residence for transferred residents. The disaster struck facility does not “discharge” its residents and the receiving facility does not “admit” the residents transitioning from the disaster struck facility. The receiving facility acts as a “contractor” to the disaster struck facility. The Contractor shall ensure that reimbursement for nursing facility care continues to the disaster struck facility (*Member’s facility of record*) for nursing facility Members who transition temporarily to an alternate facility under a mutual aid agreement in the event of a disaster. The Contractor shall continue to reimburse the Member’s facility of record for up to thirty (30) calendar days, including in circumstances where services are furnished by a receiving facility through a mutual aid agreement. The Care Coordinator shall continue to work closely with the Member throughout the MAA disaster transition process. This provision does not preclude the Contractor from its contractual obligation and ability to ensure, for example through on-going care coordination and transition planning, that Members continue to receive appropriate high quality care, consistent with the Member’s needs and preferences. All nursing facility treatment rules described in this contract remain in full effect throughout the MAA disaster related transition. If the disaster struck Nursing Facility determines that it is not able to reopen within thirty (30) calendar days, it must discharge the individuals and work with the Contractor and the Member on long-term services and support placement options of their choice including home and community based services (HCBS) waiver, Program for All-Inclusive Care for the Elderly (PACE), or admission to other nursing facilities. Nothing shall preclude an individual from requesting to be discharged to home and community based services (waivers or PACE) or admission to other nursing facilities. Reimbursement to the disaster struck nursing facility shall cease when an individual is discharged.

12.4.11 Payment Coordination with Medicare

In accordance with 42 CFR §438.3(t), the Contractor shall enter into a Coordination of Benefits Agreement (COBA) with Medicare and participate in the automated claims crossover process for claims processing for its Members who are dually eligible for Medicaid and Medicare. All crossover claims processing rules shall account for Medicare sequestration reductions when calculating payment amounts issued by the Medicaid benefit. Refer to Attachment 14, *July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo* and

Attachment 15, *MCO COB Resource Chart* for the Department's expectations during the coordination of benefits process.

12.4.12 Payment Coordination with Other Coverage

Under Section 1902(a)(25) of the Social Security Act (42 USC §1396 a (a)(25)), the State is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. Refer to Attachment 14, *July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo* and Attachment 15, *MCO COB Resource Chart* for the Department's expectations during the coordination of benefits process.

DMAS retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to initiate litigation to seek recovery of any non-health insurance funds. Members with these other resources shall remain enrolled in the CCC Plus program as long as they continue to meet eligibility requirements.

The Contractor shall notify DMAS monthly of any Members identified during that past month who are discovered to have any of the above coverage, including Members identified as having trauma injuries. The Contractor shall provide DMAS with all encounter/claims data associated with care given to Members who have been identified as having any of the above coverage.

The Contractor shall provide Member claim history when requested by the Department's TPL Unit staff to aid in the pursuit of non-health insurance resources. A file layout along with turnaround time will be specified in the *CCC Plus Technical Manual*.

12.4.12.1 Workers' Compensation

If a Member is injured at his or her place of employment and files a workers' compensation claim, the Contractor shall remain responsible for all covered benefits and services. The Contractor may seek recoveries from a claim covered by worker's compensation if the Contractor actually reimbursed providers and the claim is approved for the worker's compensation fund. The Contractor shall notify DMAS monthly of any Members identified during that past month who are discovered to have workers' compensation coverage.

If the Member's injury is determined not to qualify as a workers' compensation claim, the Contractor shall be responsible for all services provided while the injury was under review, even if the services were provided by out-of-network providers, in accordance with workers' compensation regulations.

12.4.12.2 Estate Recoveries

The Contractor is prohibited from collecting estate recoveries. The Contractor shall notify DMAS monthly of any Members identified during that past month who have died and are over the age of fifty-five (55).

12.4.12.3 Comprehensive Health Coverage

Members, determined by DMAS as having Medicare or comprehensive health coverage other than Medicaid will be assigned to the CCC Plus program. Members will not be disenrolled due to having Medicare or other comprehensive health coverage.

The Contractor, as payer of last resort, will be responsible for coordinating all benefits covered under this Contract. When the other payer is a commercial HMO organization, the Contractor is responsible for the full copayment amount. The Member may not be billed by the provider other than any Patient Pay established by DSS towards LTSS services.

The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage (e.g. Medicare, commercial insurance, and Workers' Compensation). Any moneys recovered by third parties shall be retained by the Contractor. The Contractor shall notify DMAS monthly of any Members identified during that past month that were discovered to have comprehensive health coverage.

Refer to Attachment 14, *July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo* and Attachment 15, *MCO COB Resource Chart* for the Department's expectations during the coordination of benefits process.

Prior to processing a claim for payment, the Contractor shall NOT require a provider and/or pharmacist to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. The Contractor's request for an explanation of benefits (EOB) from the provider in these instances would delay timely payment of these services. Examples of these services include, but are not limited to, LTSS waiver services such as personal care and respite care services. The Contractor can pay and pursue the Commercial insurance to assist with any potential delays of claim payments.

One waiver service exception is for private duty nursing (PDN) as these services are often covered through commercial insurance. The Contractor may only require an EOB for PDN services if the commercial carriers covers all or part of PDN services.

12.4.12.4 Early Intervention

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

- 1) Those services federally required to be provided at public expense as is the case for
 - a) assessment/EI evaluation;
 - b) development or review of the Individual Family Service Plan (IFSP); and,
 - c) targeted case management/service coordination;
- 2) Developmental services; and,
- 3) Any covered early intervention services where the family has declined access to their private health/medical insurance.

Under these circumstances, and in accordance with federal regulations, the Contractor shall require the Early Intervention provider complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form (http://infantva.org/documents/ovw-st-TaskF-Mtg-20090520Form-DecliningPriv_Ins.pdf) and submit it with the bill to the Contractor. The Contractor shall keep a copy of this form on the Member's file for a period of ten (10) years for audit purposes. Billing codes for EI services are reflected in the attached *CCC Plus Covered Services* chart.

Refer to Attachment 14, *July 13, 2018 Clarification on Coordination of Benefits with Medicare and Other Insurance Memo* and Attachment 15, *MCO COB Resource Chart* for the Department's expectations during the coordination of benefits process.

12.4.13 Provider Preventable Conditions and Services (Never Events) Which Receive No Payment

The Contractor shall comply with 42 CFR § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR §434.6(a)(12) and § 447.26. The Contractor's reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR § 447.26.

Payments for Hospital Acquired Conditions (HACs) shall be adjusted in the following manner. For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC. For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HAC. The number of reduced days shall be based on average length of stay (ALOS) on the diagnosis tables published by the ICD vendor (Thomas Reuters) used by DMAS. For example, an inpatient claim with 45 covered days identified with an HAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

No payment shall be made for services for inpatients for the following Provider Preventable Conditions (PPC): (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; (iii) surgical or otherwise invasive procedure performed on the wrong patient.

No reduction in payment for a provider preventable condition shall be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (1) the identified provider-preventable conditions would otherwise result in an increase in payment; and, (2) the Commonwealth can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

The Contractor shall submit all identified provider preventable conditions as reflected in the *CCC Plus Technical Manual*.

12.4.14 Provider Payment for Members Who Become Disenrolled

The Contractor shall not be liable for the payment of services covered under this Contract rendered to a Member outside of the dates of enrollment with the Contractor except for: (1) specially manufactured DME that was prior-authorized/ordered by the Contractor; and/or, (2) the

hospital DRG payment, if Member hospitalized (Refer to Section 3.2.4, *Enrollment Process for Individuals Hospitalized at Time of Enrollment*). In certain instances, a Member may be excluded from participation effective with retroactive dates of coverage. Providers may submit claims to the Department for services rendered during this retroactive period. Reimbursement by the Department for services rendered during this retroactive period is contingent upon the Members meeting eligibility and coverage criteria requirements.

12.4.15 Payment to Excluded Providers

The Contractor shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act.

12.4.16 Payment to a Network Provider

In accordance with 42 CFR § 438.60, the Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this contract except those required by Title XIX of the Act or direct payments for graduate medical education approved under the State Plan.

12.4.17 Reimbursement of New Provider Applicants

In accordance with § 38.2-3407.10:1 of the *Code of Virginia*, the Contractor shall establish reasonable protocols and procedures for reimbursing new provider applicants, within thirty (30) calendar days of being credentialed by the carrier, for health care services or mental health services provided to covered persons during the period in which the applicant's completed credentialing application is pending. At a minimum, the protocols and procedures shall:

1. Apply only if the new provider applicant's credentialing application is approved by the Contractor;
2. Permit reimbursement to a new provider applicant for services rendered from the date the new provider applicant's completed credentialing application is received for consideration by the Contractor;
3. Apply only if a contractual relationship exists between the Contractor and the new provider applicant or entity for whom the new provider applicant is employed or engaged; and
4. Require that any reimbursement be paid at the in-network rate that the new provider applicant would have received had he been, at the time the covered health care services were provided, a credentialed participating provider in the network for the applicable health benefit plan.

12.5 INCREASED PAYMENTS TO ENSURE ACCESS

The Contractor shall provide a uniform percentage increase to the base health plan payments made to the following providers and services:

- Private acute care hospitals for actual inpatient and outpatient hospital services provided to Medicaid managed care enrollees. For purposes of the uniform percentage increase, private acute care hospitals excludes public hospitals, freestanding psychiatric and

rehabilitation hospitals, children's hospitals, long stay hospitals, long-term acute care hospitals, and critical access hospitals. The Department shall establish the uniform percentage increases consistent with the "managed care organization hospital payment gap" as defined in Section 3-5.16 of the 2018 Appropriation Act.

- Non-state government owned acute care hospitals (Chesapeake Regional Medical Center) for actual inpatient and outpatient hospital services provided to managed care Members. The Department shall establish the uniform percentage increase consistent with the State Plan supplemental payment methodology.
- Nursing homes owned by Type One hospitals (Children's Hospital of Richmond and Community Memorial) for actual nursing home services provided to managed care Members. The Department shall establish the uniform percentage increase consistent with the State Plan supplemental payment methodology.
- Physicians affiliated with a medical school in Eastern Virginia/Tidewater that is a political subdivision of the Commonwealth for actual physician services provided to managed care Members. The Department shall establish the uniform percentage increase consistent with the State Plan average commercial rate as a percent of Medicare for the same physician practice.
- Physicians affiliated with state university teaching hospitals (University of Virginia Health Center and Virginia Commonwealth University Health System) for actual physician services provided to managed care Members. The Department shall establish the uniform percentage increase consistent with the State Plan average commercial rate as a percent of Medicare for the same physician practice.

The uniform percentage increases are subject to approval by CMS consistent with 42 CFR § 438.6(c)(1)(iii)(B). These payments are intended to improve access to and the quality of services.

Following the end of each quarter, the Department shall calculate the amounts the Contractor shall pay each provider based on encounters reported in the immediate prior quarter. Funding for these payments will be included in quarterly supplemental capitation payments. The Contractor shall make payments to providers within seven (7) days of receipt of the supplemental capitation payments. The Department shall provide the Contractor instructions for making these payments. The Contractor shall collect and provide to the Department such information as is required to support the administration and distribution of the uniform percentage increases.

SECTION 13.0 VALUE BASED PAYMENTS

13.1 BACKGROUND

Value Based Payments (VBP) includes a broad set of payment strategies intended to improve health care quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care.

The Contractor shall maintain a VBP strategy that follows the Alternate Payment Model (APM) Framework White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN), with a special emphasis on models in categories 3 and 4. [Beginning](#) in the SFY 2021 contract year, the Contractor will assure annual improvement in the level of VBP penetration until such time that the Contractor has a minimum of 10 (ten) percent of its relevant spending for medical services governed under VBP arrangements. The Department will take this figure from the Contractors' annual HCP-LAN APM Data Collection Submissions referenced below. The Department may revisit VBP penetration targets, including potential targets for the adoption of more advanced VBP (i.e., HCP LAN categories 3-4) in future years.

13.2 CONTRACTOR VBP PLAN

The Contractor's policies and procedures shall have a VBP Plan for the adoption, evolution, and growth of APMs in its network. Each VBP Plan, as specified in the *CCC Plus Technical Manual* and below, shall cover the current status of the Contractor's VBP efforts and strategies to enhance or further those efforts over the two subsequent contract years. The Contractor shall update its VBP Plan annually. The Contractor's VBP Plan shall, at a minimum, include:

- 1) Current State Review
 - a. A detailed description of all APMs the Contractor is currently using within its Medicaid provider network, by provider type and the HCP-LAN APM Framework category/sub-category into which the APM best fits (e.g., 2a, 3b, or 4a); and,
 - b. For the APMs identified above, the percentage of the Contractor's total Medicaid medical expenses expected to be paid under each type of APM model in the current contract year and prior contract year. The numerator and denominator should include all Medicaid related medical spending, including primary and acute, behavioral health, LTSS, and drug spending.
- 2) Provider Readiness, Performance Review, and Communication
 - a. Assessment of provider readiness for VBP within the Contractor's provider network;
 - b. Methods and frequency for collection and assessment of quality performance data from providers; and,
 - c. Communication and collaboration approach with providers on reviewing performance and defining strategies for improvement.
- 3) Strategy and Alignment
 - a. Effectiveness of the Contractor's APM strategies for services and populations under CCC Plus, including how the APMs affect Member outcomes, experience and associated medical spending; and

- b. Relationship to the Contractor's commercial and/or Medicare Advantage VBP strategy and discussion of how these VBP strategies align with VBP efforts under the CCC Plus program.

The Contractor's VBP Plan should consider, but is not limited to, the following Departmental goals:

- Appropriate, efficient utilization of high-cost, high-intensity clinical settings;
- Reduce all-cause hospital readmissions;
- Reduce hospital admissions for chronic disease complications.

The Contractor shall submit a VBP plan by January 1st of each contract year to achieve both Contractor and Department goals to advance VBP. The Department reserves the right to request revisions to the Contractor's VBP Plan to align with Department priority areas. These revisions may include alignment across patient populations and payer types to align with multi-payer initiatives in which Medicaid is a participant (i.e. multi-payer alignment of incentives across Medicare, Medicaid, and/or commercially insured populations in Virginia).

13.3 VBP STATUS REPORT

The Contractor shall submit a VBP Status Report which includes additional details of its Medicaid VBP initiatives. At a minimum, the Contractor shall include the following information for each VBP initiative as specified in the *CCC Plus Technical Manual* and below:

- 1) VBP Category (and applicable subcategory) (using the HCP-LAN model);
- 2) Short Description (including brief discussion of associated performance measures);
- 3) Goal(s) and measureable results;
- 4) Description of targeted providers and number of providers eligible and participating;
- 5) Description of targeted Medicaid Members, number of eligible Members whose services are covered by VBP initiative, and number of participating Members;
- 6) Total Medicaid payments to providers for services covered under VBP initiative;
- 7) Total potential Medicaid payment adjustment (either percentage or dollars) and type of adjustment (bonus, penalty, risk sharing) related to VBP initiative; and,
- 8) Potential overlap with other VBP programs or initiatives.

The VBP Status Report and HCP-LAN Data Collection Submission (see below) shall be due on April 1 of each year and the submissions shall cover the prior calendar year. The Department will provide a template for Contractors to use in completing this submission.

13.4 CONTRACTOR HCP-LAN APM DATA COLLECTION SUBMISSION

The Department will use measurement methodologies developed by HCP-LAN to evaluate the adoption, evolution, and growth of VBP arrangements in a Contractor's Medicaid provider network. See <https://hcp-lan.org/apm-refresh-white-paper/>.

Although the HCP-LAN APM data collection currently excludes LTSS, DMAS will use the measurement methodologies as the framework for VBP. Annually, each Contractor shall complete the Medicaid APM data collection tool for the twelve (12) months of the prior calendar year (e.g. April 2021 submission will cover CY 2020). Contractor submissions should include numerators and denominators that account for all relevant spending for medical services, including primary and acute, behavioral health, LTSS, and drug spending. The HCP-LAN APM

Data Collection Submission and VBP Status Report shall be due on April 1 of each contract year. The Department will provide a template for Contractors to use in completing this submission.

13.5 DMAS APPROVAL OF VBP FOR CERTAIN SERVICES

The Contractor shall have prior approval from DMAS before implementing an alternative payment arrangement or value-based payment that revise the payment method for CMHRS, LTSS, ARTS, and Early Intervention Services such that the payment rate could be less than the current Medicaid FFS rate, such as a shared risk arrangement. The Contractor does not require DMAS approval to implement arrangements that pay at least the current Medicaid FFS rate and are mutually agreed upon by the provider and the Contractor.

SECTION 14.0 PROGRAM INTEGRITY (PI) AND OVERSIGHT

14.1 GENERAL PRINCIPLES

The Contractor must have in place policies and procedures for ensuring protections against actual or potential fraud, waste and abuse. The Contractor shall comply with all federal and state requirements regarding fraud and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.

The Contractor must have a formal comprehensive Virginia Medicaid Program Integrity Plan, reviewed and updated annually, to detect, correct and prevent fraud, waste, and abuse.

14.2 PROGRAM INTEGRITY PLAN, POLICIES, & PROCEDURES

The Virginia Medicaid Program Integrity Plan must define how the Contractor will adequately identify and report suspected fraud, waste and abuse by Members, by network providers, by subcontractors and by the Contractor.

The Virginia Medicaid Program Integrity Plan must be submitted annually. The Plan must include the Contractor PI Lead and contact information. The PI plan must also include the following elements:

- 1) PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
- 2) A listing of the health plan PI contractors (unless proprietary);
- 3) A process to act as or sub-contract with a Contractor for Recovery Audit purposes; and,
- 4) A plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid.

All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal government.

The Contractor shall develop a written program integrity plan specific to the CCC Plus program.

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

The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities.

The Contractor shall provide the Department, on March 31st of each contract year, an annual summary of prior year activities and results.

The Department shall share fraudulent provider activity with the Contractor on a quarterly basis.

The Contractor will be required to notify DMAS in a timely manner, within no more than five (5) business days, regarding all internal (such as identified patterns of outliers, audit concerns, critical incidences) and external (such as hotline calls) allegations of potential improper payments and/or safety concerns of enrollees. The Contractor will be expected to promptly

perform a preliminary review of all allegations of fraud, waste, or program abuse. The Contractor shall track each of these allegations and the outcome of the preliminary review and report them to the Department on the Quarterly Summary of PI Allegations table. A unique Case ID should be created for each allegation that is consistently used to identify that case in all reporting to the Department.

Once an allegation has been vetted and determined to warrant further investigation/audit, the Contractor shall notify the Department within forty-eight (48) hours of initiating a full investigation, using the *Notification of Provider Investigation* form (Attachment 13 of this Contract) via email at: CCCPlusReporting@dmas.virginia.gov. This is regardless of whether the target of that allegation is scheduled to be investigated immediately, or is merely being placed in the queue to be investigated when resources become available. The Department reserves the right to direct the Contractor to halt investigatory activity at its discretion. The Department may identify providers through data mining or other processes and may direct the Contractor to investigate providers in their network identified through this analysis.

The Contractor shall establish written policies for all employees of the Contractor, and any Contractor or agent of the Contractor that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19.

In accordance with 42 CFR § 438.608, the Contractor's Program Integrity Plan must address the following requirements in this section.

14.2.1 Written Policies and Procedures

The Contractor shall have in place written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State Standards for the prevention, detection and reporting of incidents of potential fraud, waste and abuse by Members, by network providers, by subcontractors and by the Contractor. As required in 42 CFR § 455.1, the Contractor's Program Integrity Plan must include a method to verify whether services reimbursed were actually furnished to the Member. The Contractor must utilize a survey (telephonic or mail), explanation of benefits (EOB) mailing, or other method approved by the Department to accomplish this requirement. Regardless of the method utilized (EOB, Member survey, etc.), the Contractor's verification method must include a statistically valid sample of Members based upon a percentage of the Contractor's paid claims. The Contractor may exclude certain 'sensitive' services from these verification activities.

The Contractor should have, at a minimum, the following policies and procedures in place:

- 1) A commitment to comply with applicable statutory, regulatory and contractual commitments;
- 2) A process to respond to potential violations of Federal and State criminal, civil, administrative laws, rules and regulations in a timely basis (no later than 30 calendar days

after the determination that there is a potential violation of civil, criminal or administrative law may have occurred);

- 3) Procedures for the identification of potential fraud, waste and abuse in a Contractor's network;
- 4) A process to ensure the Contractor, agents and brokers are marketing in accordance with applicable Federal and State laws, including state licensing laws, and CMS policy;
- 5) A process to ensure that the Contractor and any subcontractor reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract;
- 6) A process to identify overpayments at any level within the Contractor's network and properly recover such overpayments in accordance with Federal and State policy;
- 7) Procedures for corrective actions designed to correct any underlying problems that result in program violations and prevent future misconduct; and,
- 8) Procedures to retain all records documenting any and all corrective actions imposed and follow-up compliance reviews for future health oversight purposes and/or referral to law enforcement, if necessary.
- 9) Provider contracts that require a network provider to report to the Contractor when it has received an overpayment, and defined procedures for the provider to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.
- 10) Written policies for all employees of the Contractor and any Contractor or agent of the Contractor that provide detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31. The written policies shall include detailed provisions regarding the Contractor's policies for detecting and preventing fraud, waste, and abuse. Any Contractor employee handbook shall provide a specific discussion of the Virginia Fraud Against Taxpayers Act, the rights of employees to be protected as whistleblowers, and the Contractor's policies and procedures for detecting and preventing fraud, waste and abuse in accordance with Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1 through 8.01-216.19.
- 11) The Contractor shall provide information and a procedure for Members, network providers and subcontractors to report incidents of potential or actual fraud, waste, and abuse to the Contractor and to the Department.
- 12) If the Contractor makes or receives annual payments of at least \$5,000,000 under this Contract, the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, to implement and maintain written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws, including the information about rights of employees to be protected as whistleblowers. [Section 1902(a)(68) of the Act; 42 CFR § 438.608(a)(6)]

The Contractor shall have a reconsideration and appeals process in place, with current standards available to providers who wish to challenge adverse decisions, such as PI audit recoveries. This process must assure that appropriate decisions are made as promptly as possible. Providers shall also have the right to appeal to DMAS after exhausting the Contractor's internal appeal process. Reference Section 15.6 *Provider Reconsiderations and Appeals*.

All policies and procedures required as a part of this Contract must be approved by the Department prior to implementation. The policies and procedures must be reviewed and approved prior to the original contract signing, at time of revision (if any), and must be made available upon request by the Department for additional review and/or approval.

14.2.2 Internal Monitoring and Audit

The Contractor shall establish and implement provisions for internal monitoring and auditing. Procedures for internal monitoring and auditing shall attest and confirm compliance with Medicaid regulations, contractual agreements, and all applicable State and Federal laws, as well as internal policies and procedures to protect against potential fraud, waste or abuse.

14.2.3 Internal Monitoring and Audit - Annual Plan

The Contractor shall have a system or plan of ongoing monitoring that is coordinated or executed by the Compliance Officer to assess performance in, at a minimum, areas identified as being at risk. The plan shall include information regarding all the components and activities needed to perform monitoring and auditing, such as Audit Schedule and Methodology, and Types of Auditing.

The annual plan shall include a schedule that includes a list of all the monitoring and auditing activities for the calendar year. Contractors shall consider a combination of desk and on-site audits, including unannounced internal audits or “spot checks,” when developing the schedule. The Internal Monitoring and Audit Plan shall consist of two components: a detailed schedule of anticipated audits for the year, as well as a retrospective analysis of audits performed from the previous year, and must include, at a minimum, the following:

Audits Planned for the Upcoming Year

- Title/Type
- Description
- Priority/Risk Level
- Frequency.

Completed Audits

A retrospective analysis of the Internal Monitoring and Audit Plan, which would include, at a minimum, the following:

- All requirements from section above
- # of Audits Planned for Each Type identified in section above
- # of Audits Completed for Each Type identified section above
- Emerging Trends
- Investigator Assigned (if applicable)
- Findings
- Recommendations
- Action Taken

14.2.3.1 Audit Development

In developing the types of audits to include in the audit plan, the Contractor shall:

- Determine which risk areas will most likely affect the organization and prioritize the monitoring and audit strategy accordingly.
- Utilize statistical methods in:
 - Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
 - Determining appropriate sample size; and
 - Extrapolating audit findings to the full universe.
- Assess compliance with internal processes and procedures.
- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

The Contractor shall also include in its plan a process for responding to all monitoring and audit results. Corrective action and follow-up shall be led by the Compliance Officer and/or Program Integrity Lead and shall consist of, at a minimum, recovery of any identified overpayments.

The Compliance Officer shall maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis.

The Contractor shall develop as part of their work plan a strategy to monitor and audit subcontractors involved in the delivery of the benefits. Specific data should be analyzed from subcontractors, as applicable and appropriate, and reviewed regularly as routine reports are collected and monitored.

The Contractor shall include routine and random auditing as part of its contractual agreement with subcontractors. The Contractor shall include in its work plan the number of subcontractors that will be audited each year, how the subcontractors will be identified for auditing, and shall make it a priority to conduct a certain number of on-site audits.

The Contractor is encouraged to invest in data analysis software applications that provides the ability to analyze large amounts of data. Data analysis should include the comparison of claim information against other data (e.g., provider, drug provided, diagnoses, or beneficiaries) to identify potential errors and/or potential fraud.

The Contractor shall cooperate with Department auditors on any Recovery Audit activity/findings.

14.2.3.2 Audit Report

The Contractor shall produce and provide to the Department upon conclusion of the investigation a standard audit report for each completed investigation. This report should utilize the *Completed Investigation Form* and include, at a minimum, the following:

- Purpose
- Methodology
- Findings (including identified overpayments)
- Proposed Action and Final Resolution

- Claims Detail List/Spreadsheet

As noted in Section 14.9, *Reporting and Investigating Suspected Fraud and Abuse to the Department* of this contract, final resolution should include, at a minimum, repayment of any identified overpayments.

14.3 COMPLIANCE OFFICER

The Contractor shall designate a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors. The Contractor shall also establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract. The Compliance Officer shall maintain a records system to track all compliance actions taken and outcomes of any follow-up reviews to evaluate the success of implementation efforts that may be provided, if necessary, to CMS or to law enforcement, and provide updates on the monitoring and auditing results and corrective action to the Compliance Committee on at least a quarterly basis. Pursuant to 42 CFR § 438.608, the Compliance Officer and Regulatory Compliance Committee shall coordinate with the Department on any fraud, waste or abuse case. The Contractor may identify different contacts for Member fraud, waste and abuse; network provider fraud, waste and abuse; subcontractor fraud, waste and abuse; and Contractor fraud, waste and abuse.

14.4 PROGRAM INTEGRITY LEAD

The Contractor shall designate a PI Lead who will represent the Contractor and be accountable to communicate PI detection activities, fraud case tracking, investigative procedures, and pre and post claim edits, PA/SA review, and any other fraud activities and outcomes. This individual must also be involved in the Department Program Integrity Collaborative. The Contractor must be aware and actively be involved with State, Federal, and CMS initiatives of Program Integrity.

14.5 TRAINING AND EDUCATION

The Contractor shall establish an effective system of program integrity training and education for the Compliance Officer, the organization's senior management, the Program Integrity Lead, all Contractor staff and subcontractors in accordance with the Federal and State standards and requirements under this contract. Contractor PI staff shall attend any required training offered by the Department. The Contractor shall be prepared to have staff members who are assigned to perform desk audits and/or field audits, to attend on-site training and orientation programs provided by DMAS.

14.6 EFFECTIVE LINES OF COMMUNICATION BETWEEN CONTRACTOR STAFF

The Contractor shall establish effective lines of communication between the Compliance Officer, Program Integrity Lead, other Contractor staff, Members, and subcontractors. Contractors shall have a system in place to receive, record, and respond to compliance questions, or reports of potential or actual non-compliance from employees and subcontractors, while maintaining confidentiality. The Contractor shall also establish effective lines of communication with its Members.

Contractors shall establish a process to document and track reported concerns and issues, including the status of related investigations and corrective action.

The Contractor shall submit an organizational chart annually that outlines the CCC Plus Program Integrity division within its chart. The organizational chart should include all divisions that handle the CCC Plus program (operations, claims, Member services, outreach/marketing, health services, etc.).

14.7 ENFORCEMENT OF STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The Contractor shall enforce program integrity standards through well-publicized disciplinary guidelines including but not limited to as described in 42 CFR §438.608.

14.8 DEVELOPMENT OF CORRECTIVE ACTION INITIATIVES

The Contractor's Program Integrity Plan shall include provisions for corrective action initiatives. The Contractor shall conduct appropriate corrective actions in response to potential violations. A corrective action plan should be tailored to address the particular misconduct identified. The corrective action plan should provide structure with timeframes so as not to allow continued misconduct but must, at a minimum, include repayment of any identified overpayments.

14.9 REPORTING AND INVESTIGATING SUSPECTED FRAUD AND ABUSE TO THE DEPARTMENT

The Contractor is required to use the templates, formats, and methodologies specified by the Department in the *CCC Plus Technical Manual* and on the CCC Plus website, located at: <http://www.dmas.virginia.gov/#/cccplusinformation>.

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). All confirmed or suspected provider fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, shall be reported to the Department within forty-eight (48) hours of discovery on the *Referral of Suspected Provider Fraud* form. This notification should be sent to DMAS via email at: CCCPlusReporting@dmas.virginia.gov. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

The Contractor may choose to utilize a pre-payment review process as a part of their program integrity plan. The Contractor shall notify the Department of each provider subject to pre-payment review within forty-eight (48) hours of initiating a pre-payment review process, using the *Notification of Provider Investigation* form (Attachment 13 of this Contract). Pre-payment review, for the purposes of this section refers specifically to a process in which the plan pends payment of a claim and then requests and reviews medical record documentation prior to releasing the claim for payment.

All suspected member fraud or other program-related misconduct shall be reported to the Department within forty-eight (48) hours of discovery on the Notice of Suspected Recipient Fraud or Misconduct form. This notification should be sent to DMAS via the email address provided on the form.

Any claims that are not paid as a result of these reviews shall be reported by the Contractor through the quarterly fraud/waste/abuse report. If pre-payment review indicates a pattern of fraud, waste, or program abuse, the Contractor shall conduct a retrospective review of that provider to identify any prior overpayments.

The Contractor shall provide information and a procedure for Members, network providers and subcontractors to report incidents of potential or actual fraud, waste and abuse to the Contractor and to the Department.

The Contractor shall report to the Department all incidents of potential or actual marketing services fraud and abuse immediately (within forty-eight (48) hours of discovery of the incident).

The Contractor shall have procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives.

Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

14.10 QUARTERLY FRAUD/WASTE/ABUSE REPORT

The Contractor shall submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must follow the format specified in the *CCC Plus Technical Manual*. This report will serve as the annual report of overpayment recoveries required under 42 C.F.R. §§ 438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following:

1. Allegations received and results of preliminary review
2. Investigations conducted and outcome
3. Payment Suspension notices received and suspended payments summary
4. Claims Edits/Automated Review summary
5. Coordination of Benefits/Third-Party Liability savings and recoveries
6. Service Authorization/Medical Necessity savings
7. Provider Education Savings
8. Provider Screening reviews and denials
9. Providers Terminated
10. Unsolicited Refunds (Provider-identified Overpayments)
11. Archived Referrals (Historical Cases)
12. Other Activities

Upon submission, DMAS will review the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation will examine ongoing reporting as well as the contents of the report to ensure that all contractual requirements are being met. DMAS will evaluate progress towards the Internal Monitoring and Audit Plan required under section 10.2.C of this contract identify any major changes or shortcomings to projected program integrity activity. The Department will evaluate this submission and provide feedback to the Contractor.

14.11 COOPERATION WITH STATE AND FEDERAL INVESTIGATIONS

The Contractor shall cooperate with all fraud, waste and abuse investigation efforts by the Department and other State and Federal offices.

14.12 MEDICAID FRAUD CONTROL UNIT (MFCU)

Some program integrity activities may identify issues that constitute potential fraud. DMAS and the Contractor are required to refer any cases of suspected fraud to the Virginia Medicaid Fraud Control Unit (MFCU). The Contractor shall cooperate fully with any request for information or technical support made by the MFCU to support their investigations. MFCU investigations may verify that some of these referrals constitute a “credible allegation of fraud.” In these instances, Contractors will be notified and shall suspend payments to those providers as set forth in 42 CFR § 455.23.

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty recovered through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

14.13 MINIMUM AUDIT REQUIREMENTS

A minimum number of investigations shall be conducted annually based on total dollars in medical claims expenditures. If the Contractor fails to meet this minimum standard, or is found to lack adequate program integrity controls, the Department reserves the right to impose a corrective action plan on the Contractor. If the Contractor subsequently fails to implement corrective action, the Department reserves the right to impose financial and non-financial penalties. For this Contract, investigations conducted by the Contractor shall involve the review of medical records for claims representing at least 3 percent of total medical expenditures.

14.14 PROVIDER AUDITS, OVERPAYMENTS, AND RECOVERIES

14.14.1 Fraud Referrals

When the Contractor identifies potential or actual fraud (as defined in 42 CFR § 455.2) by one of its providers or subcontractors, the allegation must be referred to the Department. Prior to submitting a referral to the Department, the Contractor shall have conducted a preliminary investigation of any allegation of FWA (including traditional referrals from internal and external sources, as well as leads generated through data mining). Once the Contractor has vetted the allegation and determined that it warrants a full investigation, it is at this point that the Attached *Notification of Provider Investigation* (Attachment 13 of this Contract) shall be sent to DMAS.

14.14.2 Formal Initiation of Recovery

The Contractor shall notify the Department upon formal initiation of a recovery from a solely conducted audit by the Contractor on its own network. Submission of the *Completed Investigation Form* will serve as this notification. The Contractor shall not proceed with any recoupment or withholding of any program integrity-related funds until the Department confirms that the recoupment or withhold is permissible. The Contractor shall submit adjusted encounters reflecting any identified overpayments (regardless of whether they are recovered) and report to the Department via the Quarterly Fraud/Waste/Abuse Report on any overpayments that have not been collected.

14.14.3 Class Action & Qui Tam Litigation

The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

14.14.4 Treatment of Recoveries

Generally, MCOs will be permitted to retain recoveries of overpayments identified and established through their own monitoring and investigative efforts. However, any overpayments for claims that were paid more than three years prior to the date that the Contractor formally notified the Department of the overpayment will be retained by the Department. In addition, one year from the date the Contractor is notified that they are permitted to recover an overpayment, the outstanding remainder of that overpayment will revert to the Department for collection and retention.

14.14.5 Provider Network Audits

The Department, pursuant to 42 CFR § 455, et. seq. may conduct audits of the Contractor's provider network, and as a result of those audits, recover and retain identified overpayments. At the request of the Department, the Contractor will provide any information the Department deems necessary to conduct such investigations including, but not limited to fee schedules, provider contracts, and claim payment data.

14.14.6 Fraudulent Provider Recovery with MFCU

Pursuant to the DMAS memorandum of understanding with MFCU, any recovery, in whole or in part, or penalty through the investigative efforts or litigation by the MFCU related to fraudulent provider conduct will be returned to the Commonwealth of Virginia and remain in the possession of the Commonwealth of Virginia.

14.14.7 Payment Suspension

Pursuant to 42 CFR § 455.23, the Contractor must suspend payments to providers or subcontractors against whom the Department has determined there to be a credible allegation of fraud. Upon notification from the Department that such a determination has been made, the Contractor must suspend payment as soon as possible and within one (1) business day or in accordance with the timeframes communicated by DMAS in the notice. If the Contractor believes there is good cause, as defined in 42 CFR § 455.23, to not suspend payments or to suspend payment only in part to such a provider, the Contractor must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider from payment suspension. The Department will evaluate the merit of the request for good cause exemption and notify the Contractor of the decision. Upon notification from the Department of the final determination to suspend payments, the Contractor shall suspend payments immediately in accordance with the timeframes communicated by DMAS in the notice of payment suspension.

14.14.7.1 Notice of Suspension

The Contractor must send a letter of the suspension of program payments to the suspended provider within five (5) business days of receiving notice from the Department unless requested in writing by a law enforcement agency to temporarily withhold such notice. The Contractor is

required to develop a letter following guidance issued by the Department. See the *CCC Plus Technical Manual*. The Contractor shall maintain written records of all notices of suspension activities. Upon request by the Department, the Contractor shall submit copies of suspension notices sent and other applicable documentation as requested.

14.14.8 Required Reporting Procedures

Under 42 C.F.R. § 438.608(a), the Contractor or subcontractor shall, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract:

- Implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
- Implement and maintain arrangements or procedures for prompt notification to the Department when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence or death of the Member.
- Implement and maintain arrangements or procedures for notification to the Department when it receives information about a change in the network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

SECTION 15.0 MEMBER AND PROVIDER GRIEVANCES AND APPEALS

15.1 GENERAL REQUIREMENTS

The Contractor shall have a system in place to respond to grievances, internal appeals, reconsiderations, and claims received from Members and providers. Additionally, the Contractor shall ensure that Members and providers are sent written notice of any adverse benefit determination or adverse action that informs Members and providers of their rights to appeal through the Contractor as well as their rights to access the Department's State fair hearing and provider appeal systems after they have exhausted their appeals with the Contractor. This process shall ensure that appropriate decisions are made as promptly as possible. The Member internal appeals process shall include provisions for expedited appeals for Members within seventy-two (72) hours from receipt of the appeal request. The Contractor shall develop policies and procedures regarding the grievance and internal appeal processes. These shall be reviewed and approved by DMAS prior to implementation. The Contractor shall notify providers and Members of their rights to grievances and appeals with the Contractor. The Contractor shall ensure that all network providers are informed, at the time they enter into a contract, about all Member grievance, appeal, and fair hearing procedures, timeframes, and associated Member rights as specified in 42 CFR 438.400 through 42 CFR 438.424 and described within this section of this Contract. As described in the *CCC Plus Technical Manual*, the Contractor shall provide DMAS with monthly reports indicating the number of grievances and internal appeal requests received as well as the detailed analysis and disposition.

Written materials for Members shall use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs or those who are not English language proficient. Members shall be informed that information is available in alternate formats and how to access those formats.

The Contractor shall provide appeals, grievance forms and/or written procedures to Members or providers who wish to register written appeals or grievances. Additionally, the Contractor shall provide reasonable assistance to Members 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 shall provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action.

The Contractor shall ensure that neither the individual nor a subordinate of any such individual who makes decisions on grievances or appeals was involved in any previous level of review or decision-making. In any case where the reason for the grievance or appeal involves clinical issues or is related to denials 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.

The Contractor shall ensure that decision-makers on Member grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or

the Member's authorized representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The Contractor agrees to be fully compliant with all state and federal laws, regulations, and policies governing the Member and provider grievances and appeals processes, as applicable, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited Member appeal requests. The Contractor shall be financially liable for all judgments, penalties, costs, and fees related to an appeal in which the Contractor has failed to comply fully with said requirements.

The Contractor and its subcontractors, as appropriate, shall include the minimum elements identified on the DMAS templates for 1) adverse benefit determinations and 2) internal appeal decisions. The templates are located at: <http://www.dmas.virginia.gov/#/cccplushealthplans>. DMAS shall review and approve the form and content of the Contractor's adverse benefit determinations and internal appeal decisions prior to implementation. The minimum elements for adverse benefit determinations are found in Section 15.4.1, *Notice of Adverse Benefit Determination* and the minimum elements for internal appeal decisions are found in Section 15.4.2, *Contractor Internal Appeals*.

15.2 GRIEVANCES

The DMAS Appeals Division does not handle grievances. A Member may file a grievance and a provider may file a complaint with the Contractor. In accordance with 42 CFR §438.408, the Contractor shall be responsible for properly responding to all grievances and complaints. In accordance with 42 CFR §438.400 et seq. and as directed by DMAS, the Contractor shall have a system in place for addressing Member grievances, including grievances regarding reasonable accommodations and access to services under the Americans with Disabilities Act. As part of that process, the Contractor shall have written policies and procedures that describe the grievance process and how it operates, and the process shall comply with federal requirements and NCQA standards. The Contractor shall also have a system in place to address provider complaints and shall have written policies and procedures that describe the provider complaint process. These written directives shall describe how the Contractor intends to receive, track, review, and report all Member inquiries and grievances and provider complaints. The Contractor shall make any changes to its grievance and complaints procedures that the Department requires. The Contractor shall submit the procedures and any changes to the procedures to DMAS prior to signing the original Contract, at revision, upon request, and as needed. The Contractor shall maintain written records of all Member grievance and provider complaint activities and notify DMAS of all internal grievances through a reporting format approved by DMAS.

The Contractor's grievance process shall allow a Member, an attorney, or a Member's authorized representative (provider, family member, etc.) acting on behalf of the Member, to file a grievance at any time, either orally or in writing. With the exception of an attorney, an authorized representative must have the Member's written consent to file a grievance. The Contractor shall acknowledge receipt of each grievance. Grievances received orally can be acknowledged orally.

The Contractor shall resolve a grievance and provide notice as expeditiously as the Member's health condition requires, within state established timeframes not to exceed ninety (90) calendar days from the date the Contractor receives the grievance in a format and language that meets, at a minimum, the standards described in 42 CFR § 438.10. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is need for additional information and that a delay in rendering the decision is in the Member's interest. If the Contractor extends the timeline for a grievance not at the request of the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay; within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision; and resolve the grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires.

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 that provide the basis for the decision; and a clear explanation of any further rights available to the Member or provider under the Contractor's grievance process.

15.3 GENERAL APPEALS REQUIREMENTS

The Contractor shall maintain written records of all Member and provider appeal activities at all levels in the manner and format reflected in the *CCC Plus Technical Manual*. The Contractor is required to respond promptly, unless DMAS requests a response within twenty-four (24) hours, to any requests made by DMAS pertaining to appeals.

The Contractor shall attend and defend the Contractor's decisions at all DMAS appeal hearings or conferences, whether in person or by telephone, as deemed necessary by the DMAS Appeals Division. Contractor travel and telephone expenses in relation to appeal activities shall be borne by the Contractor. Failure to attend and defend the Contractor's actions at all appeal hearings and/or conferences shall result in the application of liquidated remedies as set forth in this Contract.

The Contractor does not have the right to appeal decisions from DMAS State fair hearings or provider informal or formal appeals.

15.4 MEMBER APPEALS

As a prerequisite to filing an appeal to DMAS, any Member, Member's attorney, or Member's authorized representative (provider, family member, etc.) acting on behalf of the Member, wishing to appeal an adverse benefit determination must first file an internal appeal with the Contractor within sixty (60) calendar days from the date on the notice of adverse benefit determination. The Contractor shall have procedures in place to handle standard and expedited internal appeals.

A Member may request continuation of services during the Contractor's internal appeal and DMAS' State fair hearing. A determination on continuation of services shall be made in accordance with 42 CFR § 438.420 and the regulations governing the CCC Plus program. If the

determination is made to continue benefits, the Contractor must continue the Member's benefits so long as all of the requirements of 42 CFR § 438.420(b) are met. If the final resolution of the appeal upholds the Contractor's action and services to the Member were continued while the internal appeal of State fair hearing was pending, the Contractor may recover the cost of the continuation of services from the Member.

15.4.1 Notice of Adverse Benefit Determination

In accordance with 42 C.F.R. § 438.404, the Contractor shall give the Member written notice of any adverse benefit determination. For termination, suspension, or reduction of previously authorized Medicaid-covered services, such notice shall be provided at least ten (10) days in advance of the date of its action. For denial of payment, such notice shall be provided at the time of action. For standard service authorization decisions that deny or limit services, the notice is required as expeditiously as the Member's condition requires and within the timeframes referenced in Section 6.2.10, *Service Authorization Timeframes*. For cases in which a provider indicates or the Contractor determines that following the standard authorization timeframe could seriously jeopardize the Member's life, 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 seventy-two (72) hours after receipt of the request for service.

At a minimum, the notice shall explain:

- 1) The action the Contractor has taken or intends to take;
- 2) The reasons for the action, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
- 3) The citation to the law or policy supporting such action;
- 4) The Member's or the Member's representative's right to file an internal appeal with the Contractor, including information on exhausting the Contractor's appeal processes and an explanation that the Member and/or representative has a right to file an appeal with DMAS for a State fair hearing only after the Contractor's internal appeal process has been exhausted;
- 5) The procedures for exercising the Member's rights to appeal;
- 6) The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
- 7) If applicable, the Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to repay the costs of these services; and
- 8) The right to be represented by an attorney or other individual.

The written notice shall be translated for individuals who speak prevalent languages. Additionally, written notices shall include language explaining that oral interpretation is available for all languages and how to access it.

15.4.2 Contractor Internal Appeals

Initial appeals shall be filed with the Contractor. The filing of an internal appeal and exhaustion of the Contractor's internal appeal process is a prerequisite to filing an appeal to DMAS.

The Contractor's appeals process shall include the following requirements:

- 1) Acknowledge receipt of each appeal;
- 2) An appeal may be submitted orally or in writing by the Member, Member's attorney, or Member's authorized representative. The Contractor shall recognize oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal). If the Member does not request an expedited appeal pursuant to 42 CFR § 438.410, the Contractor shall require the Member to follow an oral appeal with a written, signed appeal;
- 3) Provide the Member a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing. The Contractor shall inform the Member of the limited time available for this, especially in the case of expedited resolution;
- 4) Provide the Member and his or her representative the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor or at the direction of the Contractor in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for standard (thirty (30) calendar days) and expedited (seventy-two (72) hours) internal appeals; and
- 5) Consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.

The Contractor shall respond in writing to standard internal appeals as expeditiously as the Member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal. In accordance with § 438.408(c)(1), the Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the Member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is a need for additional information and that a delay in rendering the decision is in the Member's interest.

In accordance with § 438.408(c)(2), if the Contractor extends the timeframe for an appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay. In addition, the Contractor shall resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. For any internal appeals decisions not rendered within thirty (30) calendar days where the Member has not requested an extension, the Contractor shall make reasonable efforts to provide oral notice and shall within two (2) calendar days give the Member written notice of the

reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision.

The Contractor shall establish and maintain an expedited review process for internal appeals when the Contractor determines (on a request from the Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) 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. In accordance with 42 CFR § 438.410(b), the Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports a Member's internal appeal. In instances where the Member's request for an expedited internal appeal is denied, the internal appeal shall be transferred according to the timeframe for standard resolution of internal appeals, and the Member shall be given prompt oral notice of the denial. Within two (2) calendar days of the oral notice of denial, the Member shall be sent written notice of the reason for the decision to deny the request for an expedited appeal and informed of the right to file a grievance if the Member disagrees with that decision.

The Contractor shall provide written notice and make reasonable efforts to provide oral notice, of the resolution of an expedited internal appeal within seventy-two (72) hours from the initial receipt of the appeal. For standard internal appeals, the Contractor shall issue its internal appeal decision as expeditiously as the Member's health condition requires and shall not exceed thirty (30) calendar days from the initial date of receipt of the internal appeal request in a format, that meets, at a minimum, the standards described in 42 CFR § 438.10. In accordance with 42 CFR § 408, the Contractor may extend the timeframe for expedited or standard appeals by up to an additional fourteen (14) calendar days if the Member requests the extension or if the Contractor provides evidence satisfactory to DMAS that there is a need for additional documentation and that a delay in rendering the decision is in the Member's interest. For any extension not requested by the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay; written notice within two (2) calendar days to the Member of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with that decision. The Contractor shall resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

All Contractor decisions to internal appeals shall be in writing and shall include, but not be limited to, the following information:

- 1) The decision reached by the Contractor, including a specific discussion of the reason for any adverse benefit determination, including citations to the policies, procedures, and/or authority that support the decision;
- 2) The date the Member's appeal request was received;
- 3) The date of the decision; and,
- 4) For appeals not resolved wholly in favor of the Member:
 - a. The right to request an appeal of the Contractor's final denial through the DMAS State fair hearing process. The final denial letter shall clearly identify that the Contractor's internal appeal process has been exhausted, and include the timeframe for filing an appeal to DMAS, the submission methods and related

- address and phone numbers to file an appeal, and list pertinent statutes/regulations governing the appeal process; and,
- b. The right to request an expedited appeal, the circumstances under which expedited resolution is available, and how to request it;
 - c. The right to request to receive benefits while the State fair hearing is pending and how to make the request, explaining that the Member may be held liable for the cost of those services if the State hearing decision upholds the Contractor to the extent that services were furnished (continued) solely because of the requirements of this section. [42 CFR § 438.420(d)];
 - d. A list of titles and qualifications, including specialties, of individuals participating in the appeal review;
 - e. The right to be represented by an attorney or other individual; and,
 - f. Information on how to contact the Office of the State Long-Term Care Ombudsman, Department for Aging and Rehabilitative Services.

15.4.3 Member Appeals To DMAS

In general, Members who have received an internal appeal decision that upholds the Contractor's denial in whole or in part have the right to appeal the internal appeal decision to DMAS by requesting a State fair hearing. Members also have the right to appeal DMAS's decision to move them to a different Contractor directly to DMAS without first having to seek an internal appeal decision from the Contractor.

15.4.3.1 For Cause Disenrollment Determinations

In accordance with 42 CFR § 438.56(e)(2), Members who are dissatisfied with DMAS' determination on the Member's for cause request to disenroll from one health plan to another shall have the right to appeal DMAS' decision through the State fair hearing process.

15.4.3.2 Contractor Adverse Internal Appeal Decisions

Members have the right to appeal the Contractor's internal appeal decision upholding its adverse benefit determinations to DMAS. However, the Contractor's internal appeal process must be exhausted or deemed exhausted due to the Contractor's failure to adhere to the notice and timing requirements prior to a Member filing an appeal with the DMAS Appeals Division. Denials of benefits that are offered by the Contractor beyond those covered by the State Plan and not included in the capitation rate calculation are not appealable to a State fair hearing.

15.4.3.3 State Fair Hearing Process

DMAS Member appeals are conducted in accordance with 42 CFR § 431 Subpart E and DMAS' Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370. Adverse benefit determinations include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed.

Standard appeals may be requested orally or in writing to DMAS by the Member or the Member's authorized representative. Expedited appeals may be filed by telephone or in writing. The appeal may be filed at any time after the Contractor's internal appeal process is exhausted but must be requested no later than 120 calendar days from the date of the Contractor's internal appeal decision.

Within twenty-four (24) hours of a request by DMAS, the Contractor shall either: fax (or email if requested by email) a copy of the Member's internal appeal decision to the DMAS Appeals Division at 804-452-5454; or, if there has been no internal appeal decision, notify the Appeals Division in writing that the Member has not exhausted the Contractor's appeal process.

Upon receipt of notification by DMAS of an appeal, the Contractor shall prepare and submit an appeal summary describing the basis of the adverse benefit determination to the DMAS Appeals Division, the DMAS CCC Plus contract monitor, and the Member involved in the appeal in accordance with required time frames. In addition, the Contractor shall e-mail a complete copy of the appeal summary to DMAS at CCCPlusAppeals@dmass.virginia.gov on the same day that it files an appeal summary with the DMAS Appeals Division. The summary shall be completed in accordance with 12 VAC 30-110-70, which describes notification requirements and also serves as a guideline for information necessary to include in both the notice and the summary. The appeal summary shall 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 standard appeals, the DMAS Appeals Division requests that the Contractor submit the appeal summary to DMAS within twenty-one (21) calendar days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all standard appeals, the summary shall be received by DMAS at least ten (10) calendar days prior to the scheduled hearing date and mailed to the Member on the date submitted to the DMAS Appeals Division. For expedited appeals that meet the criteria set forth in 42 CFR § 438.410, the appeal summary shall be faxed to DMAS and faxed or overnight mailed to the Member, as expeditiously as the Member's health condition requires, but no later than four (4) hours after DMAS informs the Contractor of the expedited appeal. Failure to submit appeal summaries within the required timeframe or with the required content shall result in performance penalties as described in this Contract.

Appeals to DMAS that do not qualify as expedited shall be resolved or a decision shall be issued by DMAS within ninety (90) days from the date the Member filed the internal appeal with the Contractor, not including the number of days the Member took to subsequently file for a State fair hearing. The timeline for resolution or issuance of a decision in State fair hearing appeals may be extended for delays not caused by DMAS, in accordance with 42 CFR § 431.244(f)(4) and 12 VAC 30-110-30 relating to the extension of Medicaid appeal decision deadlines for non-agency caused delays.

Appeals to DMAS that qualify as expedited appeals shall be resolved within seventy-two (72) hours or as expeditiously as the Member's condition requires.

In accordance with 42 CFR § 438.424, if the appeal decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor shall authorize the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives the notice reversing the decision. If the appeal decision reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Contractor must pay for those services.

If the appeal decision remands the case back to the MCO, the MCO shall follow the remand instructions, after which it shall promptly issue a written notice to the Member in accordance with the requirements described throughout this Contract, including, but not limited to, Subsections 6.2.12, *Adverse Benefit Determination*, 11.11, *Member Communications and Enrollment Materials* and 15.1, *General Requirements*.

DMAS' final administrative appeal decision may be appealed through the court system by the Member. However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, DMAS and/or its counsel at the Office of the Attorney General (OAG) may have a need to confer with the Contractor to gain further information about the appealed action. The Contractor shall respond to inquiries from DMAS or the OAG within one business day or sooner, if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

15.5 PROVIDER APPEALS

The first level of a provider appeal is a reconsideration with the Contractor. For services that have been rendered, providers have the right to appeal adverse actions. However, the provider shall exhaust the Contractor's reconsideration process prior to filing an appeal with the DMAS Appeals Division.

15.5.1 Reconsiderations

The Contractor shall have a reconsideration process in place available to providers who wish to challenge adverse actions made by the Contractor. This process shall assure that appropriate decisions are made as promptly as possible. The Contractor shall submit its reconsideration process to DMAS for review and approval prior to implementation.

If a provider has rendered services to a Member enrolled with the Contractor in a Medicaid program and has either been denied authorization or reimbursement for the services or has received reduced authorization or reimbursement, that provider can request a reconsideration of the denied or reduced authorization or reimbursement. Before appealing to DMAS, providers must first exhaust the Contractor's reconsideration process. Providers in the Contractor's network may not appeal the Contractor's enrollment or terminations decisions to DMAS.

The Contractor's reconsideration process shall include the following requirements:

- 1) Provide a reasonable amount of time for a provider to submit a reconsideration request;
 - 2) Acknowledge receipt of each reconsideration request;
 - 3) Ensure that the individuals who make decisions on reconsiderations were not involved in any previous level of review or decision making;
 - 4) A reconsideration request shall be submitted in writing;
 - 5) Provide the provider a reasonable opportunity to present evidence and allegations of fact or law. The Contractor shall inform the provider of the limited time available for this;
- and,

- 6) Allow the provider the opportunity, before and during the reconsideration process, to examine the provider's case file, including any medical records and any other documents and records considered during the reconsideration process.

All Contractor reconsideration decisions shall be in writing and shall include, but not be limited to, the following information:

- a) The decision reached by the Contractor, including a specific discussion of the reason for any adverse action, including citations to the policies, procedures, and/or authority that support the decision;
- 2) The date the provider's appeal request was received;
- 3) The date of the decision; and,
- 4) For appeals not resolved wholly in favor of the provider, the right to request an appeal to DMAS of the Contractor's reconsideration decision through the DMAS informal appeals process. The final decision shall clearly identify that the Contractor's reconsideration process has been exhausted and include the timeframe for filing an appeal to DMAS, the submission methods and related address and facsimile number to file an appeal, and list pertinent statutes/regulations governing the appeal process, and the right to be represented by an attorney.

15.5.2 Provider Appeals To DMAS

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.* There are two levels of administrative appeal: (i) the informal appeal, and (ii) the formal appeal. The informal appeal is before an Informal Appeals Agent employed by DMAS. The formal appeal is before a hearing officer appointed by the Supreme Court of Virginia, and a Formal Appeals Representative employed by DMAS helps present DMAS' position. The Supreme Court hearing officer writes a recommended decision for use by DMAS' Director in issuing the Final Agency Decision. The Contractor shall assist DMAS by presenting DMAS' position in the administrative appeals process in conjunction with appeals of Contractor reconsideration decisions filed by providers.

All provider appeals to DMAS shall be submitted in writing and within thirty (30) calendar days of the Contractor's adverse reconsideration decision to the DMAS Appeals Division, 600 East Broad Street, Richmond, VA 23219. The Contractor's reconsideration decision shall include a statement that the provider has exhausted its reconsideration rights with the Contractor and that the next level of appeal is with DMAS. The reconsideration decision shall include the standard appeal rights to DMAS, including the time period and address to file the appeal.

DMAS' normal business hours are from 8:00 a.m. to 5:00 p.m. Monday through Friday, Eastern time. Any documentation or correspondence, including but not limited to notices of appeal, case summaries, pleadings, briefs or exceptions, submitted to the DMAS Appeals Division after 5:00 p.m. shall be date stamped on the next day DMAS is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely.

Upon receipt of notice that DMAS has received an appeal from a provider involving services provided or being provided to the Contractor's Member, the Contractor shall verify that the provider has exhausted the Contractor's reconsideration process. Further the Contractor shall verify, based upon the Contractor's records, that the appeal to DMAS meets the DMAS

timeliness requirements (i.e., within thirty (30) calendar days of the Contractor's last date of denial). The Contractor shall notify the DMAS Appeals Division within twenty-four (24) hours of the receipt of the appeal notice to DMAS, of any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal does not appear to meet DMAS' timeliness requirements based upon the Contractor's records.

The Contractor shall attend and defend the Contractor's reconsideration decisions at all appeal hearings or conferences, whether informal or formal, or whether in person, by telephone, or as deemed necessary by the DMAS Appeals Division. If the Contractor's reconsideration decision was based in whole or part, upon a medical determination, including but not limited to medical necessity or appropriateness or level of care, the Contractor shall provide sufficiently qualified medical personnel to attend the appeal-related conference(s) and hearing(s). All appeal activities, including but not limited to travel, telephone expenses, copying expenses, staff time, and document retrieval and storage, shall be borne by the Contractor. Failure to attend or defend the Contractor's reconsideration decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees, as well as any other performance penalties specified in this Contract.

15.5.3 Informal Appeals

Providers appealing a Contractor's reconsideration decision shall file a written notice of informal appeal with the DMAS Appeals Division within thirty (30) calendar days of the provider's receipt of the Contractor's reconsideration decision. The provider's notice of informal appeal shall identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within thirty (30) calendar days of receipt of the Contractor's reconsideration decision shall result in an administrative dismissal of the appeal.

The Contractor shall file a written case summary with the DMAS Appeals Division within thirty (30) calendar days of the filing of the provider's notice of informal appeal. For each adjustment, patient, and service date or other disputed matter identified by the provider in its notice of informal appeal, the case summary shall explain the factual basis upon which the Contractor relied in making its reconsideration decision and identify any authority or documentation upon which the Contractor relied in making its reconsideration decision. The Contractor shall e-mail a complete copy of the case summary to DMAS at CCCPlusAppeals@dmas.virginia.gov on the same day that it files the case summary with the DMAS Appeals Division.

The DMAS Informal Appeals Agent (IAA) shall conduct the conference within ninety (90) calendar days from the filing of the provider's notice of informal appeal. If the Contractor, the provider, and the IAA agree, the conference may be conducted by way of written submissions. If the conference is conducted by way of written submissions, the IAA shall specify the time within which the provider may file written submissions, not to exceed ninety (90) calendar days from the filing of the notice of informal appeal. If a provider submits written submissions after filing the notice of appeal, the Contractor is responsible for submitting a response within the time period set by the IAA. Only written submissions filed within the time specified by the IAA shall be considered.

The conference may be recorded at the discretion of the IAA and solely for the convenience of the IAA. Because the conference is not an adversarial or evidentiary proceeding, no other recordings or transcriptions shall be permitted. Any recordings made for the convenience of the IAA shall not be released to DMAS, the Contractor, or the provider.

Upon completion of the conference, the IAA shall specify the time within which the provider may file additional documentation or information, if any, not to exceed 30 calendar days. Only documentation or information filed within the time specified by the IAA shall be considered.

The informal appeal decision shall be issued within one hundred eighty (180) calendar days of receipt of the notice of informal appeal. Providers have the right to appeal the DMAS informal appeal decision in accordance with 12 VAC 30-20-560, as a formal appeal.

15.5.4 Formal Appeals

Any provider appealing a DMAS informal appeal decision shall file a written notice of formal appeal with the DMAS Appeals Division within thirty (30) calendar days of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal shall identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within thirty (30) calendar days of receipt of the informal appeal decision shall result in dismissal of the appeal.

At the formal level, the Contractor assists DMAS' staff counsel in preparing DMAS' evidence and acts as a witness at a hearing before a hearing officer appointed by the Virginia Supreme Court. The Contractor shall supply the necessary expertise to defend its actions and shall assist the Formal Appeals Agent in the preparation of all hearing matters leading to the Final Agency Decision.

DMAS and the provider shall file with the DMAS Appeals Division all documentary evidence on which DMAS or the provider relies within twenty-one (21) calendar days of the filing of the notice of formal appeal. Simultaneous with filing, the filing party shall transmit a copy to the other party and to the hearing officer. Only documents filed within twenty-one (21) calendar days of the filing of the notice of formal appeal shall be considered. DMAS and the provider shall file any objections to the admissibility of documentary evidence within seven (7) calendar days of the filing of the documentary evidence. Only objections filed within seven (7) calendar days of the filing of the documentary evidence shall be considered. The hearing officer shall rule on any objections within seven (7) calendar days of the filing of the objections.

The hearing officer shall conduct the hearing within forty-five (45) calendar days from the filing of the notice of formal appeal, unless the hearing officer, DMAS, and the provider all mutually agree to extend the time for conducting the hearing. Notwithstanding the foregoing, the due date for the hearing officer to submit the recommended decision to DMAS' Director shall not be extended or otherwise changed.

If there has been an extension to the time for conducting the hearing, the hearing officer is authorized to alter the due dates for filing opening and reply briefs to permit the hearing officer to be in compliance with the due date for the submission of the recommended decision.

Within thirty (30) calendar days of the completion of the hearing, DMAS and the provider shall file their opening briefs with the DMAS Appeals Division. Any reply brief from DMAS or the provider shall be filed within ten (10) calendar days of the filing of the opening brief to which the reply brief responds. Simultaneous with filing either the opening brief or the reply brief, the filing party shall transmit a copy to the other party and to the hearing officer.

Formal hearings shall be transcribed by a court reporter retained by DMAS.

The hearing officer shall submit a recommended decision to DMAS Director with a copy to the provider within one hundred twenty (120) calendar days of the filing of the formal appeal notice. If the hearing officer does not submit a recommended decision within one hundred twenty (120) calendar days, then DMAS shall give written notice to the hearing officer and the Executive Secretary of the Supreme Court that a recommended decision is due.

Upon receipt of the hearing officer's recommended decision, DMAS Director shall notify DMAS and the provider in writing that any written exceptions to the hearing officer's recommended decision shall be filed with the DMAS Appeals Division within fourteen (14) calendar days of receipt of DMAS Director's letter. Only exceptions filed within fourteen (14) calendar days of receipt of DMAS Director's letter shall be considered. The DMAS Director shall issue the Final Agency Decision within sixty (60) calendar days of receipt of the hearing officer's recommended decision.

15.5.5 Court Review

The provider may appeal DMAS' Final Agency Decision through the court system in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq.* However, the court review is limited to legal issues only. No new evidence is considered. During the court appeal process, DMAS and/or its counsel at the Office of the Attorney General (OAG) may have a need to confer with the Contractor to gain further information about the appealed action. However, the Contractor is not a party to the lawsuit because the issue being contested is DMAS' Final Agency Decision. The Contractor shall respond to inquiries from DMAS or the OAG within one business day or sooner if the situation warrants a quicker response. Furthermore, the Contractor is responsible for complying with the court's final order, which could possibly include a remand for a new hearing.

15.6 EVALUATION OF GRIEVANCES AND APPEALS

The Contractor shall, at a minimum, track, trends in grievances, internal appeals, and reconsiderations. The Contractor's internal appeals, reconsiderations, and grievances system shall be consistent with Federal and State regulations and the most current NCQA standards. The grievances, internal appeals, and reconsiderations process shall include the following:

1. Procedures for registering and responding to grievances in a timely fashion;
2. Documentation of the substance of the grievance or appeal and the actions taken;
3. Procedures to ensure the resolution of the grievance;

4. Aggregation and analysis of these data and use of the data for quality improvement.
5. The Contractor shall 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 Medicaid from commercial members if the Contractor does not have a separate system for the Medicaid program.

15.7 GRIEVANCE AND APPEAL REPORTING

By the 15th day of each month, the Contractor shall submit a report to DMAS of all of the previous month's provider and Member grievances and appeals as reflected in the *CCC Plus Technical Manual*. The Contractor may use reports from its existing Member Services system if the system meets DMAS' criteria.

Grievance categories identified shall be organized or grouped by the following general guidelines:

1. Transportation
2. Access to Services/Providers
3. Provider Care and Treatment
4. Care Coordination
5. MCO Customer Service
6. Payment and Reimbursement Issues
7. Administrative Issues

Appeal categories identified shall be organized or grouped by the following general guidelines:

1. Transportation
2. MCO Administrative Issues
3. Benefit Denial or Limitation
4. Provider Enrollment

15.8 RECORDKEEPING AND DOCUMENT PRESERVATION

Recordkeeping and document preservation are important to ensure the integrity of the appeals process, to assist in identifying and responding to trends, and to meet federal and state legal requirements.

15.8.1 Recordkeeping And Reporting Requirements

In accordance with 42 CFR § 438.416, the Contractor shall maintain records of grievances and appeals and must review the information as part of its ongoing quality improvement strategy. The record shall be accurately maintained in a manner accessible to DMAS and shall be made available upon request to CMS. The record of each grievance or appeal must contain, at a minimum, all of the following information:

1. A general description of the reason for the appeal or grievance.
2. The date received.
3. The date of each review or, if applicable, review meeting.
4. Resolution at each level of the appeal or grievance, if applicable.
5. Date of resolution at each level, if applicable.
6. Name of the covered person for whom the appeal or grievance was filed.

Also refer to Section 15.7, *Grievance and Appeal Reporting*.

15.8.2 Document Preservation

The Contractor is responsible for the preservation and production of documents associated with any Appeal. The Contractor shall be responsible for all costs related to the preservation and production of documents as required in response to a subpoena, FOIA request, or any litigation involving the Contractor or DMAS, including but not limited to, external Appeals.

SECTION 16.0 INFORMATION MANAGEMENT SYSTEMS

16.1 GENERAL REQUIREMENTS

The Contractor shall maintain Information Systems (Systems) that will enable the Contractor to meet all of the Department's and this Contract's requirements. The Contractor's Systems shall be able to support the current DMAS requirements, and any future IT architecture or program changes. Solutions shall be compliant with COV Information Technology Resource Management (ITRM) policies, standards, and guidelines, and may be updated from time to time. A complete list can be located: <http://www.vita.virginia.gov/library/default.aspx?id=537>.

The Contractor shall:

- 1) Ensure a secure, HIPAA-compliant exchange of Member information between the Contractor and the Department and any other entity deemed appropriate by the Department. Such files shall be transmitted to the Department through secure FTP, HTS, or a similar secure data exchange as determined by the Department;
- 2) Develop and maintain a website that is accurate, up-to-date, and designed in a user-friendly way that enables Members and providers to quickly and easily locate all relevant information. The Contractor shall establish appropriate links on the Contractor's website that direct users back to the Department's web portal;
- 3) Cooperate with the Department in its efforts to verify the accuracy of all Contractor data submissions to the Department; and,
- 4) Actively participate in any DMAS Systems workgroups, as directed by the Department.

16.2 DESIGN REQUIREMENTS

The Contractor shall comply with the Department's requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract. The Contractor's Systems shall interface with the Department's VaMMIS/MES system, the DMAS Virtual Gateway, and other DMAS IT architecture.

16.3 SYSTEM ACCESS MANAGEMENT AND INFORMATION ACCESSIBILITY REQUIREMENTS

In accordance with 42 CFR § 438.242(b)(3), the Contractor shall make all collected data available to the State and upon request to CMS. The Contractor shall make all systems and system information available to authorized DMAS and other agency staff to evaluate the quality and effectiveness of the Contractor's data and Systems.

The Contractor is prohibited from sharing or publishing DMAS data and information without prior written consent from the Department

16.4 SYSTEM AVAILABILITY AND PERFORMANCE REQUIREMENTS

The Contractor shall ensure that its Member and provider web portal functions and call centers are available to Members and providers twenty-four (24) hours a day, seven (7) days a week.

Prior to implementation, upon revision, or upon request, the Contractor shall draft an alternative plan that describes access to Member and provider information in the event of System failure and submit to the Department for approval. Such approved plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted

to the Department upon request. In the event of System failure or unavailability by the Contractor or one of its contracted vendors, the Contractor shall notify the Department upon discovery and implement the COOP immediately. The Contractor shall send the notification via email to the CCC Plus Operations Manager and to cccplusreporting@dmas.virginia.gov within one (1) business hour of discovery of the issue.

The Contractor shall preserve the integrity of Member-sensitive data and be able to produce the data that resides in both a live and archived environment.

16.5 ELECTRONIC CARE COORDINATION SYSTEM

The Contractor shall utilize an electronic care coordination system that maximizes the opportunity to share and integrate data and information among the Contractor, its multiple service areas, helplines, providers, Members, and Care Coordinators quickly and efficiently. The system should allow staff (e.g., customer service, nurse helpline, medical management) who may be contacted by a Member regarding care coordination to have immediate access to the most recent case-specific information within the Contractor's electronic system. The data contained within the electronic system may include the following: administrative data, call center notes, helpline notes, provider service notes, a Member's care coordination notes, and any recent inpatient or emergency department utilization. The system must also have the capability to share or access relevant information (i.e., ICP, utilization reports, care treatment plans, etc.) with the Member, Member's provider(s), and Care Coordinators. The Contractor shall also be required to send and receive relevant data with subcontractors (i.e., to/from the Contractor's care coordination or other systems) to facilitate effective care coordination and transitions of care.

The Contractor shall submit to the Department for approval at implementation, at revision, or upon request, the policies and procedures of its electronic system and other tools Care Coordinators will use to integrate care for Members, including integrating Medicare for dual eligible individuals. The policies and procedures should place emphasis on how the system facilitates communication so that the Contractor, providers, helpline, Member, subcontractors and Care Coordinators can receive real time or near real time data (e.g., utilization management, claims data, experience with the Contractor, subcontractors, etc.) to better coordinate care, follow Members through episodes of care, and streamline care transitions to ensure positive health outcomes for Members. In the policies and procedures, the Contractor shall describe: (1) the types of data stored in the electronic care coordination system; (2) how information is fed into the system (e.g., real time, manual entry, etc.), how frequently (e.g., daily, weekly, etc.), and from what sources(s) (e.g., subcontractors); and, (3) which providers and staff have access to the data, how they access the data, and for what purposes; and (4) the Contractor's ability to capture (send/receive) relevant information to report to the Department for care coordination and monitoring purposes.

The Contractor agrees to provide utilization management, health risk assessment, individualized care plan and care coordination data to an electronic data system designed by the Department beginning on April 1, 2019. The data system will receive and transmit information using standardized data exchange file formats and processes as specified by DMAS and defined in the *CCC Plus Technical Manual*. DMAS will work with the Contractor to allow sufficient time for a collaborative design process toward this purpose. The Contractor shall participate in meetings to determine the composition and content of the data, data exchange processes,

functionality and defined usage of the system by the Contractors, and the frequency and format of the data exchange process. Contractors shall also share required data with DMAS on a real time or near real time basis, at no additional cost to the Department. DMAS shall be required to exchange agreed data elements with contractors to facilitate efficiencies and enhance care coordination efforts provided by the contractors.

The Contractor shall work closely with the Department in the implementation of the Care Review Management System (CRMS). The phased-in approach for this platform will take place between July and November 2020, with further guidance in a forthcoming CRMS Technical Manual.

16.6 CENTRAL DATA REPOSITORY

The Department is expanding its data integration and analytics capabilities by developing a system that collects, integrates, and analyzes data from a variety of sources across the full continuum of care (primary, acute, behavioral, institutional, and community based). The Department will track health metrics for the Medicaid population across fee-for-service and all managed care programs. This data system will help the Department evaluate how well the CCC Plus program is serving individuals, while identifying best practices and opportunities for improvement. This comprehensive data mining approach will enable the Department to project risk, enhance care coordination, mitigate service gaps, and promote efficiencies.

The Contractor shall provide raw data, including data from subcontractors. The data shall be compliant with industry standards (e.g., National Information Exchange Model) and State companion guides. At a minimum, required data shall include:

- 1) Service authorizations;
- 2) Full provider networks;
- 3) Appeals and grievances;
- 4) Care coordination data;
- 5) Formulary data;
- 6) Financial management reports and transaction data for any off systems payments including, but not limited to:
 - a. MLR reports, BOI data
 - b. Lump sum payments to providers
 - c. Incentive payments to providers
 - d. Cost recovery transactions (e.g., third party liability explanation of benefits, fraud/waste investigations, and/or legal actions); and,
- 7) Encounter claims using the HIPAA Compliant Transactions and Code Sets and file formats following the Department's EDI requirements.

The Department will collect, analyze, and report data in a reliable and timely manner. The Contractor shall work collaboratively with the Department to develop solutions that align with the Department's data integration goals, based upon evidenced-based data standards which ensure the highest degree of data quality and integrity.

The Contractor shall submit the required data in the timeframe and required format(s). The Contractor shall be subject to liquidated damages and sanctions when data is submitted contrary

to the Department's established standards of timeliness, completeness and accuracy, and where the method of submission is non-compliant with this Contract.

Beginning in the Fall 2018, the Department will begin working with the Contractor to develop a mechanism to collect service authorization (SA) data from all CCC Plus MCOs. The SA data will be collected as part of a phased implementation plan, beginning with pharmacy SA claims data. The Contractor shall work closely with the Department to develop the technical requirements for providing the SA data as well as the mechanism for data transmission, including file formats and submission frequency. The SA data reporting implementation is expected to take place in 2019.

16.7 DATA INTERFACES SENT TO AND RECEIVED FROM DMAS

The Contractor shall have adequate resources to support the Department's interfaces and the care coordination technology system described herein. The Contractor shall be able to send and receive interface files. Interface files are explained in the *CCC Plus Technical Manual* and include, but are not limited to:

Inbound Interfaces

- EDI X12 5010 837I Facility Encounters
- EDI X12 5010 837P Professional Encounters
- EDI X12 5010 837D Dental Encounters (The Contractor shall hold these encounters for submission to the Department in the future with at least 60 days advance notice from DMAS).
- NCPDP 4.4 (Pharmacy Encounters)
- CCC Plus provider network files
- CCC Plus MTR (Service Authorization information)
- Clinical and care coordination related data

Outbound Interfaces

- EDI X12 5010 834 weekly files
- EDI X12 5010 820 monthly capitation payment file
- Medical Transition Report, including service authorizations and claims data
- DMAS provider network file

The Contractor shall use the file formats as described in the *CCC Plus Technical Manual*. The Contractor shall conform to HIPAA (X12 and NCPDP) compliant standards and all State and Federal standards for data management and information exchange and shall implement new versions as made available by HIPAA and NCPDP according to the Department's needs and guidance.

The Contractor shall demonstrate controls to maintain information integrity.

The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to the Department for reconciliation processes.

16.8 INTERFACE AND CONNECTIVITY TO THE VIRGINIA MEDICAID MANAGEMENT INFORMATION SYSTEM (VAMMIS) AND MEDICAID ENTERPRISE SYSTEM (MES)

The Contractor's interface with VaMMIS/MES shall include, but will not be limited to, receiving Medicaid participant enrollment information in HIPAA standard EDI X12 834 format; the submission of encounter data in the HIPAA standard X12, 837I, 837P, and the NCPDP D.0 formats; and receiving monthly capitation payments in the HIPAA standard X12 820 format. All Contractor's staff shall have access to equipment, software and training necessary to accomplish their stated duties in a timely, accurate, and efficient manner. The Contractor shall supply all hardware, software, communication and other equipment necessary to meet the requirements of this Contract.

It is the responsibility of the Contractor to ensure that bandwidth is sufficient to meet the performance requirements of this Contract. The Contractor will be granted access to the Department's EDI portal used for submission and receiving of X12 standard data files and other non-X12 data files. This access will be through the secured EDI portal maintained by the Department.

The Contractor will be granted access to VAMMIS through the web portal (<https://www.virginiamedicaid.dmas.virginia.gov>) with an ACF2 secure sign on. This will enable the Contractor to view eligibility and pertinent VAMMIS data as deemed necessary by the Department. The Contractor's Help Desk employees supporting this Contract shall have access to the Internet.

16.9 DATA QUALITY REQUIREMENTS

16.9.1 General Requirements

The Contractor shall meet all data requirements as defined by the Department. All data shall be transmitted in a HIPAA-compliant manner. The Department will require all data to be submitted based on Uniform Data Specifications that will be described by the Department in future guidance. This guidance will include, but will not be limited to, electronic data interchange (EDI) companion guides, EDI implementation guides, CCC Plus Data Manual, CCC Plus reporting requirements, or other documents that refer to this section of the Contract. All deadlines and schedules for data submissions shall be as set forth in this Contract, unless a later date is agreed to between the parties.

The Contractor shall disclose its payment cycle schedules, including subcontractors, to the Department by January 15, 2019 and notify the Department immediately of any changes to the payment cycle.

The Contractor shall provide notification, to the Department within two (2) business days, of any anticipated changes that may have an impact on the substance or process of data exchanges between the parties, and shall engage with testing before submitting files into EPS production.

The Department may require any data inclusive or relevant to the Members from the Contractor within sixty (60) calendar days' notice, in accordance with the format, mode of transfer, schedule for transfer, and other requirements detailed by the Department in its supporting documentation.

All supporting documentation may be modified at the discretion of the Department, and the Contractor shall have sixty (60) days from the date of the document's modification to comply. As described by the Department in its supporting documentation, the Contractor shall successfully exchange all required data with the Department no later than one hundred eighty (180) calendar days after the start of the contract. For newly required data, the Contractor shall have sixty (60) calendar days to implement the exchange of each data set as specified by the Department. The Contractor shall produce any required or requested data according to the specifications, format, and mode of transfer established by the Department, or its designee, within sixty (60) calendar days of notice.

At a minimum, the Contractor shall transmit all data files in the format described in the Uniform Data Specifications guidance documentation including, but not limited to the following:

- 1) All encounter data;
- 2) Financial data and reports for payments to providers contracted to provide services to Members;
- 3) Service authorizations (approved, denied, and pending); and,
- 4) Provider network data for any providers who are eligible to provide services to the Members.

The Department may also require additional data sets, which shall be defined in supporting documentation at the time requested. The Contractor shall have sixty (60) calendar days from the date of the request to provide such requested additional data, which may include, but is not limited to, the following:

- 1) clinical data;
- 2) visit verification data;
- 3) assessment data; and,
- 4) medical record data.

In accordance with 42 CFR § 438.242(b), the Contractor shall screen all data received from providers for completeness, logic and consistency. All data submissions are required to be certified. Data certification forms shall be signed by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign on behalf of the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall keep track of every record submitted to the Department or its designee and the tracking number assigned to each. At the end of each calendar month, the Contractor shall report this data to the Department with the required certification.

The Contractor shall disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor shall provide prior notification to the Department of any anticipated changes that may have an impact on the substance or process of data exchanges between the parties, and shall engage with testing in order to ensure continuity of existing data exchanges.

The following requirements shall apply to all submissions. For each data submission, the Contractor shall:

- 1) Collect and maintain 100% of the data required by the Department.

- 2) Submit complete, timely, reasonable, and accurate data as defined by the Department in its supporting documentation including, but not limited to, the Data Quality Scorecard, which shall include:
 - a) Metrics that measure completeness, timeliness, and accuracy of the data;
 - b) Benchmarks that describe whether the Contractor's performance is compliant with the Department's requirements;
 - c) A description of how each measure is calculated by the Department;
- 3) Use standard formats, include required data elements, and meet other submission requirements as detailed in its supporting documentation;
- 4) Participate in user acceptance testing with the Department in order to measure the level at which the test submissions meet data and data quality requirements before routine submissions from the Contractor begin;
- 5) Ensure that Contractor data can be individually linked to Department data at the record level (e.g. Contractor data on Members can be linked to the Department's unique Member identifier); and,
- 6) Provide any reports on required data as requested by the Department.

16.9.2 Data Reconciliation and Potential Audit Requirements

The Department may request a sample extract of previously submitted data from the Contractor that shall be compared to data received by the Department. At the discretion of the Department, the Contractor shall participate in site visits and other reviews and assessments by the Department, or its designee, for the purpose of evaluating the completeness of the Contractor's data inventory as disclosed to the Department, and to evaluate the collection and maintenance of data required by the Department. Upon request by the Department, or its designee and with thirty (30) calendar days' notice, the Contractor shall provide DMAS-specified Member records in order to permit the Department to conduct data validation assessments.

The Department, or its designee, may investigate suspected data quality issues including, but not limited to, deviations from expected data volume, or expected data corrections, voids or adjustments. Suspected data quality issues discovered by such investigations may result in the addition of metrics to the Data Quality Scorecard or the requirement that the Contractor replace data with suspected data quality issues at no cost to the Department. Any cost incurred by the Department to reprocess replacement data that the Department determines has data quality issues shall be passed through in its entirety to the Contractor. Costs for replacing such data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

16.9.3 Data Inventory and Data Quality Strategic Plan Requirement

At least twice yearly, or as otherwise requested by the Department, the Contractor shall submit to the Department a data inventory including, but not limited to:

- 1) the data's origin (*i.e.* what entity originally generated the data);
- 2) the business purpose of the data and reason for its existence;
- 3) a comprehensive description of all metadata elements, including:
 - a. a list of all data fields
 - b. a business description of the content of each field
 - c. the field's format
 - d. a list of valid values (where the data field is defined by a limited value set); and,

- 4) description of the format, schedule, and any other required details regarding how the data is transmitted to DMAS, if that source is required by the Department.

Should the Contractor possess a new data source with data on the Members, the Contractor shall inform the Department sixty (60) calendar days prior to that data source's acquisition or creation.

The Contractor shall provide the Department with an Annual Data Quality Strategic Plan in accordance with the specifications of the Department that addresses:

- 1) The Contractor's plan for ensuring high quality data that complies with the Department's standards for accuracy, timeliness, and completeness as described in the Data Quality Scorecard or other supporting documentation;
- 2) Plans and timelines for improving performance on the metrics in the Data Quality Scorecard, unless the Contractor is compliant on all measures;
- 3) What procedures and automated checks exist in the Contractor's systems to prevent transmission of non-compliant data; and,
- 4) The compliance actions and data quality standards expected of service providers, billing providers, sub-contractors, or vendors, to ensure that the transmission of data from these entities to the Contractor is compliant with Department's requirements.

16.9.4 Data Requirements for Encounters, Financial Transactions, Service Authorizations and Provider Data

16.9.4.1 Encounters

The Contractor shall submit encounter data for Member services on which the Contractor incurred a financial liability, and shall include claims for provided services that were eligible to be processed, but where no financial liability was incurred. The Contractor shall submit encounters according to the Medicaid Enterprise System (MES) Encounters Processing Solution (EPS) CCC Plus Encounters Technical Manual as well as the Companion Guide. The Department, or its designee, may investigate suspected encounter data quality issues including, but not limited to, deviations from:

- a. expected utilizations;
- b. actual visits to expected visits;
- c. service date lag time benchmarks;
- d. expected EDI fail amounts; and,
- e. average paid amount per service, by billing code.

2. The Contractor shall also:

- a. Collect and maintain 100% of all encounter data for each covered service and supplemental benefit services provided to Members, including encounter data from any sub-capitated sources. Such data must be able to be linked to the Department's eligibility data;
- b. Develop a process and procedure to identify drugs administered under section 340B of the Public Health Service Act as codified at 42 USC 256b, as drugs dispensed pursuant to this authority are not eligible for the Medicaid Drug Rebate Program as directed in Section 4.8.8, *Drug Rebates* of this Contract; and,
- c. Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) calendar days of the Contractor's payment date and in the form and

- manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in its supporting documentation.
- d. Payment cycle data must be submitted and certified according to the CCC Plus Encounter Technical Manual.
 - e. The Contractor's systems shall generate and transmit encounter data files according to the Department's requirements and any additional specifications as may be provided by the Department and updated from time to time.

In accordance with 42 CFR§ 438.602(e), the Contractor shall comply with any audit arranged for by DMAS to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by Contractor. The Contractor shall cooperate with the DMAS designated auditor(s) to ensure the audit is completed within the timeframe specified by the Department.

In accordance with 42 CFR§ 457.1201, the Contractor shall attest to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

If the Department or the Contractor determines at any time that the Contractor's encounter data is not complete and accurate, the Contractor shall:

- 1) Notify DMAS, prior to encounter data submission and within two (2) business days of discovery, that the data is not complete or accurate, and provide an action plan and timeline for resolution and approval.
- 2) Submit for DMAS approval a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level. Timeframe for submission shall be established by the Department, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements.
- 3) Implement the DMAS-approved corrective action plan within DMAS approved timeframes. Implementation completion shall not exceed thirty (30) calendar days from the date that the Contractor submits the corrective action plan to the Department for approval.
- 4) Participate in a validation review to be performed by the Department, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the encounter data is complete and accurate. The Department, or its designee, shall determine whether the Contractor is financially liable for such validation review.

16.9.4.2 Provider Network

The Contractor shall:

- 1) Collect and maintain 100% of all provider data for providers in that Contractor's or sub-contractor's network where the Contractor has incurred a financial liability or denied services for Members; and
- 2) Submit complete, timely, reasonable, and accurate provider network data to the Department daily, prior to the Contractor's submission of encounters, and in the form and manner specified by the Department. The Department will use this provider file submission for CCC MCO assignments and encounter processing. The first

- submission shall be sent sixty (60) days prior to the Department's program implementation. Standard formats, required data elements, and other submission requirements shall be detailed in the *CCC Plus Technical Manual*; and
- 3) Submit to the Enrollment Broker a complete provider file in a Department approved electronic format thirty (30) calendar days prior to the effective date of the Contract. An updated file with all of the changes to the network shall be submitted to the Enrollment Broker weekly thereafter or more frequently, if needed, during any program expansions (e.g., upon adding additional populations to the CCC Plus program). Refer to the *CCC Plus Technical Manual*; and
 - 4) Submit to the Department a complete provider network file on a monthly basis at start-up for network analysis. The CCC Plus Network Requirements Submission Manual (NRSM) details the submission requirements, including frequency of submission (on-going) data elements, and file format.

16.9.4.3 Financial Transactions

The Contractor shall:

- 1) Collect and maintain 100% of all Health Care Claim Payment and Remittance Advice data for payments to providers contracted to provide services to Members; and
- 2) Submit complete, timely, reasonable, and accurate financial data to the Department within two (2) business days of the Contractor's payment cycle and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

16.9.4.4 Service Authorizations

The Contractor shall:

- 1) Collect and maintain 100% of all service authorization data for services authorized, pending, or denied for Members.
- 2) Ensure that service authorization data includes utilization data for all claims associated with services provided pursuant to the specific authorization;
- 3) Submit complete, timely, reasonable, and accurate service authorization data to the Department no less than weekly, and in the form and manner specified by the Department. Standard formats, required data elements, and other submission requirements shall be detailed in supporting documentation.

16.9.5 Data Quality Penalties

Where DMAS determines that the Contractor has failed to comply with the Departments' data exchange requirements or is non-compliant with data quality benchmarks, DMAS may impose the sanctions set out below effective January 1, 2018. The process for the Department's imposition of sanctions shall comply with the requirements of 42 CFR §380, Subpart I.

The Department shall develop for the Contractor a Data Quality Scorecard (DQS), which shall be described in the Encounter Technical Manual. The DQS shall be the basis for applying data quality penalties. If a new data quality metric is to be added to the Data Quality Scorecard, the Contractor shall have ninety (90) calendar days before the performance measured by that metric becomes subject to data quality withholds.

Where DMAS determines that the Contractor has failed to submit required data or meet a data quality benchmark on any metric of the Data Quality Scorecard, the Department shall send a notice of non-compliance. The Department reserves the right to apply penalties for non-compliance.

A Notice of Non-Compliance by the Department to the Contractor shall include:

- 1) A description of the data quality issue and the Contractor's performance on any metrics that triggered the non-compliance notice;
- 2) The action that shall be taken by the Contractor in order to cure the performance failure; and
- 3) Financial withhold or penalties as a result of non-compliance.

The Department may require the Contractor to replace any non-compliant data with compliant data at no cost to the Department. Any cost incurred by the Department to reprocess replacement data shall be passed through in its entirety to the Contractor. Costs for replacing non-compliant data with replacement data shall be based upon any charges from the Department to a third party as well as Department staff time.

16.9.6 Secure E-mail with the Department

- 1) The Contractor shall provide secure email access (TLS-encryption) between DMAS and the Contractor for correspondence containing sensitive private health information (PHI) or personal identifiable information (PII). The TLS technique is required for communications between DMAS and the contractor containing sensitive information.
- 2) Neither direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. DMAS will provide no special application server(s) for this purpose.
- 3) It is recommended that routing of emails between DMAS and the Contractor shall support Secure SMTP over Transport Layer Security (TLS) RFC 3207 (or latest) over the Internet. The vendor will coordinate TLS encryption set up with DMAS technical security staff as needed to establish TLS.
- 4) TLS email encryption shall be maintained through the mail gateway. Bidirectional TLS email encryption must be tested, documented and maintained between DMAS and the Contractor's SMTP server.
- 5) DMAS additionally has implemented functionality that allows for point-to-point TLS email encryption.
- 6) All expenses incurred in establishing a secure connectivity between the Contractor and DMAS, any software licenses required, and any training necessary shall be the responsibility of the Contractor.

16.9.7 Compliance with VITA Standard

The Contractor shall comply with all State laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. These accessibility standards are state law (see § 2.2-3502 and § 2.2-3503 of the *Code of Virginia*). The Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor shall also keep abreast of any future changes

to the Virginia Code as well as any subsequent revisions to the Virginia Information Technologies Standards.

The Contractor, at a minimum, shall comply with VITA standards, which may be found on the VITA website at <http://www.vita.virginia.gov>. The Department requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that will document the Contractor's compliance with the most stringent requirements listed below:

- 1) Section 1902 (a) (7) of the Social Security Act (SSA);
- 2) 45 CFR Parts 160, and 164 Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Genetic Information Nondiscrimination Act (GINA); Other Modifications to the HIPAA Rules; Final, January 25, 2013
- 3) COV ITRM Policy SEC5519-00 (latest version);
- 4) COV ITRM Standard SEC501-07 (latest version).

The following specific security measures shall be included in the Risk Management and Security Plan Computer hardware controls that ensure acceptance of data from authorized networks only:

- 1) Manual procedures that provide secure access to the system with minimal risk.
- 2) Multilevel passwords, identification codes or other security procedures that shall be used by State agency or Contractor personnel;
- 3) All Contractor database software changes may be subject to the Department's approval prior to implementation; and,
- 4) System operation functions shall be segregated from systems development duties.

If requested, the Contractor agrees that the Plan will be made available to appropriate State and Federal agencies as deemed necessary by the Department. If any changes to the Plan occur during the contract period, the Contractor shall notify the Department within thirty (30) calendar days to the change occurring.

The Contractor shall modify its IT systems to accept Medicare enrollment data and to load the data in the Contractor's care coordination system for use by Care Coordinators, DM/Population Health and UM staff.

16.10 DATA SECURITY AND CONFIDENTIALITY OF RECORDS

The Contractor shall take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Member names.

The Contractor shall put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 CFR § 164.530(c).

The Contractor shall meet the security standards, requirements, and implementation specifications as set forth in 45 CFR Part 164, subpart C, the HIPAA Security Rule.

16.10.1 Personal Data

The Contractor shall inform each of its employees of the laws and regulations related to confidentiality if the employee has any involvement with personal data or other confidential information (whether with regard to design, development, operation, or maintenance).

16.10.1.1 Return of Personal Data

The Contractor shall return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of the Department in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by the Department, will destroy such data or material.

16.10.1.2 Destruction of Personal Data

For any PHI received regarding an Eligible Beneficiary referred to Contractor by the Department, and who does not enroll in Contractor's plan, the Contractor shall destroy the PHI in accordance with standards set forth in *NIST Special Publication 800-88, Guidelines for Media Sanitizations*, and all applicable State and Federal privacy and security laws including HIPAA and its related implementing regulations, at 45 CFR Parts 160, 162, and 164, as may be amended from time to time.

16.10.2 Research Data

The Contractor shall seek and obtain prior written authorization from the Department for the use of any data pertaining to this Contract for research or any other purpose not directly related to the Contractor's performance under this Contract.

16.10.3 Information Sharing

During the course of an Member's enrollment or upon transfer or termination of enrollment, and subject to all applicable Federal and State laws, the Contractor shall arrange for the transfer, at no cost to the Department or the Member, of medical information regarding such Member to any subsequent provider of medical services to such Member, as may be requested by the Member or such provider or directed by the Department, the Member, regulatory agencies of Virginia, or the United States Government. With respect to Members who are in the custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Member, a copy of said Member's Medical Records in a timely manner.

16.10.4 HIPAA Disclaimer

The Department makes no warranty or representation that compliance by the Contractor with this agreement or the HIPAA regulations will be adequate or satisfactory for the Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure, nor shall the Department be liable to the Contractor for any claim, loss or damage related to the unauthorized use or disclosure of any information received by the Contractor from the Department or from any

other source. The Contractor is solely responsible for all decisions made by the Contractor regarding the safeguarding of PHI.

To the extent that the Contractor uses one or more providers and/or subcontractors to render services under this Contract, and such providers/subcontractors receive or have access to protected health information (PHI), each such provider/subcontractor shall sign an agreement with the Contractor that complies with HIPAA. The Contractor shall ensure that any providers/subcontractors to whom it provides PHI received from the Department (or created or received by the Contractor on behalf of the Department) agrees in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor under this Contract.

16.10.5 Use of Disclosure of Information

The use or disclosure of information concerning Contract services or Members obtained in connection with the performance of this Contract shall be in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule requirements, and provisions of the American Recovery and Reinvestment Act of 2009, wherein Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 111-5). Section 13402 of the HITECH Act addresses requirements for business associates under HIPAA regarding Breach Notification.

The Contractor may use or disclose PHI received from the Department, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business. The Contractor may disclose PHI for such purposes if the disclosure is required by law, or if the Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially, that it will be used or further disclosed only as required by law of for the purpose for which it was disclosed to the person, and that person will notify the Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.

For purposes of this Contract, unsecured PHI means PHI which is not encrypted or destroyed. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by the HIPAA Privacy Rule or this Contract which compromises the security or privacy of the PHI by posing a significant risk of financial, reputational, or other harm to the Member.

Except as otherwise limited in this Contract, the Contractor may use or disclose protected health information (PHI) to perform functions, activities, or services for, or on behalf of, the Department as specified in this Contract. In performance of Contract services, Contractor agrees to:

- 1) Not use or further disclose PHI other than as permitted or required by the terms of this Contract or as required by law;
- 2) Use appropriate safeguards to prevent use or disclosure of PHI other than as permitted by this Contract;
- 3) Report to DMAS any use or disclosure of PHI not provided for by this Contract of which it becomes aware;
- 4) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic

Protected Health Information that it creates, receives, maintains or transmits on behalf of DMAS as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the American Recovery and Reinvestment Act (P.L. 111-5) when effective;

- 5) Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate safeguards to protect it;
- 6) Report to the Department any security incident of which it becomes aware;
- 7) Impose the same requirements and restrictions contained in this Contract on its subcontractors and agents to whom Contractor provides PHI received from, or created or received by a Contractor on behalf of the Department;
- 8) Provide access to PHI contained in a designated record set to the Department, in the time and manner designated by the Department, or at the request of the Department, to a Member in order to meet the requirements of 45 CFR § 164.524.
- 9) Make available PHI for amendment and incorporate any amendments to PHI in its records at the request of the Department;
- 10) Document and provide to the Department information relating to disclosures of PHI as required for the Department to respond to a request by a Member for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528;
- 11) Make its internal practices, books, and records relating to use and disclosure of PHI received from, or created or received by a Contractor on behalf of the Department, available to the Secretary of the U.S. Department of Health and Human Services Secretary for the purposes of determining compliance with 45 CFR Parts 160 and 164, subparts A and E; and,
- 12) At termination of the Contract, if feasible, return or destroy all PHI received from, or created or received by a Contractor on behalf of the Department that the Contractor still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the Contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within five (5) business days via email to the Department's Division of Integrated Care at CCCPlus@dmass.virginia.gov, as well as the Department's Office of Compliance and Security at HIPAAprivacy@dmass.virginia.gov.

16.10.6 Disclosure and Confidentiality

The Contractor shall have a confidentiality agreement in place with individuals of its workforce who have access to PHI. Issuing and maintaining these confidentiality agreements will be the responsibility of the Contractor. The Department shall have the option to inspect the maintenance of said confidentiality agreements.

16.10.7 Disclosure to Workforce

The Contractor shall not disclose PHI to any individual in its workforce except to those persons who have authorized access to the information, who have received privacy training in PHI, and who have signed an agreement to hold the information in confidence.

The Contractor understands and agrees that data, materials, and information disclosed to the Contractor may contain confidential and protected data. The Contractor, therefore, shall ensure that data, material, and information gathered, based upon or disclosed to the Contractor for the purpose of this Contract, shall not be disclosed to others or discussed with other outside parties without the prior written consent of the Commonwealth of Virginia.

16.10.8 Accounting of Disclosures

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to: the date made; the name of the person or organization receiving the PHI; the Member's address, if known; a description of the PHI disclosed; and, the reason for the disclosure, as required by 45 CFR § 164.528. The Contractor shall, within thirty (30) calendar days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

16.10.9 Disclosure to the U.S. Department of Health and Human Services

The Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Department (or created or received by the Contractor on behalf of the Department) available to the Secretary of the Department of Health and Human Services (DHHS) or its designee for purposes of determining the Contractor's compliance with HIPAA and with the Privacy Regulations issued pursuant thereto. The Department shall provide the Contractor with copies of any information it has made available to DHHS under this section of this Contract.

16.10.10 Reporting Breach of Unsecured PHI

The Contractor shall report to the Department any use or disclosure of PHI not provided for by this Contract of which it becomes aware. Initial notification regarding any breach of unsecured PHI must be immediate or as soon as possible after discovery. Formal notification shall be delivered within five (5) business days from the first day on which such breach is known by Contractor or an employee, officer or agent of Contractor other than the person committing the breach, or as soon as possible following the first day on which Contractor or an employee, officer or agent of Contractor other than the person committing the breach should have known by exercising reasonable diligence of such breach via email to the Department's Division of Integrated Care at CCCPlus@dmas.virginia.gov, as well as the Department's Office of Compliance and Security at HIPAAprivacy@dmas.virginia.gov. Notification shall include, to the extent possible, the identification of each Member whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Contractor shall also provide the Department with any other available information at the time Contractor makes notification to the Department or promptly thereafter as information becomes available. Such additional information shall include (i) a brief description of what happened, including the date of the breach; (ii) a description of the types of unsecured PHI that were involved in the breach; (iii) any steps the Contractor believes Members should take to protect themselves from potential harm resulting from the breach; and (iv) a brief description of what Contractor is doing to investigate the breach, mitigate harm to Members, and protect against any future breaches.

In the event of impermissible use or disclosure by Business Associate of unsecured protected health information, the Business Associate shall notify in writing all affected Members as required by Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Business Associate shall be responsible for all costs associated with such notification.

16.10.11 Access to PHI

The Contractor shall provide access to PHI contained in a designated record set to the Department, in the time, manner, and format designated by the Department, or at the request of DMAS, to an individual in order to meet the requirements of 45 CFR Part 164.

16.10.12 Amendment to PHI

The Contractor shall make PHI available for amendment and incorporate any amendments to PHI in its records at the request of the Department in a time and manner as designated by the Department.

Further, the Contractor hereby agrees to comply with the terms set forth in the Department's Confidentiality Agreement.

16.10.13 Access to Confidential Information

Except as otherwise required by law, including, but not limited to, the Virginia Freedom of Information Act, access to confidential information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to this Contract, including the United States Department of Health and Human Services; the Office of the Attorney General of the Commonwealth of Virginia, including the Medicaid Fraud Control Unit; and such others as may be required by the Department.

In complying with the requirements of this section, the Contractor and the Commonwealth shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and Members of public assistance, and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The Contractor shall have written policies and procedures for maintaining the confidentiality of data, including medical records and Member information and appointment records for treatment of sexually transmitted diseases and submit prior to signing the initial contract, at revision or upon request to the Department.

The Contractor shall comply with the Department's Security Requirements for vendors.

16.10.14 Audits, Inspections, and Enforcement

With thirty (30) days' notice, the Department may inspect the facilities, systems, books and records of the Contractor to monitor compliance with HIPAA in such a manner that does not unreasonably interfere with normal business operations. The Contractor shall promptly remedy take reasonable action against any violation of any term of HIPAA and shall certify the same to the Department in writing. The fact the Department inspects, or fails to inspect, or has the right to inspect, the Contractor's facilities, systems and procedures does not relieve the Contractor of

its responsibility to comply with HIPAA, nor does the Department's failure to detect, or to detect but fail to call the Contractor's attention to or require remediation of any unsatisfactory practice constitute acceptance of such practice or waiving of the Department's enforcement rights.

The Department may terminate the Agreement without penalty if the Contractor repeatedly violates HIPAA or any provision hereof, irrespective of whether, or how promptly, the Contractor may remedy such violation after being notified of the same. In case of any such termination, the Department shall not be liable for the payment of any services performed by the Contractor after the effective date of the termination, and the Department shall be liable to the Contractor in accordance with the Agreement for services provided prior to the effective date of termination.

The Contractor acknowledges and agrees that any Member who is the subject of PHI disclosed by the Department to the Contractor is a third party beneficiary of HIPAA and may, to the extent otherwise permitted by law, enforce directly against the Contractor any rights such individual may have under this HIPAA, the Agreement, or any other law relating to or arising out of the Contractor's violation any provision of HIPAA.

SECTION 17.0 REPORTING REQUIREMENTS

17.1 GENERAL REQUIREMENTS

Consistent with Federal and State guidelines, the Contractor shall be responsible for robust and transparent reporting on critical elements of CCC Plus covered services and the Contractor's major systems. The Contractor shall have adequate resources to support CCC Plus program reporting needs as required by this Contract. Examples of data to be included in reports shall include, but are not limited to, behavioral health, pharmacy, LTSS, claims service authorizations, provider networks, grievances and appeals, quality, program integrity, expenditures related to rebalancing efforts (institutional vs. community based), call center statistics (broken out by behavioral health including crisis calls and all other service categories), timeliness of assessments, individualized care plans and care plan revisions, participant health and functional status, marketing, outreach, and training, high-utilizer intervention activities, under-utilization analysis with reasons, appointment assistance activities, value based payment activities and related dashboards.

Within this and other sections of the Contract, certain reports are detailed. However, the majority of the required reports are reflected in the *CCC Plus Technical Manual*. The Contractor shall report detailed data in the areas listed above on a weekly, monthly, quarterly, and annual basis by program area, including separate reports for LTSS, behavioral health, and ARTS services. ARTS services reporting should reflect requirements within the *ARTS Technical Manual*. The Contractor shall also provide a monthly detailed business review report in a presentation style format that highlights the Contractor's overall system of care. The Contractor's detailed business report shall include a detailed review and trend analysis of the Contractor's on-going experience (i.e., utilization, activities, outcomes, etc.), as well as performance metrics for all program areas and major systems. The Contractor shall adhere to delivery of all reports established by the Department and noted within the *CCC Plus Technical Manual* and this Contract. The Contractor shall refer to the *CCC Plus Technical Manual* for the appropriate reporting formats, instructions, submission timetables, and technical assistance.

The Department may, at its discretion, change the content, format or frequency of reports. In addition, the Department may, at its discretion, require the Contractor to submit additional reports both ad hoc and recurring. If the Department requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format required by the Department. The Department, upon its discretion, may extend the timeframe for any new submission or changes to existing reports up to ninety (90) days. Notification will be provided to the Contractor at the time of the requested change.

The Contractor shall submit all reports to the Department according to the schedule below (if not specified elsewhere):

DELIVERABLES	DUE DATE
Daily Reports	Within two (2) business days
Weekly Reports	Wednesday of the following week

DELIVERABLES	DUE DATE
Monthly Reports	No later than the 15 th of the following month
Quarterly Reports	Last day of month following the end of the quarter
Semi-Annual Reports	January 31 st and July 31 st
Annual Reports	No later than March 31 st after the end of the calendar year.
On Request Reports	As required by the Department.

The Contractor shall submit all reports electronically and in the manner and format prescribed by this Contract and the *CCC Plus Technical Manual*. The Contractor shall ensure that all reports are complete and accurate or may be subject to liquidated damages as specified in Section 18.0, *Enforcement, Remedies and Compliance* for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by this Contract until all deficiencies have been corrected.

The Contractor shall transmit to and receive from the Department all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by the Department, so long as the Department’s direction does not conflict with the law.

As part of this Contract, the Contractor shall review all reports submitted to the Department to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

If the Department changes the content, format, or frequency of reports, or requires the Contractor to submit additional ad hoc or recurring reports the Contractor will be given sixty (60) days’ notice.

17.2 ALL PAYERS CLAIM DATABASE

The Contractor shall comply with the requirements as set forth by the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, to administer the health care data reporting initiative established by the General Assembly for the operation of the Virginia All-Payer Claims Database pursuant to §32.1-276.7:1 of the *Code of Virginia* for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Specifically, the Contractor shall be responsible for the submission of paid claims data related to services provided under this contract. Such data submission, pursuant to §32.1-276.7:1 of the *Code of Virginia*, has been determined by the Department of Medical Assistance Services to support programs administered under Titles XIX and XXI of the Social Security Act.

17.3 CRITICAL INCIDENT REPORTING AND MANAGEMENT

At initial Contract implementation, at revision, or upon request by the Department, the Contractor shall provide their policies and procedures for review and approval regarding the finding, reporting and management of critical incidents that Members experience while in nursing facilities, inpatient behavioral health or HCBS settings (e.g., an adult day care center, a Member's home or any other community-based setting), among other settings. A critical incident is any incident that threatens or impacts the well-being of the Member. Critical incidents shall include, but are not limited to, the following: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death (not primarily related to the natural course of the patient's illness or underlying condition) of a Member.

The policies and procedures shall reflect how the Contractor identifies, documents, tracks, reviews, and analyzes critical incidents. In addition the policies and procedures shall address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations (including findings from Adult Protective Services (APS) and Child Protective Services (CPS) (if available); identify trends and patterns; identify opportunities for improvement; and develop, implement and evaluate strategies to reduce the occurrence of incidents.

The Contractor shall require its staff and contracted CCC Plus program providers to report, respond to, and document critical incidents to the Contractor in accordance with applicable requirements.

The Contractor shall develop and implement a critical incident reporting process, including the form to be used to report critical incidents and reporting timeframes. The maximum timeframe for reporting an incident to the Contractor shall be twenty-four (24) hours. The initial report of an incident within twenty-four (24) hours may be submitted verbally, in which case the person/agency/entity making the initial report shall submit a follow-up written report within forty-eight (48) hours.

As a part of Critical Incident Reporting and Management, the Contractor shall participate, when requested, in a Mortality Review Team. The Mortality Review Team will consist of individuals from the Department and other CCC Plus Contractors. The purpose of the team will be to review findings, cause, and prevention of critical incidents.

Refer to the CMHRS Manual for provider requirements associated with reporting of critical incidents and adverse outcomes pertaining to community health and rehab services.

17.4 CONTRACTOR REQUIREMENTS TO RESPOND

The Contractor shall receive and respond to all inquiries and requests made by the Department in time frames and formats specified by the Department. The Contractor shall acknowledge and provide a status update on written, electronic, or telephonic requests for information or assistance from the Department involving enrollees or providers within the time frames specified by the Department. The Contractor's acknowledgement must include a planned date of resolution.

Requests identified by the Department as urgent requests for assistance or information (e.g. issues involving legislators, FOIA, good cause, etc.) must be given priority and completed in accordance with the request of and instructions from the Department.

MCOs may request an extended timeframe for response and resolution of non-urgent requests, after initial acknowledgement of request and prior to the expiration of the original specified timeframe. Request for extension to include reason for extended timeframe for response and requested date for new response date.

SECTION 18.0 ENFORCEMENT, REMEDIES, AND COMPLIANCE

18.1 CCC PLUS PROGRAM EVALUATION ACTIVITIES

The Department and its designated agents will conduct ongoing evaluations of the Contractor and the CCC Plus program from multiple perspectives using both quantitative and qualitative methods. The evaluations will be used for program improvement purposes and to assess the Contractor's and the program's overall impact on various outcomes including but not limited to, enrollment patterns, Member access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, behavioral health, home health, prescription drugs, nursing facility, waiver), integrated care strategies, care coordination, Department staff and provider experiences.

Evaluations will include surveys, site visits, claims and encounter data analysis, focus groups, key informant interviews, observations, waiver assurance results, reporting records, and document reviews. The Contractor shall participate in evaluation activities as directed by the Department or its designee and provide information or data upon request and in the manner requested.

18.2 COMPLIANCE MONITORING PROCESS (CMP)

The Department shall be responsible for conducting an ongoing contract Compliance Monitoring Process (CMP). As part of this process, the Department shall review the performance of the Contractor in relation to the performance standards outlined in this Contract. The Department may, at its sole discretion, conduct any or all of the following activities, as part of the CMP:

- 1) Collect and review standard hard copy and electronic reports and related documentation, including encounter data, which the Contractor is required, under the terms of this Contract, to submit to the Department or otherwise maintain;
- 2) Conduct Contractor, network provider, and subcontractor site visits; and,
- 3) Review Contractor policies and procedures, and other internal documents.

The purpose of the CMP is to detect and respond to issues of noncompliance and remediate contractual violations when necessary. The CMP uses a tiered points system to achieve the Department's goal of Contract Compliance. Furthermore, the CMP is comprised of a seven (7) level point system described below.

18.2.1 CMP Point System

The Contractor incurs points due to issues of non-compliance. These points accumulate over a rolling 12-month schedule. The Department shall carry over all active points from the previous contract cycle, however, points more than twelve (12) months old expire and will no longer be counted. No points will be assigned for a violation the Contractor is able to document that the precipitating circumstances were completely beyond its control and could not have been foreseen (i.e., natural disasters, a lightning strike disables a computer system, etc.).

In cases where the Contractor is believed to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential Members, inappropriate Member billing, etc.), the Department may assess or levy points on the Contractor. The Department will mitigate or consider waiving sanctions solely at its discretion for the following reasons:

- 1) The infraction is due to an unforeseen circumstance (including but not limited to acts of nature, DMAS IM issues, etc.) beyond the Contractor’s control;
- 2) The infraction is during the first year of the Contractor’s operation;
- 3) The Contractor identifies and self-reports the infraction. The Contractor must communicate these infractions to the Department in writing within thirty (30) business days of discovery.
- 4) It is the first time the Contractor incurs the infraction.

18.2.2 Progressive Sanctions Based on Accumulated Points

Progressive sanctions will be based on the number of points accumulated at the time of the most recent compliance violation/incident. A compliance violation, unless otherwise defined, will be at the Department’s discretion based on the severity of the incident, likelihood of incident recurrence, and totality of circumstances surrounding the incident. Financial sanctions shall be imposed per infraction type. A Corrective Active Plan (CAP) or other sanctions may be imposed in addition to the fines listed below. The Department has a seven (7) level compliance point system within its CMP. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

Level	Point Range	Corrective Mechanism	Financial Sanctions/Fines
1	1-15	See 18.2.3	\$ 1,000
2	16-25	See 18.2.3	\$ 5,000
3	26-50	See 18.2.3	\$10,000
4	51-70	See 18.2.3	\$20,000
5	71-100	See 18.2.3	\$30,000
6	101-150	Suspend Enrollment	N/A
7	> 150	Possible Termination	N/A

18.2.3 Compliance Violation Types

18.2.3.1 One (1) Point Violations

The Department may, at its discretion, assess one (1) point per incident of noncompliance when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor’s failure, as determined by the Department, impairs the Department’s ability to properly oversee and/or analyze Contractor performance. Examples of one point violations include, but are not limited to, the following:

- 1) Noncompliance with Encounter Submissions – Critical Errors - If the Department finds that the Contractor is unable to comply with the critical error standards related to encounter data submissions following the Department’s EDI requirements.
- 2) Failure to use the most current CCC Plus Contract as the basis for reporting, including all Contract Amendments to date at the time of submission.
- 3) Failure to comply with the reporting format reflected in the most current *CCC Plus Technical Manual*.
- 4) Failure to meet reporting requirements of the Virginia All-Payer Claims Database (to be assessed monthly until corrected).

18.2.3.2 Five (5) Point Violations

The Department may, at its discretion, assess five (5) points per incident of noncompliance when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts: (1) impairs a Member's or potential Member's ability to obtain accurate information regarding the Contractor services; (2) violates a care coordination process; impairs a Member's or potential Member's ability to obtain correct information regarding services; or, infringes on the rights of a Member or potential Member. Examples of five (5) point violations include, but are not limited to, the following:

- 1) Failure to provide accurate provider panel information.
- 2) Failure to provide Member materials to new Members in a timely manner.
- 3) Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a Member of his or her right to a state hearing when the Contractor proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- 4) Failure to staff a 24-hour call-in system with appropriate trained medical personnel.
- 5) Failure to meet the monthly call-center requirements for either the Member services or the 24-hour call-in system lines.
- 6) Provision of false, inaccurate or materially misleading information to health care providers, the Contractor's Members, or any eligible individuals.
- 7) Use of unapproved marketing or Member materials.
- 8) Failure to appropriately notify the Department, or Members, of provider panel terminations.
- 9) Failure to comply with a CAP (Corrective Action Plan).
- 10) Failure to actively participate in quality improvement projects or performance improvement projects facilitated by the Department and/or the EQRO.
- 11) Failure to meet provider Access to Care & Network Standards.
- 12) Failure to comply with the Department's defined critical encounter submission requirements (e.g., timeliness, failed voids, rebate date, etc.).
- 13) Noncompliance with Claims Adjudication Requirements - [Examples include, but are not limited to, the Contractor failing to: (1) electronically accept and adjudicate claims to final status; (2) notify providers of the status of their submitted claims; (3) notify non-contracting providers of procedures for claims submissions when requested; or (4) notify contracting and non-contracting providers of the status of their submitted claims.]

18.2.3.3 Ten (10) Point Violations

The Department may, at its discretion, assess ten (10) points per incident of noncompliance when the Contractor fails to meet an administrative and/or procedural program requirement, and the Contractor's failure, as determined by the Department, has one of the following impacts: (1) affects the ability of the Contractor to deliver, or a Member to access, covered services; (2) places a Member at risk for a negative health outcome; or, (3) jeopardizes the safety and welfare of a Member. Examples of ten (10) point violations include, but are not limited to, the following:

- 1) Discrimination among Members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).

- 2) Failure to assist a Member in accessing needed services in a timely manner after receiving a request from the Member.
- 3) Failure to provide medically-necessary Medicaid covered services to Members.
- 4) Failure to comply with the oversight requirements of Subcontractors.
- 5) Failure to comply with the Program Integrity Requirements set forth in this Contract.
- 6) Failure to participate in transition of care activities or discharge planning activities.
- 7) Failure to process prior authorization requests within the prescribed time frames.
- 8) Repeated failure to comply with an ongoing or previously implemented CAP (Corrective Action Plan).
- 9) The imposition of cost-sharing or copays on Members that are in excess of the cost-sharing limits or copays permitted under the Medicaid program.
- 10) The imposition of any copays on Native American Members.
- 11) Misrepresentation or falsification of information that the Contractor furnishes to the Department.
- 12) Misrepresentation or falsification of information that the Contractor furnishes to a Member, potential Member, or health care provider.
- 13) Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR §§ 422.208 and 422.210.

18.3 OTHER – SPECIFIC PRE-DETERMINED SANCTIONS

18.3.1 Adequate network-minimum provider panel requirements

The Department may assess sanctions (e.g. CAPs, points, freeze enrollment, impose fines) if: (1) the Contractor violates any provider network requirements, or (2) a Contractor’s Member has experienced problems accessing necessary services due to lack of an adequate provider network. This provision would not apply to ARTS as described in Section 8.2.6, *Behavioral Health (Including ARTS)*.

18.3.2 Submissions of Reporting Deliverables

All submissions, data and documentation submitted by the Contractor must be received by the Department as specified in this Contract. If the Contractor fails to provide the Department with any required submission, data or documentation (including failure to use the proper templates contained in the *CCC Plus Technical Manual*), the Department may assess points on a “per report” basis, as outlined in Section 18.2.3.1, *One (1) Point Violations* unless the Contractor requests and is granted an extension by the Department.

18.4 REMEDIAL ACTIONS

The Department reserves the right to employ, at the Department’s sole discretion, any of the remedies and sanctions set forth herein and to resort to other remedies provided by law. In no event may the application of any of the following remedies preclude the Department’s right to any other remedy available in law or regulation.

The Department will work with the Contractor and the Contractor’s network providers to correct problems and will recoup funds if the Contractor fails to correct a problem within a timely manner, as determined by the Department.

18.4.1 Damages

In the event of any breach of the terms of the Contract by the Contractor, the Contractor shall, at a minimum, pay damages to the Department for such breach at the sole discretion of the Department.

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 enforcement of the Contract requirement at issue and any associated damages, including damages that, under the terms of the RFP or Contract, may be retroactively assessed.

18.4.2 Federally-Prescribed Sanctions for Noncompliance

Pursuant to 42 CFR § 438.700, the Department shall establish intermediate sanctions for noncompliance, as specified in § 438.702. The Department will base its determinations on findings from onsite surveys, Member or other complaints, financial status, or any other source.

In accordance with Section 1903(m)(5)(B)(ii) and 1932(e)(1)(A) of the Social Security Act (the Act) the Department will deny or withhold payments for Members when, and for so long as, payment for those Members is denied by CMS, based on the state's recommendation and the determinations specified below, including when the Contractor:

- 1) Fails to substantially provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to a Member covered under the Contract;
- 2) Imposes premiums or charges Members in excess of the premiums or charges permitted under Title XIX of the Act;
- 3) Acts to discriminate among Members on the basis of their health status or needs for health care services. This includes termination of enrollment 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 probable need for substantial future medical services;
- 4) Misrepresents or falsifies information that it furnishes to CMS or to the state;
- 5) Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider;
- 6) Fails to comply with the requirements for physician incentive plans (PIPs), as set forth (for Medicare) in 42 CFR §422.208 and 42 CFR §422.210; or
- 7) Distributed directly, or through any agent or independent Contractor marketing materials that contain false or misleading information.

In addition, the Department will deny payments to the Contractor for new Members when, and for so long as, payment for those Members is denied by CMS. CMS may deny payment to the Commonwealth for new Members if CMS' determination is not contested timely by the Contractor.

In accordance with Section 1932(e)(2)(A) of the Act, the State will impose the following civil money penalties, as follows:

- 1) For each determination that the Contractor fails to substantially provide medically necessary services or fails to comply with the physician incentive plan requirements, a maximum of \$25,000.
- 2) For each determination that the Contractor discriminates among Members on the basis of their health status or requirements for health care services or engages in any practice that has the effect of denying or discouraging enrollment with the entity by eligible Members based on their medical condition or history that indicates a need for substantial future medical services, or the MCO misrepresents or falsifies information furnished to the Secretary of Health and Human Services, State, Member, potential Member, or health care provider, a maximum of \$100,000.
- 3) For each determination that the Contractor has discriminated among Members or engaged in any practice that has denied or discouraged enrollment, the money penalty may be as high as \$15,000 for each Member not enrolled as a result of the practice, up to a maximum of \$100,000.
- 4) With respect to a determination that the Contractor has imposed premiums or charges on Members in excess of the premiums or charges permitted, the money penalty may be a maximum of \$25,000 or double the amount of the excess charges, whichever is greater. The excess amount charged must be deducted from the penalty and returned to the Member concerned.

Sections 1932(e)(2)(B) and 1903(m) of the Act specifies the conditions for appointment of temporary management. DMAS shall impose temporary management sanctions if the Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Act or as described in 42 CFR §438.706(b) - (d).

Section 1932(e)(3) of the Act specifies that if an Contractor has repeatedly failed to meet the requirements of Section 1903(m) or Section 1932(e) of the Act, the State must (regardless of what other sanctions are provided) impose temporary management and allow Members to disenroll without cause. The Department may not delay the imposition of temporary management to provide a hearing before imposing this sanction. The Department may not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not recur. [42 CFR § 438.706(b)-(d).]

Section 1932(e)(4) of the Act allows the State to terminate contracts of any MCO that has failed to meet the requirements of Section 1903(m), 1905(t)(3), or 1932(e) of the Act and enroll the entity's Members with other managed care entities or allow Members to receive medical assistance under the State Plan other than through a MCO.

18.4.2.1 Sanction by CMS: Hearing Rules for MCOs

Title 42 CFR § 438.730 allows the Commonwealth to recommend that CMS impose the denial of payment sanction for new Members of the Contractors when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements set forth in 42 CFR § 438.730, as described in this Contract.

In accordance with 42 CFR §438.730 the Commonwealth must give the Contractor a hearing before termination occurs, and the Commonwealth must notify the Members enrolled with the Contractor of the hearing and allow the Members to disenroll if they choose without cause.

When the Commonwealth decides to recommend imposing the CMS sanction described in 42 CFR §438.730, this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within fifteen (15) days.

18.4.2.2 Notice of Sanction

If the Commonwealth's determination becomes CMS' determination per 42 CFR §438.730, the Commonwealth takes all of the following actions:

- 1) Gives the Contractor written notice of the nature and basis of the proposed sanction.
- 2) Allows the Contractor fifteen (15) days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction.
- 3) May extend the initial fifteen (15) day period for an additional fifteen (15) days, as follows:
 - (i) The Contractor submits a written request that includes a credible explanation of why it needs additional time.
 - (ii) The request is received by CMS before the end of the initial period.
 - (iii) CMS has not determined that the Contractor's conduct poses a threat to a Member's health or safety.

18.4.2.3 Informal Reconsideration

- 1) If the Contractor submits a timely response to the notice of sanction, the Department will:
 - (i) Conduct an informal reconsideration that includes review of the evidence by a Department official who did not participate in the original recommendation;
 - (ii) Give the Contractor a concise written decision setting forth the factual and legal basis for the decision; and
 - (iii) Forward the decision to CMS.
- 2) The Department's decision under 42 CFR §438.730 becomes CMS' decision unless CMS reverses or modifies the decision within fifteen (15) days from date of receipt by CMS.
- 3) If CMS reverses or modifies the Department's decision, the Department sends the Contractor a copy of CMS' decision.

18.4.2.4 Denial of Payment

CMS, based upon the recommendation of the Department, may deny payment to the Commonwealth for new Members of the Contractor under section 1903(m)(5)(B)(ii) of the Act in the following situations:

- 1) If a CMS determination that an Contractor has acted or failed to act, as described in paragraphs (b)(1) through (6) of §438.700, is affirmed on review under paragraph (d) of 42 CFR §438.730.
- 2) If the CMS determination is not timely contested by the Contractor under paragraph (c) of this 42 CFR §438.730.

Under §438.726(b), CMS' denial of payment for Members automatically results in a denial of payments by the Department to the Contractor for the same Members.

18.4.2.5 Effective Date of Sanction

If the Contractor does not seek reconsideration, a sanction is effective fifteen (15) days after the date the Contractor is notified under paragraph (c) of 42 CFR §438.730 of the decision to impose the sanction.

If the Contractor seeks reconsideration, the following rules apply:

- 1) Except as specified in 42 CFR §438.730 (d)(2), the sanction is effective on the date specified in CMS' reconsideration notice.
- 2) If CMS, in consultation with the Department, determines that the Contractor's conduct poses a serious threat to an enrollee's health or safety, the sanction may be made effective earlier than the date of the agency's reconsideration decision under 42 CFR §438.730 (d)(1)(ii).

18.4.2.6 CMS' Role

CMS retains the right to independently perform the functions assigned to the Commonwealth under paragraphs (a) through (d) of 42 CFR §438.730. At the same time that the Commonwealth sends notice to the Contractor under 42 CFR §438.730 (c)(1), CMS forwards a copy of the notice to the OIG. CMS conveys the determination described in 42 CFR §438.730(b) to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and 42 CFR§ 1003. In accordance with the provisions of 42 CFR§ 1003, the OIG may impose civil money penalties on the Contractor in addition to, or in place of, the sanctions that may be imposed under 42 CFR §438.730.

18.4.3 Other Specified Sanctions

In addition to the sanctions authorized by federal law, the Department's regulations provide sanction authority (12VAC30-120-410). In accordance with 42 CFR §438.702, In addition to Federally prescribed sanctions described above, the Department retains authority to impose additional sanctions under State statutes or State regulations to address areas of noncompliance. If the Department determines that the Contractor failed to provide one (1) or more of the contract services required under the Contract, or that the Contractor failed to maintain or make available any records or reports required under the Contract by the Department which the Department may use to determine whether the Contractor is providing contract services as required, the following remedies may be imposed:

18.4.3.1 Suspensions of New Enrollment

The Department may suspend the Contractor's right to enroll new Medicaid Members (voluntary, automatically assigned, or both) under this Contract (12VAC30-120-410(A)). The Department may make this remedy applicable to specific populations served by the Contractor or the entire contracted area. The Department, when exercising this option will notify the Contractor in writing of its intent to suspend new Medicaid enrollment at least thirty (30) calendar days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Department, or it may be indefinite. The Department may also suspend new Medicaid enrollment or disenroll Medicaid Members in anticipation of the Contractor not being able to comply with any requirement of this Contract or with Federal or State laws or regulations at its current enrollment level. Such suspension shall not be subject to the thirty (30) calendar day notification requirement.

The Department may also notify Members of Contractor non-compliance and provide such Members an opportunity to enroll with another MCO without cause.

18.4.3.2 Department-Initiated Disenrollment

The Department may reduce the number of current Members by disenrolling the Contractor's Medicaid Members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

18.4.3.3 Reduction in Maximum Enrollment Cap

The Department may reduce the maximum enrollment level or number of current Medicaid Members. The Contractor shall be given at least thirty (30) calendar days notice prior to the Department taking any action set forth in this paragraph.

18.4.3.4 Suspension of Marketing Services and Activities

The Department may suspend a Contractor's marketing activities which are geared toward potential Members. The Contractor shall be given at least ten (10) calendar days notice prior to the Department taking any action set forth in this paragraph.

18.4.3.5 Additional Financial Sanctions

In accordance with 42 CFR § 438.701(b), the Department may impose additional financial sanctions/penalties provided for under Virginia statutes or regulations to address noncompliance. Sanctions are addressed in DMAS regulations at 12VAC30-120-140.

18.4.3.6 Withholding of Capitation Payments and Recovery of Damage Costs

When the Department withholds payments under this section, the Department will submit to the Contractor a list of the Members for whom payments are being withheld, the nature of the services denied, and payments the Department must make to provide medically necessary services. In any case under this Contract where the Department has the authority to withhold capitation payments, the Department also has the authority to use all other legal processes for the recovery of damages. The Department may withhold portions of capitation payments or otherwise recover damages from the Contractor in the following situations:

1. Whenever the Department determines the Contractor failed to provide one (1) or more of the medically necessary covered contract services, the Department may direct the Contractor to

provide such service or withhold a portion of the Contractor's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services. The Contractor shall be given at least seven (7) calendar days written notice prior to the withholding of any capitation payment.

2. Whenever the Department determines that the Contractor has failed to perform an administrative function required under the Contract, the Department may withhold a portion of future capitation payments to compensate for the damages which this failure entails. For the purposes of this section, "administrative function" is defined as any contract service.

18.4.3.7 Procedures For Withholding Capitation Payments

In any case where the Department intends to withhold capitation payments or recover damages through the exercise of other legal processes, the following procedures shall be used:

1. The Department shall notify the Contractor of the Contractor's failure to perform required administrative functions under the Contract.
2. The Department shall give the Contractor thirty (30) calendar days' notice to develop an acceptable plan for correcting this failure.
3. If the Contractor has not submitted an acceptable correction action plan within thirty (30) calendar days, or has not implemented this plan within the timeframe in the approved action plan, the Department will provide the Contractor with a written document itemizing the damage costs for which it intends to require compensation seven (7) calendar days prior to withholding any capitation payment. The Department shall then proceed to recover said compensation.
4. The Department shall notify the Contractor when it is determined that the Contractor is not in compliance with a provision in this Contract. Notice shall be sent requesting a Corrective Action Plan to resolve the error. If the Contractor fails to respond to the Department's request in three (3) business days, the Department shall notify the Contractor in writing of its failure to respond to the Department is a violation of this Contract. If the Contractor continues to withhold corrective action within one (1) week of the date of the letter, the Department's Director shall notify the Contractor that its continued failure to act will result in one or a combination of the following remedies to the Department:
 - a. withhold of capitation;
 - b. withhold/suspension of future enrollment;
 - c. fines for violation not to exceed \$10,000 per occurrence; and/or termination of the Contract.

18.4.3.8 Suspension of Medicaid Payments in Cases of Fraud

In accordance with 42 CFR § 455.23, Managed Care Organizations are subject to payment suspensions. The Department shall suspend payments to the Contractor based upon a pending investigation of a credible allegation of fraud. Credible allegation of fraud is defined under 42 CFR § 455.2 as any allegation, which has been verified by the State, from any source, including: fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all

allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. DMAS does not have to notify the Contractor first of suspension of payments. The Contractor must be granted an administrative review where State law requires this.

18.4.3.9 Probation

The Department may place a Contractor on probation, in whole or in part, if the Department determines that it is in the best interest of Medicaid Members and the Department. The Department may do so by providing the Contractor with a written notice explaining the terms and the time period of the probation. The Contractor shall, immediately upon receipt of such notice, provide services in accordance with the terms set forth and shall continue to do so for the period specified or until further notice. When on probation, the Contractor shall work in cooperation with the Department, and the Department may institute ongoing review and approval of Contractor Medicaid activities.

18.5 CORRECTIVE ACTION PLAN

If, at any time, DMAS reasonably determines that the Contractor is deficient in the performance of its obligations under the Contract, DMAS may require the Contractor to develop and submit a corrective action plan (CAP) that is designed to correct such deficiency. The CAP gives the Contractor the opportunity to analyze and identify the root causes of the identified findings and observations, and to develop a plan to address the findings and observations to ensure future compliance with this Contract and State/Federal regulations. The Contractor's first step in preparing a CAP is to review the specific findings/observations noted in the communication received from the Department and determine the root cause of the deficiency. CAPs must always include the necessary information and be submitted in the method as required in the *CCC Plus Technical Manual*. If a CAP does not contain the necessary information, an additional sanction or violation point value may be assessed.

DMAS will approve, disapprove, or require modifications to the Corrective Action Plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the Corrective Action Plan as approved by DMAS. Failure to implement the Corrective Action Plan may subject the Contractor to termination of the Contract by DMAS or other intermediate sanctions as described in Section 18.0, *Enforcement, Remedies and Compliance*.

18.6 INTERMEDIATE SANCTIONS AND CIVIL MONETARY PENALTIES

In addition to termination, DMAS will impose any or all of the sanctions noted in this Contract upon any of the events below provided, however, that DMAS will only impose those sanctions determined to be reasonable and appropriate for the specific violations identified. Sanctions will be imposed in accordance with regulations that are current at the time of the sanction. Sanctions will be imposed in accordance with this section if the Contractor:

1. Fails substantially to provide Covered Services required to be provided under this Contract to Members;
2. Imposes charges on Members in excess of any permitted under this Contract;
3. Discriminates among Members or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

4. Misrepresents or falsifies information provided to DMAS and its authorized representatives, Members, prospective Members, or its Provider Network;
5. Fails to comply with requirements regarding physician incentive plans;
6. Fails to comply with Federal or State statutory or regulatory requirements related to this Contract;
7. Violates restrictions or other requirements regarding marketing;
8. Fails to comply with quality management requirements;
9. Fails to comply with any corrective action plan required by DMAS;
10. Fails to comply with financial solvency requirements;
11. Fails to comply with reporting requirements; or
12. Fails to comply with any other requirements of this Contract.

Such sanctions may include:

1. Financial penalties consistent with 42 CFR § 438.704;
2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 USC § 1396 u-2(e)(2)(B);
3. Suspension of Enrollment (including assignment of Members);
4. Suspension of payment to the Contractor;
5. Disenrollment of Members;
6. Suspension of marketing; and
7. Denial of payment as set forth in 42 CFR § 438.730.

If DMAS has identified a deficiency in the performance of a subcontractor or provider and the Contractor has not successfully implemented an approved corrective action plan, DMAS may:

1. Require the Contractor to subcontract with a different Entity deemed satisfactory by DMAS; or
2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

Before imposing any intermediate sanctions, DMAS will give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DMAS elects to provide.

18.7 NOTICE OF SANCTION AND PRETERMINATION HEARING

18.7.1 Notice of Sanction

In accordance with 42 CFR §438.710, except as provided in §438.706(c), before imposing any of the intermediate sanctions specified in this Contract, the Department will give the affected entity timely written notice that explains the following:

- (1) The basis and nature of the sanction.
- (2) Any appeal rights available to the Contractor.

18.7.2 Pre-Termination Hearing

In accordance with 42 CFR §438.710, before imposing the intermediate sanction to terminate this Contract with the Contractor, the Department must provide the entity a pre-termination hearing, including all of the following procedures:

- 1) Give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.
- 2) After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination.
- 3) For an affirming decision, give Members of the Contractor notice of the termination and information, consistent with §438.10, on the individual's options for receiving Medicaid covered services following the effective date of termination.

SECTION 19.0 CONTRACTOR PAYMENT AND FINANCIAL PROVISIONS

The Contractor shall establish and maintain a financial management capability sufficient to ensure that the requirements of this Contract are met.

19.1 FINANCIAL STATEMENTS

19.1.1 Bureau of Insurance Filings

The Contractor shall submit to the Department a copy of all quarterly and annual filings submitted to the Bureau of Insurance. A copy of such filing shall be submitted to the Department on the same day on which it is submitted to the Bureau of Insurance. Any revisions to a quarterly and/or annual BOI financial statement shall be submitted to the Department on the same day on which it is submitted to the BOI.

19.1.2 Annual Audit by Independent Contractor

The Contractor shall provide the Department with a copy of its annual audit report required by the Bureau of Insurance at the time it is submitted to the Bureau of Insurance. The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The Contractor shall provide the Department a copy of such an audit within thirty (30) calendar days of completion of the audit.

19.1.3 Financial Report to the Department

The Contractor shall submit quarterly financial reports to the Department's Provider Reimbursement Division that details revenue, medical expenditures by category, total Member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, balance sheets, detailed information on related party transactions and all administrative expenses associated with the CCC Plus program using the format developed by the Department as specified in the *CCC Plus Technical Manual*. The report shall be submitted on a quarterly basis to the Department following the same schedule as reports for the BOI with the exception of the 4th quarter report also known as the annual report which must be submitted within two (2) weeks after the BOI due date. This report is subject to audit and verification by the Department. For Contractors with multiple Medicaid lines of business in Virginia, the quarterly report should segregate and report data for each program (CCC Plus, Medallion, etc.) and reconcile to the annual BOI reports.

On an annual basis, each contractor shall submit supplemental information related to administrative expenses that (1) identify all non-allowable expenses for Medicaid reimbursement and (2) allocate its administrative expenses across major eligibility groups.

Non-allowable expenses for Medicaid reimbursement include but are not limited to:

- Related party management fees in excess of actual cost;
- Lobbying expenses, Contributions, State and Federal income taxes;
- Administrative fees for services provided by a parent organization, which did not represent a pass through of actual costs;
- Management fees relating to non-Virginia operations;

- Management fees paid for the sole purpose of securing an exclusive arrangement for the provision of services for specific MCO enrollees; and/or,
- Administrative fee/royalty licensing agreements for services provided by a parent organization, which did not represent a pass through of actual costs, and Accruals for future losses.)

19.2 REPORTING OF REBATES

The Contractor shall report on a quarterly basis within forty five (45) days of the end of the quarter all rebates invoiced and rebates collected on drugs or devices dispensed to any Medicaid Member from pharmaceutical manufacturers, distributors or any other source since the plan's participation in the CCC Plus program. Refer to the *CCC Plus Technical Manual* for the format and requirements.

Managed care encounter claims are required to be submitted in a timely manner and in full compliance with the DMAS published Companion Guide (e.g. NCPDP Payer Specifications, NCPDP Post-Adjudication Standard). Any impact to the collection of manufacturer rebates allowed under federal law that is the result of delayed encounter claim submission to DMAS or the omission of required claim level data elements will be assessed as a contract penalty at the full amount of lost manufacturer rebates.

19.3 FINANCIAL RECORDS

Throughout the duration of the Contract term, the Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor shall notify the Department at least thirty (30) calendar days prior to making any changes to its basis of accounting.

19.4 INTERNAL CONTROLS REPORT

The Contractor shall provide the Department, at a minimum, a report from its external auditor on the effectiveness of its internal controls. If the report discloses deficiencies in internal controls, the Contractor shall include management's corrective action plans to remediate the deficiency. If available, the report shall be compliant with the AICPA Statement on Standards for Attestation Engagements (SSAE) No 16, Reporting on Controls at a Service Organization, Service Organizations Controls (SOC) 2, Type 2 Report, and include the Contractor and its third-party service providers. If a review of internal controls has not been performed, a peer review report shall be submitted. Reports shall be provided annually each June 1st for the preceding calendar year.

19.5 FINANCIAL SOLVENCY

The Bureau of Insurance of the Virginia State Corporation Commission regulates the financial stability of all licensed MCOs in Virginia. The Contractor agrees to comply with all Bureau of Insurance standards.

19.6 CHANGES IN RISK BASED CAPITAL REQUIREMENTS

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in risk based capital requirements imposed by the Bureau of Insurance or any other entity.

19.7 HEALTH INSURER FEE

The Department recognizes that the health insurer fee imposed by the Affordable Care Act is a cost to some CCC Plus health plans that should be recognized in actuarially sound capitation rates. The Department will reimburse the Contractor for the fee associated with the Virginia Medicaid line of business. DMAS will make an adjustment for the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes but the adjustment shall not exceed the Federal or State corporate income taxes reported on the plan's annual financial statement and allocated to the Virginia Medicaid line of business.

The Contractor shall furnish a copy of its Letter 5067C Final Fee Calculation from the IRS to DMAS for 2018 by September 15 if any such fee was payable. Along with a copy of the letter 5067C, each plan shall show the methodology for allocating the health insurer fee to each Virginia Medicaid line of business and certify the results. The Department will utilize this information to determine plan specific PMPM adjustments to the CY 2018 capitation rates. There will be separate components for the fee itself and the impact of non-deductibility of the health insurer fee on Federal and State corporate income taxes. A health insurance premium adjustment will be determined after the amounts due are known in the fall. DMAS will make an aggregated retroactive adjustment by December 31, 2019.

The Contractor shall compare its final CY 2018 state and corporate income tax liability for the Medicaid line of business reported to the Bureau of Insurance and the capitation adjustment for the impact of non-deductibility of the health insurer fee and refund the difference, if any, between the capitation adjustment and the actual tax liability to the Department by April 30, 2020.

19.8 MINIMUM MEDICAL LOSS RATIO (MLR) AND LIMIT ON UNDERWRITING GAIN

The Contractor shall be subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a contract specific basis and will only include revenue and expense experience applicable to Members (excluding Medicaid Expansion Members) included under the contract. The MLR is calculated first followed by the calculation of the Underwriting gain limit.

In accordance with 42 CFR §§438.8(k) and 438.8(n), the Contractor shall attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports.

The Contractor shall be subject to a minimum MLR of 85%. The MLR shall be determined as the ratio of (i) incurred claims plus expenditures for activities that improve health care quality plus expenditures on activities to comply with certain program integrity requirements divided by (ii) adjusted premium revenue. If the MLR for a reporting year is less than 85% then the

Contractor shall make payment to the Department equal to the deficiency percentage applied to the amount of adjusted premium revenue.

The Contractor is required to report a MLR annually based on 42 CFR § 438.8. The Contractor shall submit to the Department, in the form and manner prescribed by the Department, the necessary data to calculate and verify the MLR within eleven (11) months of the end of the reporting year. The MLR reporting year shall be the contract year.

In accordance with 42 CFR §§438.8(k) and 438.8(m) and, in any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the Department, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and meeting the applicable requirements. Additionally, in any instance where a state makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the MCP must submit a new MLR report meeting the applicable requirements.

The MLR shall reflect the following, if applicable:

- a. Expenditures that benefit multiple contracts or populations (such as Medicaid Expansion and non-Expansion), or contracts other than those being reported, must be reported on a pro rata basis [per 42 CFR§438(g)(1)(ii)];
- b. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract and/or population incurring the expense [per 42 CFR§438(g)(2)(ii)]; and,
- c. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities[per 42 CFR§438(g)(2)(iii)].

In accordance with 42 CFR §438.8(h), a credibility adjustment is added to the MLR calculation before calculating any remittances. A credibility adjustment to a calculated MLR may be added if the MLR reporting year is partially credible. The Contractor shall not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

In accordance with 42 CFR §438.8(k)(3), the Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

The Contractor shall report to the Department the following information for each MLR reporting year based on data through the ninth month following the MLR reporting year:

- a. Total incurred claims;

- b. Expenditures on quality improving activities;
- c. Expenditures on activities related to program integrity compliance;
- d. Non-claims costs;
- e. Premium revenue;
- f. Taxes, licensing and regulatory fees;
- g. Methodology for allocation of expenditures;
- h. Any credibility adjustment applied;
- i. The calculated MLR;
- j. Any remittance owed to the State;
- k. A reconciliation of the information reported in this report with the audited financial report;
- l. A description of the aggregation method by covered population; and,
- m. The number of Member months.

If the Contractor is required to make a payment to the Department, the payment shall be due to the Department no later than twelve (12) months following the MLR reporting year.

The Contractor shall be subject to a maximum underwriting gain for the MLR reporting year expressed as a percentage of Medicaid premium income. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for the calendar year developed in the same manner as the MLR (i.e. with data through the ninth month following the MLR reporting year). Such amounts shall be determined consistent with the reporting requirements for the Contractor's Annual Financial Statement filed with the Virginia Bureau of Insurance with two exceptions. First, the non-claims costs should exclude the amount, if any, of non-allowable expenses as described in Section 19.1.3, *Financial Report to the Department*. Second, the benefit claims, administrative expense and premium revenue associated with the Medicaid Expansion Members shall be excluded.

If the underwriting gain percentage for the MLR year in which the contract became effective exceeds three percent (3.00%) then the Contractor shall make payment to the Department equal to one-half of the underwriting gain in excess of three percent of Medicaid premium income up to 10 percent. The Contractor shall return 100 percent of the underwriting gain above 10 percent. Such amount will be remitted to DMAS as a refund of an overpayment. To illustrate, if the underwriting gain is 9% then the Contractor shall refund to the Department 3.0% of Medicaid premium income. If the underwriting gain is 11% then the Contractor shall refund to the Department 4.5% of Medicaid premium income. If the underwriting gain is 4.0% then the Contractor shall refund to the Department 0.5% of Medicaid premium income.

All of the variables used in the calculation of the underwriting gain limit and the amount of any resulting payment shall be determined as if the limit did not exist but shall reflect any refund amount required due to the MLR contract provision. Contractors are required to notify the Department and provide supplemental information in the event that this limit impacted the financial results reported for a quarter. This supplemental financial information should include revised values for Medicaid underwriting gain and Medicaid premium income determined without application of the limit.

The limit on underwriting gain will not apply for a given calendar year if the Contractor has fewer than 120,000 Member months during the calendar year. In addition, the limit on underwriting gain shall not apply to a Contractor for a given calendar year if the Contractor has less than 12 months of experience in the program at the beginning of the calendar year. If the Contractor is required to make a payment to the Department under this Contract provision, the payment shall be due to the Department no later than December 1 of the following calendar year.

The Contractor is prohibited from providing bonus and/or incentive payments to contracted providers or subcontractors which are determined based in whole or in part on the applicability of this contract provision.

19.9 RISK MANAGEMENT PROVISIONS

19.9.1 Pharmacy Reinsurance Pool

The Department will operate a Pharmacy Reinsurance pool. The objective of the pool is to spread the risk of excessive pharmacy claims equitably across all participating Contractors. Ninety percent (90%) of a Member's annual prescription drug costs above a \$175,000 attachment point will be aggregated/pooled across all Contractors participating in the CCC Plus program. The \$175,000 attachment point is used for an annual contract. The attachment point amount will be pro-rated for contract durations other than annual. Such claims will be referred to as pharmacy reinsurance claims.

The amount to be used in the computation of a Member's annual prescription drug costs (including prescription drugs administered in a physician's office or outpatient hospital setting) will be the Contractor paid amount after reduction by any Medicare/TPL payment. The Contractor shall notify the Department quarterly of all Members whose prescription drug costs have exceeded the \$175,000 attachment point during the contract year. All reinsurance claims are subject to medical review by the Department. The pooled amount is not combined with other DMAS Managed Care programs, even if, during a contract year, the Contractor participates in more than one program and a Member incurred costs while covered by the Contractor in another program, his/her eligibility changes, moves into the CCC Plus program and incurs additional costs.

The Department will allocate the aggregate/pooled reinsurance claims to each MCO on the basis of premium income. Contractors whose total pharmacy reinsurance claims in the contract year exceed the allocated pooled amount will be reimbursed for the excess. Contractors whose total pharmacy reinsurance claims are less than the allocated pooled amount will be required to reimburse the Department for the deficiency. The total of the excess and deficient amounts for all Contractors will offset such that the Department bears no risk with regard to the underlying pharmacy reinsurance claims. Contractors are required to submit documentation for pharmacy reinsurance claims within thirty (30) calendar days of each quarter end for the first three quarters of the contract year. The documentation must be submitted using the file format and guidelines in the *CCC Plus Technical Manual*. The quarterly periods end on March 31, June 30, September 30 and December 31 of the contract year. The deadline for the final quarter, ending June 30, will be three (3) months following the quarter end, to ensure reasonable time for outstanding physician and outpatient hospital claims. The Department will determine and report the

allocated/pooled amount quarterly by Contractor or provide notice to each Contractor if additional information is required.

The Department reserves the right to perform audits on reinsurance claims. Terms of the audit process will be disclosed prior to implementation of the audits, providing the Contractor with appropriate advance notice.

19.9.2 Risk Corridor for Medicaid Expansion Population

A risk corridor program will be utilized during the first two and a half (2 1/2) years of this Contract. The risk corridor program creates a mechanism for sharing risk for projected benefit costs between DMAS and the Contractor. If the Contractor incurs benefit costs that are less than 98 percent (98%) of the target amount, the Contractor will refund a percentage of those savings to DMAS. For the definition of “target amount” refer to Section 23.1, *Definitions* of this Contract. If the Contractor incurs benefit costs that are greater than 102 percent (102%) of the target amount, the Contractor will receive payments from DMAS to offset a percentage of those losses. Benefit cost is an amount equal to the total costs paid by the Contractor in providing benefits covered by the plan. Benefit cost excludes allowable administrative costs paid by the Contractor. The risk corridor calculation shall be made based on the Contractor’s experience during the contract year.

19.9.2.1 DMAS Payments To The Contractor

The Contractor will receive payment from DMAS in the following amounts under the following circumstances: (1) When the Contractor’s benefit costs for services allowed under 42 CFR § 438.3(c)(1)(ii) in any contract year are more than 102 percent (102%) but not more than 106 percent (106%) of the target amount, DMAS pays the Contractor an amount equal to 50 percent (50%) of the target amount in excess of 102 percent (102 %) of the target amount; and (2) When the Contractor’s benefit costs for services allowed under 42 CFR § 438.3(c)(1)(ii) in any contract year are more than 106 percent (106%) of the target amount, DMAS pays to the Contractor an amount equal to the sum of 2 percent (2%) of the target amount plus 100 percent (100%) of benefit costs in excess of 106 percent (106%) of the target amount.

19.9.2.2 Contractor’s Remittance Of Charges

The Contractor must remit charges to DMAS in the following amounts under the following circumstances: (1) If the Contractor’s benefit costs for services allowed under 42CFR 438.3(c)(1)(ii) in any contract year are less than 98 percent (98%) but not less than 94 percent (94%) of the target amount, the Contractor must remit charges to DMAS an amount equal to 50 percent (50%) of the difference between 98 percent (98%) of the target amount and the benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii); and (2) When the Contractor’s allowable costs for any benefit year are less than 94 percent (94%) of the target amount, the Contractor must remit charges to DMAS an amount equal to the sum of 2 percent (2%) of the target amount plus 100 percent (100%) of the difference between 94 percent (94%) of the target amount and the benefit costs for services allowed under 42 CFR 438.3(c)(1)(ii).

The Contractor is required to report to DMAS the amount of benefit costs incurred for services allowed under 42 CFR § 438.3(c)(1)(ii) for the contract year within eleven (11) months following the contract year. Such amount shall be calculated based on data through the ninth month following the contract year. The amount of benefit costs for services allowed under 42 CFR §

438.3(c)(1)(ii) will not be affected by any service level agreement penalties described in Section 8.0, *Provider Network Management* of this Contract. Such reporting is required to be certified by the Contractor. Any charges owed to DMAS or payments owed to the Contractor will be paid to the respective party no later than twelve (12) months after the contract year..

19.10 CAPITATION RATES

19.10.1 Payment to the Contractor

In accordance with 42 CFR§ 438.3(c)(2) capitation payments shall only be made by the Department, and shall only be retained by the Contractor, for Medicaid eligible Members enrolled with the Contractor. The Department shall issue capitation payments on behalf of Members at the rates established in this Contract and modified during the annual contract renewal process. Except for amounts covered by reinsurance in 19.9, the Contractor shall accept the established capitation rate paid monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for June enrollment will occur in July, July payment will be made in August, etc.).

Capitation rates for the CCC Plus program will be consistent with payment and contracting requirements under 42 CFR § 438 Subpart A. DMAS will use either FFS claims data or MCO encounter data to calculate PMPM costs from a two-year base period, and adjust for any policy and program changes between the base period and the rate year and trend to the rate year. DMAS will include adjustments for managed care and administrative costs.

If an individual is enrolled with the Contractor the first day of any given month, that MCO has the responsibility of providing services to that Member including in instances where the Member moves to another locality. If the Member moves to a locality where the Contractor is not approved to participate, the Member will be dropped from the plan's enrollment at the end of the month of change.

In accordance with 42 CFR §438.6, capitation rate cells are based on several factors (e.g., eligibility group, age, locality, level of care, primary payer, etc.) and is automatically generated by the system using the information in the system at the time of payment.

In addition to monthly capitation payments, the Department shall make a "kick payment" for all maternity deliveries. The maternity payment reimburses health plans for their inpatient and professional payments associated with a live birth. A delivery is defined based on the following surgical procedure codes:

- 10D00Z0: Classical C-Section
- 10D00Z1: Low Cervical C-Section
- 10D00Z2: Extraperitoneal C-Section
- 10D07Z3: Low Forceps Vaginal Delivery
- 10D07Z4: Mid-Forceps Vaginal Delivery
- 10D07Z5: High-Forceps Vaginal Delivery

- 10D07Z6: Vacuum Vaginal Delivery
- 10D07Z7: Internal Version for Vaginal Delivery
- 10D07Z8: Other Vaginal Delivery
- 10E0XZZ: Delivery, Products of Conception, External, No Device, No Qualifier

A maternity kick payment will be triggered upon receipt of a valid encounter with one of the qualifying procedure codes above. Maternity kick payments will be generated once a month for all qualifying encounters in the prior month.

The rate cells are included on the rate pages attached to this contract. The Department will utilize a blended rate for populations that meet Nursing Facility Level of Care criteria and receive services either in a nursing home setting or in the community under the CCC Plus Waiver, at the standard benefit.. The blended rate will be based on target percentages for the mix of Member months in nursing homes and the CCC Plus Waiver standard benefit that are designed to keep improving the percentage of Members in the community under the CCC Plus Waiver, standard benefit.

Blended rates will be determined prospectively based on each plan's Nursing Facility/CCC Plus Waiver standard benefit population mix.

In addition, the Department will risk adjust the rates for the Non-Dual Community No LTSS (ABD without LTSS) population prospectively based on the CDPS risk adjustment model and the Member enrollment by Contractor and region.

In accordance with 42 CFR § 438.604(a)(2); 42 CFR § 438.606; 42 CFR § 438.3; 42 CFR § 438.5(c), the Contractor shall be required to submit data, including encounter data, on the basis of which the Department certifies the actuarial soundness of the capitation rates to the contracted health plans, including base data that is generated by the contracted health plans.

The Contractor shall accept the Department's electronic transfer of funds to receive capitation payments using the EDI X12 820 standard. The 820 Capitation Payment file will list all of the Members for whom the Contractor is being reimbursed. The 820 is processed on the last Friday of the calendar month and is available to the Contractor on the following Monday. The file includes individual Member month detail with current and retroactive capitation payment adjustments.

19.10.2 Performance Withhold Program

The Department introduced the Performance Withhold Program (PWP), previously the Performance Incentive Program, to reinforce VBP principles by setting performance standards and expectations for Contractors in key areas influencing Member health and health outcomes. By tying financial incentives to Contractor performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to Members. This effort also aligns with the Virginia Medicaid focus areas by including measures pertaining to behavioral health and chronic conditions.

19.10.2.1 Calendar Years (CY) 2019 and 2020

In CY 2019 and 2020, the PWP will focus on measures of Contractor performance in facilitating high quality care for Members with behavioral health and chronic conditions. These measures were also included in the list of core quality measures identified for reporting in CY 2018. The table below entitled “Performance Withhold Program Measures for CY 2019 & 2020” identifies the withhold measures.

Performance Withhold Program Measures for CY 2019 & 2020

Measure	Domain	Measure Type	CY 2019 & 2020 Weight
Follow-up after Emergency Department visit alcohol or other drug dependence	Behavioral Health	HEDIS	15%
Follow-up after Emergency Department visit for mental illness	Behavioral Health	HEDIS	20%
Initiation and engagement of alcohol and other drug dependence treatment	Behavioral Health	HEDIS	15%
COPD and asthma in older adults admissions rate	Chronic Conditions	PQI 05	15%
Comprehensive diabetes care	Chronic Conditions	HEDIS	20%
Heart failure admissions rate	Chronic Conditions	PQI 08	15%

The Department reserves the right to augment the measures included in the PWP composite in future years; however, all measures displayed in the table above will remain part of the composite for both CY 2019 and 2020. The withhold percentage will also remain one percent (1%) for the CY 2019 and 2020 PWP. In order to align the PWP program with the upcoming CCC Plus contract year change from CY to SFY, there will be a one-time withhold window that spans 18 (eighteen) months (i.e., January 2020 through June 2021). Contractors will earn back these funds based on CY 2020 performance. Following this one-time window, future PWP capitation rate withholding will occur on an SFY basis and the Contractor will earn back withheld amounts based on CY performance (e.g., SFY 2022 withhold amounts earned back based on CY 2021 performance). Additional details concerning the withhold, including required performance thresholds and other information regarding the methodology will be made available in the *CCC Plus Technical Manual*.

19.10.2.2 Future Years

Beginning July 1, 2020, the CCC Plus Contract will begin to operate on a SFY schedule. The withhold percentage will remain one percent (1%) during this transition and continue at one percent (1%) in future years.

19.10.3 CCC Plus Clinical Efficiencies

In December 2016, the Joint Legislative Audit and Review Commission (JLARC) published a study titled *Managing Spending in Virginia's Medicaid Program* (<http://jlarc.virginia.gov/medicaid-2016.asp>). Among the study's recommendations, JLARC called for the Department to work with its actuary to identify potential inefficiencies in the Medallion program and adjust capitation rates to account for these inefficiencies. The Virginia General Assembly subsequently enacted, and the Governor signed, budget language to execute this recommendation. To implement this mandate, the Department contracted with its actuary to identify clinical efficiencies under its managed care programs. The Department believes it is important to promote symmetry between the Medallion and CCC Plus programs whenever appropriate, and that it is reasonable to apply a similar approach to clinical efficiency adjustments under both programs. The first set of clinical efficiency analyses focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits, as well as efficient utilization and management of prescription drugs.

19.10.3.1 Clinical Efficiency Measurement

To allow for more current and active measurement for the clinical efficiency areas, the Department developed performance measures for clinical efficiencies relating to hospital admissions, hospital readmissions, and emergency department visits. These measures allow the Department to run the clinical efficiency analysis on current data and facilitate transparency in the calculation of each measure. As part of this transparency, the Department will make clinical efficiency measure technical specifications available for Contractors to deploy for performance monitoring in a manner consistent with the Department. The Department will also provide annual performance reports to each Contractor illustrating the Contractor's performance across these three (3) clinical efficiency areas.

19.10.3.2 Performance Incentives

Previous Department policy applied the clinical efficiency analysis as an adjustment to capitation rates. The Department has amended this policy to improve incentives for clinical performance and reward Contractors that achieve reductions in medically necessary and/or potentially preventable utilization of high acuity settings through the provision of high quality care that improves Member health and clinical outcomes.

Beginning in SFY 2021, the Department will convert the clinical efficiency capitation rate adjustment into a capitation withhold methodology. Both the Medallion and CCC Plus program rates will incorporate a 0.25% withhold specifically devoted to the Contractor's performance on the three (3) clinical efficiency performance measures pertaining to hospital admissions, hospital readmissions, and emergency department visits. Prior to the start of each SFY, Contractors will receive a customized report from the Department illustrating the performance levels it must achieve on each measure to earn back the clinical efficiency withhold amount. This report will illustrate the Contractors' results on each measure and thresholds for full and partial credit in a given SFY for each of the three (3) clinical efficiency performance measures.

The Department will evaluate the Contractor's performance using the SFY (July 1 through June 30) after allowing a six (6) month claims run-out period to ensure data completeness. The Department will evaluate clinical efficiency measure performance using only encounter data submitted by the Contractor. No other data will be used in assessing the Contractor's performance under these three (3) clinical performance measures, so all Contractors should take the necessary steps to ensure data is accurate and complete prior to the end of the six (6) month claims run-out period following each SFY.

19.10.3.3 Final Determinations

The Department reserves the right to amend, adjust, or otherwise modify any and all provisions, in part or in whole, associated with the application of the clinical efficiency performance measures and associated withhold, including, but not limited to, the adjustment of performance thresholds associated with clinical efficiency measures in the event mitigating and/or unforeseen factors make the achievement of such results unreasonable.

The Department will make all final determinations on Contractor clinical efficiency measure performance, reasonableness determinations, and the corresponding amount of the clinical efficiency withhold the Contractor earns back based on its clinical efficiency measure performance. The Department will work with the Contractors to address any disagreements in determinations on these points, but in the event that the Department and the Contractor are unable to come to agreement, Department decisions are final and not subject to appeal.

19.10.4 Modifications to Capitation Rates

DMAS may propose modifications, additions, or deletions to the rate cell structure over the course of the Contract or in future contracts. Any changes will be reflected in a modification to the CCC Plus Contract.

Rates will be updated using a similar process for each contract year. Rate changes would be considered for budget changes effective July 1 that affect one or more adjustments to the capitation rates, any changes to contracts that are used as the basis for adjustments to the capitation rates, other policy changes or more current information necessary to calculate accurate payment rates for the Contract. Changes would be considered material if it exceeds 0.5 percent for any eligibility category. Changes will be applied, if necessary on a retrospective basis, to effectuate accurate payments for each month.

19.10.5 American Recovery and Reinvestment Act of 2009

All payments to the Contractor are conditioned on compliance with the provisions of the American Recovery and Reinvestment Act of 2009.

19.10.6 Suspension of Payments

DMAS may suspend payments to Contractor in accordance with 42 CFR § 455.23 as determined necessary or appropriate by DMAS.

19.10.7 Rating Category Changes

The Capitation Rates will be updated following a change in a Member's status relative to the rate cell. As part of Capitation Payment processing, the rating category of each Member will be determined based on their status on the first day of the month.

19.10.8 Medicaid Capitation Reconciliation

DMAS will implement a process to reconcile Enrollment and Capitation Payments for the Contractor that will take into consideration the following circumstances:

- Transitions between rate categories;
- Retroactive changes in eligibility, rate categories, or Member contribution amounts, level of care, Member FIPS; and,
- Changes through new Enrollment, disenrollment, or death.

The reconciliation may identify underpayments or overpayments to the Contractor.

Retroactive adjustments to enrollment and payment shall be forwarded to the Contractor as soon as possible upon receipt of updated/corrected information. The Contractor shall cover retroactive adjustments to enrollment without regard to timelines of the adjustment. The Contractor shall assure correct payment to providers as a result of enrollment updates/corrections. DMAS shall assure correct payment to the Contractor for any retroactive enrollment adjustments.

DMAS will reconcile payments related to the MEMA adjustment on a periodic basis.

19.10.9 Recoupment/Reconciliation

The Department shall recoup a Member's capitation payment for a given month in cases in which a Member's exclusion or disenrollment was effective retroactively. The Department shall not recoup a Member's capitation payment for a given month in cases in which a Member is eligible for any portion of the month.

This provision applies to cases where the eligibility or exclusion can occur throughout the month including but not limited to, death of a Member, cessation of Medicaid eligibility, or transfer to an excluded CCC Plus program Medicaid category, change in level of care status, and Member FIPS.

The Department shall recoup capitation payments made in error by the Department. The Contractor may recover any payments made for services provided to impacted Members from providers in accordance with the MCO's Contract with the Provider.

When membership is disputed between two Contractors, the Department shall be the final arbitrator of Contractor enrollment and reserves the right to recoup an inappropriate capitation payment.

The Contractor shall not be liable for the payment of any services covered under this Contract rendered to a Member after the effective date of the Member's exclusion or retroactive disenrollment.

If this Contract is terminated, recoupments shall be handled through a payment by the Contractor within thirty (30) calendar days after Contract termination or thirty (30) calendar days following determination of specific recoupment requirements, whichever comes last.

The Department shall reconcile payments on a quarterly basis. The quarterly reconciliation shall be based on adjustments known to be needed through the end of the quarter. The reconciliation payment adjustments will be reflected in the capitation payment process. See the *CCC Plus Technical Manual* for detailed information.

19.10.10 Audits/Monitoring

DMAS will conduct periodic audits to validate rate category assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by DMAS.

19.10.11 Payment in Full

The Contractor shall accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

Notwithstanding any contractual provision or legal right to the contrary, the parties to this Contract agree there shall be no redress against the other party, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the Department, the Contractor shall rely on its own resource to project likely experience under the Contract.

19.11 CERTIFICATION (NON-ENCOUNTERS)

The Contractor shall submit non-encounter financial information (sub-capitation payments, rebates, other financial transactions, etc.) requested by the Department at least annually to be used in capitation rate setting. Any payment information from the Contractor that is used for rate setting purposes which has not been submitted through the Encounter Processing System of the Medicaid Enterprise System or any payment related data required by the State shall be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor shall use the *Certification of Data* form (attached), for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

19.12 CCC PLUS DISCRETE INCENTIVE PROGRAM

The CCC Plus Discrete Incentive Transition Program (the program) provides financial rewards for Contractors that successfully transition complex Members residing in a NF to a home and community based setting for a sustained period. Members' ability to receive services in their community offers the potential for improved health status and quality of life at a lower cost. Transitions from a NF or institutional setting to the community can be challenging, particularly for Members doing so following an extended NF stay. For those Members, it is often necessary to research and rebuild a significant number of medical and social supports essential for them to sustain a successful transition to their community. Such transitions require additional effort and resources, and the Department will reward Contractors when these transitions result in better care outcomes and quality of life for Members.

For the purposes of this program, the Department defines a successful transition as the transition of a NF resident that has received NF services for at least one continuous year to a community setting for a period of at least nine consecutive months, during which the Member does not receive more than thirty (30) combined days of care in inpatient hospital and skilled nursing facility settings. The Department plans to begin this program in July Contract year 2019, meaning the first month eligible to qualify as part of the nine consecutive months required for a successful transition would be July Contract year 2019.

19.12.1 Eligible Member Requirements

CCC Plus Members eligible for this program are those Members with:

- 1) Continuous residence in a NF for a period of at least 12 consecutive months;
- 2) Continuous benefit package of indicator of 1 or 2; and
- 3) Continuous enrollment in the Virginia CCC Plus program during the same period.

The Department will send each Contractor a list of its Members who meet these criteria and are thus eligible under the program. The Department will work with Contractors to verify and validate that the identified Members are eligible under the program. The Department will distribute the first lists to the Contractors in May 2019, prior to the beginning of the program in July CY 2019, and continue to distribute such lists three times a year in May, September, and January.

All Member transitions to the community under this program must be voluntary and done with the informed consent of the Member. No requirements of this program shall be interpreted to impinge on a Member's ability to return to a NF setting of care at any time and for any reason should they so choose when such return is consistent with appropriate medical practice.

19.12.2 Successful Transition Requirements

For an eligible Member to be deemed a successful transition under the program, the Member must:

- 1) Transition to a community setting and receive waiver services;
- 2) Maintain their waiver status for at least nine consecutive months; and
- 3) Experience no more than 30 combined days of care in inpatient hospital and skilled nursing facility settings during this nine-month period.

For those individuals included on the list of eligible Members, the Department will track transitions to the community, the duration of the eligible Member's community status, and any instances of care the Member receives in an inpatient hospital or skilled nursing facility setting.

For those eligible Members that register nine months of continuous community status, the Department will notify the Contractor of successful transitions three times a year in August, December, and April. The Department will verify, in consultation with the relevant Contractors, whether an identified Member constitutes a successful transition.

19.12.3 Financial Incentives

Contractors will receive a one-time payment of \$7,500 for each successful transition accomplished under the program. The Department will verify all successful transitions accomplished by Contractors three times annually, making applicable bonus payments to Contractors in October, February, and June of a given year. The Department will distribute the first bonus payments under the program to Contractors in October Contract year 2020. A Contractor may only earn a bonus payment one time for an eligible Member in a three (3)-year period.

19.12.4 Final Determinations

The Department will make all final determinations on what constitutes an eligible Member, successful transition, and proper application of financial incentives earned by the Contractor. The Department will work with Contractors to address any disagreements in determinations on these points, but in the event the Department and the Contractor are unable to come to agreement, Department decisions are final and not subject to appeal.

19.12.5 Compliance Reviews

Department staff or a Department-designated contractor may conduct reviews to ensure that the Contractor provided true and accurate statements regarding the application of this policy. The Department has the authority to perform reviews at any time on the above statements.

19.13 EMERGENCY ROOM UTILIZATION PROGRAM

The Department shall allow for the pending, reviewing and the reducing of fees for avoidable emergency room claims for codes 99282, 99283 and 99284, both physician and facility. The Department shall utilize the avoidable emergency room diagnosis code list currently used for MCO clinical efficiency rate adjustments. If the emergency room claim is identified as a preventable emergency room diagnosis, The Department shall direct the Contractor to default to the payment amount for code 99281, commensurate with the acuity of the visit.

These requirements are contingent on a State Plan Amendment and final budget.

19.14 MEDICAID HOSPITAL READMISSIONS POLICY

Hospital readmissions shall include cases when Members are readmitted to a hospital for the same or a similar diagnosis within thirty (30) days of discharge, excluding planned readmissions,

obstetrical readmissions, admissions to critical access hospitals, or in any case where the Member was originally discharged against medical advice. If the Member is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases shall be paid at fifty (50) percent of the normal rate, except that a readmission within five (5) days of discharge shall be considered a continuation of the same stay and shall not be treated as a new case. Similar diagnoses shall be defined as ICD diagnosis codes possessing the same first three (3) digits.

These requirements are contingent on a State Plan Amendment and final budget.

SECTION 20.0 APPEAL RIGHTS OF THE CONTRACTOR

For violations set forth in 42 CFR § 438.700 (a) the Department may impose the sanctions provided therein.

The Department shall follow the procedures set forth in 42 CFR §§ 438.700 through 724 allowing the Department to impose the sanctions provided therein.

The Contractor shall have all the appeal rights provided for in 42 CFR § 438.710.

20.1 CONTRACTOR RIGHT TO APPEAL

The Contractor shall have the right to appeal any adverse action taken by the Department. The Contractor may not submit to the Department for resolution under this section disputes relating to Medicaid eligibility requirements or covered services.

20.2 DISPUTES ARISING OUT OF THE CONTRACT

As provided for in *Code of Virginia* §2.2-4363, as amended, disputes arising out of this Contract, whether for money or other relief, are to be submitted by the Contractor for consideration by the Department. Disputes must be submitted in writing, with all necessary data and information, to the Contract Administrator or designee.

Disputes will not be considered if submitted later than sixty (60) calendar days after the date on which the Contractor knew of the occurrence giving rise to the dispute or the beginning date of the work upon which the dispute is based, whichever is earlier. Further, no claim may be submitted unless written notice of the Contractor's intention to file the dispute has been submitted at least thirty (30) calendar days prior to a formal filing of the dispute, and such thirty (30) calendar days is to be counted from the date of the occurrence or the beginning date of the work upon which the dispute is based, whichever is earlier.

20.3 RESOLUTION OF CONTRACT DISPUTES

For any dispute arising out of this Contract, except for any dispute resulting from any breach of statute or regulation, the parties shall first attempt to resolve their differences informally.

Should the parties fail to resolve their differences after good-faith efforts to do so, then the parties may proceed with formal avenues for resolution of the dispute.

20.3.1 Escalation Procedures

The following escalation procedures shall be followed with respect to risks and/or issues arising out of this Contract by both parties (the "Escalation Procedures"). Risks and issues shall first be surfaced by the personnel for either party; i.e., by either the Department or the Contractor Account Manager for the Contract (the "First Level of Escalation"). If the applicable risk and/or issue is not resolved at the First Level of Escalation within ten (10) calendar days from the date that the issue or risk is first documented in writing by one party to the other party, either party may escalate the unresolved risk and/or issue to increasingly higher levels of management within each party based on the individuals within the reporting structure for each party described below:

Level of Escalation	DMAS	Health Plan
First	Compliance Officer	Health Plan Account Manager for the Contract
Second	Director of Integrated Care (IC)	Health Plan Chief Executive Officer (CEO) or designee
Third	Agency Director	Health Plan Chief Executive Officer (CEO) or designee

Either party may change the name and/or title of one or more of the Escalation Levels set forth above, where such change shall be effective upon written notice to the other party provided under this Contract.

20.3.2 Dispute Resolution

The Parties will make good faith efforts to first resolve internally any dispute by escalating it to higher levels of management, consistent with the escalation procedure of this Contract.

In accordance with §2.2-4363 of the Code of Virginia, Contractual claims, whether for money or other relief, shall be submitted in writing to the public body from whom the relief is sought no later than sixty (60) days after final payment; however, written notice of the Contractor's intention to file such claim must be given to such public body at the time of the occurrence or beginning of the work upon which the claim is based. Pendency of claims shall not delay payment of amounts agreed due in the final payment. The relevant public body shall render a final decision in writing within thirty (30) days after its receipt of the Contractor's written claim.

The Contractor may not invoke any available administrative procedure under §2.2-4365 of the Code of Virginia nor institute legal action prior to receipt of the decision of the relevant public body on the claim, unless that public body fails to render its decision within thirty (30) days. The decision of the relevant public body shall be final and conclusive unless the Contractor, within six (6) months of the date of the final decision on the claim, invokes appropriate action under §2.2-4364, Code of Virginia or the administrative procedure authorized by §2.2-4365, Code of Virginia.

Upon request from the public body from whom the relief is sought, Contractor agrees to submit any and all contractual disputes arising from this Contract to such public body's alternative dispute resolution (ADR) procedures, if any. Contractor may invoke such public body's ADR procedures, if any, at any time and concurrently with any other statutory remedies prescribed by the Code of Virginia.

In the event of any breach by a public body or a private institution, Contractor's remedies shall be limited to claims for damages and Prompt Payment Act interest and, if available and warranted, equitable relief, all such claims to be processed pursuant to this section. In no event shall

Contractor's remedies include the right to terminate any license or support services hereunder except as is expressly set forth in this Contract.

20.4 PRESENTATION OF DOCUMENTED EVIDENCE

The Contractor is obligated to present to the Department all witnesses, documents, or other evidence necessary to support its claim. Evidence that the Contractor has but fails to present to the Department will be deemed waived and may not be presented to the Circuit Court.

The Contractor shall have the burden of proving to the Department by a preponderance of the evidence that the relief it seeks should be granted.

SECTION 21.0 RENEWAL/TERMINATION OF CONTRACT

21.1 CONTRACT RENEWAL

The initial term of this Contract is August 1, 2017 through December 31, 2017 with automatic renewal thereafter for a period of five (5) fiscal years, with the potential for up to five (5) 12-month extensions. The Contract is automatically renewed annually beginning the first day of each fiscal year. The Contractor may elect not to renew its Contract with the Department at the end of the term of the Contract for any reason, provided it meets the timeframe for doing so set forth in the paragraph below in this section.

The Contractor may opt out of automatic renewal clause if it provides notice to the Department in writing at least six (6) full calendar months prior to the renewal. If the Contractor fails to notify the Department of the non-renewal on or before this date, the Contract will be automatically renewed.

At the Department's sole discretion and for good cause shown, a nonrenewal notice with less than six (6) full calendar months' notice may be accepted from the Contractor. The notice shall include an explanation of the Contractor's grounds for non-renewal and acceptance, if any, must be in writing from the Department. For it to be effective, the Contractor must receive from the Department a written acceptance of a nonrenewal of less than (6) six months.

21.2 SUSPENSION OF CONTRACTOR OPERATIONS

The Department may suspend a Contractor's operations, in whole or in part, if the Department determines that it is in the best interest of CCC Plus Members to do so. The Department may do so by providing the Contractor with written notice. The Contractor shall, immediately upon receipt of such notice, cease providing services for the period specified in such notice, or until further notice.

21.3 TERMS OF CONTRACT TERMINATION

This Contract may be terminated in whole or in part:

1. By the Contractor, for convenience, with not less than one hundred eighty (180) calendar days advance written notice;
2. By the Department, for convenience, with not less than ninety (90) calendar days advance written notice;
3. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
4. By the Department, as specified below, if the Department determines that the instability of the Contractor's financial condition threatens delivery of MLTSS services and continued performance of the Contractor's responsibilities; or
5. By the Department, as specified below, if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

If at any time the CCC Plus contract is terminated by either the Contractor or the Department, the Contractor's D-SNP contract with the Department shall also be terminated.

Each of the conditions for Contract termination is described in the following paragraphs.

21.3.1 Termination for Convenience

The Contractor may terminate this Contract, with or without cause, upon one hundred eighty (180) calendar days advance written notice.

The Department may terminate this Contract, without cause, upon ninety (90) calendar days advance written notice.

21.3.2 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are withdrawn, restricted, limited, or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. Shall the Contractor be unable or unwilling to provide covered services at reduced capitation rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. Determinations by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

21.3.3 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

21.3.4 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as “Termination for Default.”

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract has been terminated, in full or in part, for default. This written notice will identify all of the Contractor’s responsibilities in the case of the termination, including responsibilities related to Member notification, network provider notification, refunds of advance payments, and liability for medical claims.

In the event that the Department determines that the Contractor’s failure to perform its duties and responsibilities under this Contract results in a substantial risk to the health and safety of its Members, the Department may immediately terminate this Contract prior to providing notice to the Contractor.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor’s failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling Contract termination. Nothing herein shall be construed as limiting any other remedies which may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding capitation payments due less any assessed damages.

21.4 TERMINATION PROCEDURES

21.4.1 Continued Obligations of the Parties

In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Virginia Medicaid program, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Member at the time of such termination or withdrawal until the Member has been disenrolled from the Contractor's health plan. DMAS will disenroll the Member by the end of the month that termination, expiration, or non-renewal of this contract is effective.

21.4.2 Continuity of Services

The Contractor recognizes that the services under this contract are vital to DMAS and must be continued without interruption and that, upon contract termination, a successor, either DMAS or another Contractor, may continue them. The Contractor agrees:

1. To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
2. To make all DMAS owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and,
3. That DMAS shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.

The Contractor shall, upon written notice from DMAS, furnish phase-in/phase-out services for up to ninety (90) calendar days after this contract expires and shall negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the DMAS' approval.

The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after Contract termination that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this Contract. All phase-in/phase-out work fees must be approved by the DMAS in writing prior to commencement of said work.

21.4.3 Liability for Medical Claims

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include all of the hospital inpatient claims incurred for Members hospitalized at the time of termination.

21.4.4 Notification of Members

If DMAS elects to terminate or not renew the Contract, DMAS will notify all Members covered under this Contract of the date of termination and the process by which those Members will continue to receive care. In all cases of termination, the Contractor shall be responsible for notifying Members about the termination. All notifications from the health plan must be approved in advance. In cases of termination for default or financial instability, the Contractor shall be responsible for covering the costs associated with such notification. In cases of

termination for convenience, the costs associated with such notification shall be the responsibility of the party which terminated the Contract. In cases of termination due to unavailability of funds or termination in the best interest of the Department, the Department shall be responsible for the costs associated with DMAS issued notifications. The Contractor shall conduct these notification activities within a time frame established by the Department.

21.4.5 Transition of Membership

Upon cancelation of the contract in any region of the Commonwealth, the Department will:

1. Reassign individuals to the remaining health plans in the region if there are at least two (2) health plans still participating;
2. Within the first five (5) years of the CCC Plus Contract, offer participation to a qualifying health plan that responded to the Request for Proposal (RFP).

21.4.6 Notification of Network Providers

In all cases of termination, the Contractor shall be responsible for notifying its network providers about the termination of the Contract and about the reassigning of its Members by the Department to other MCOs and for covering the costs associated with such notification. The Contractor shall conduct these notification activities within a time frame established by the Department.

21.4.7 Other Procedures on Termination

Upon delivery by certified or registered mail to the Contractor of a Notice of Termination specifying the nature of the termination and the date upon which such termination becomes effective, the Contractor shall:

1. Stop work under the Contract on the date specified and to the extent specified in the Notice of Termination;
2. Place no further orders or subcontracts for materials, services, or facilities;
3. Terminate all orders, provider network agreements and subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;
4. Assign to the Department in the manner and to the extent directed all of the rights, titles, and interests of the Contractor under the orders or subcontracts so terminated, in which case the Department shall have the right, at its discretion, to settle or pay any or all claims arising out of the termination of such orders and subcontracts;
5. Within ten (10) business days from the effective date of termination, transfer title to the State (to the extent that the title has not already been transferred) and deliver, in the manner and to the extent directed, all data, other information, and documentation in any form that relates to the work terminated by the Notice of Termination;
6. Complete the performance of such part of the work as has not been specified for termination by the Notice of Termination;
7. Take such action as may be necessary, or as the Department may direct, for the protection and preservation of the property which is in the possession of the Contractor and in which the Department has acquired or may acquire interest; and,
8. Assist the Department in taking the steps necessary to assure an orderly transition of requested services after notice of termination.

The Contractor hereby acknowledges that any failure or unreasonable delay on its part in affecting a smooth transition will cause irreparable injury to the State which may not be adequately compensable in damages. The Contractor agrees that the Department may, in such event, seek and obtain injunctive relief as well as monetary damages. Any payments made by the Department pursuant to this section may also constitute an element of damages in any action in which Contractor fault is alleged.

The Contractor shall proceed immediately with the performance of the above obligations, notwithstanding any delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Upon termination of this Contract in full, the Department shall require the Contractor to return to the Department any property made available for its use during the Contract term.

SECTION 22.0 GENERAL TERMS AND CONDITIONS

22.1 NOTIFICATION OF ADMINISTRATIVE CHANGES

The Contractor shall notify DMAS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor shall notify DMAS in no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Members.

22.2 ASSIGNMENT

The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of DMAS.

22.3 INDEPENDENT CONTRACTORS

The Contractor, its employees, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the Department or its authorized agents.

22.4 BUSINESS TRANSACTION REPORTING

22.4.1 Proposed Acquisition or Purchase/Sale of Virginia Medicaid Health Plan

The Department requires review of any proposed acquisition or purchase of an existing Medicaid health plan. The proposed acquisition must benefit both the Commonwealth and the Department and must assure minimal disruption to Medicaid Members and providers. As part of the review process, the Department requires the Contractor to provide the following within one hundred and eighty (180) days or upon reasonable certainty of, the proposed acquisition date, but in no case less than ninety (90) days of the proposed acquisition taking effect:

- A letter of intent which describes the purpose and manner of the sale, including the acquisition plan, method and terms (e.g. stock or asset transfer);
- A proposed effective date, copies of BOI and VDH approval, and NCQA certification;
- A detailed description of the parent/acquiring company to include health insurance history and experience, Medicaid managed care experience (including state Medicaid recommendations and sanctions, if any);
- A project plan including completion of any network development, information technology changes and requirements, and communications;
- An organizational chart indicating the retention of current and key personnel, as well as any staff changes;
- A list of the acquisition/implementation team at the MCO with their title and role on the team including a project lead;
- Profit and enrollment projections;
- Any additional information requested by the Department, including Acquisition/Purchase Requirements as outlined in the *CCC Plus Technical Manual*.

The Department will send a notice to Members at the Contractor's expense notifying them of changes and shall review all Member and provider correspondence relating to the merger/acquisition prior to its disbursement by the Contractor.

The Department will review and respond to the Contractor regarding the Notification and submission of the acquisition/purchase requirements. An acquisition or purchase/sale may require a Contract amendment.

The Department may consider waiving specific requested requirements upon written request from the Contractor.

Pursuant to 42 CFR § 438.66(d) the Department reserves the right to conduct a readiness review upon receipt of change of ownership notification when deemed necessary.

22.5 LOSS OF LICENSURE

If, at any time during the term of this Contract, the Contractor or any of its Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary Federal or State approvals, the Contractor shall report such loss to DMAS. Such loss may be grounds for termination of this Contract.

22.6 INDEMNIFICATION

The Contractor shall indemnify and hold harmless the Commonwealth of Virginia, and DMAS from and against any and all liability, loss, damage, costs, or expenses which DMAS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its subcontractors provided that:

1. The Contractor is notified of any claims within a reasonable time from when CMS and DMAS become aware of the claim; and,
2. The Contractor is afforded an opportunity to participate in the defense of such claims.

22.7 CONFLICT OF INTEREST

For the duration of this Contract, neither the Contractor nor its subcontractors may have any interest that will conflict, as determined by DMAS with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, DMAS requires that neither the Contractor nor its subcontractor have any financial, legal, contractual, or other business interest in any entity performing CCC Plus program enrollment functions for DMAS or Related Entity(ies), if any.

22.8 INSURANCE FOR CONTRACTOR'S EMPLOYEES

The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide DMAS with certification of same upon request. The Contractor, and its professional personnel providing services to Members, shall obtain and maintain appropriate professional liability insurance coverage. The Contractor shall, at the request of DMAS, provide certification of professional liability insurance coverage.

22.9 IMMIGRATION AND CONTROL ACT OF 1986

By signing this Contract the Contractor certifies that they do not and shall not during the performance of this Contract employ illegal alien workers or otherwise violate the provisions of the Federal Immigration Reform and Control Act of 1986.

22.10 SEVERABILITY

Invalidity of any term of this Contract, in whole or in part, shall not affect the validity of any other term. The Department and the Contractor further agree that in the event any provision is deemed invalid, they shall immediately begin negotiations for a suitable replacement provision.

22.11 ANTI-BOYCOTT COVENANT

During the time this Contract is in effect, neither the Contractor nor any affiliated company shall participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by the *Code of Virginia* § 38.2-505 . Without limiting such other rights as it may have, DMAS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one (51) percent of the ownership interests of the Contractor.

22.12 RECORD RETENTION, INSPECTION, AND AUDITS

Consistent with Federal managed care regulations at 42 CFR 438.3(u), the Contractor shall maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years.

In accordance with 12VAC30-120-1730, for Members who are children under age 21 and enrolled in the Tech program, the Contractor shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age.

Consistent with Federal managed care regulations 42 CFR § 438.3(h), the Contractor shall make the records maintained by the Contractor and its Provider Network, as required by the Department and other regulatory agencies, available to the Department and its agents, designees or contractors or any other authorized representatives of the Commonwealth of Virginia or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its subcontractors that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or, determinations of amounts payable.

The Contractor shall make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Members, and any additional

relevant information that the Department may require, in a manner that meets the Department's record maintenance requirements.

The Contractor shall comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with Federal and State requirements.

22.13 OPERATION OF OTHER CONTRACTS

Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder. However, the Contractor shall provide the Department with a complete list of such plans and services, upon request. The Department will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law.

Nothing in this Contract may be construed to prevent DMAS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

22.14 PREVAILING CONTRACT

This Contract supersedes all prior agreements, representations, negotiations, and undertakings not set forth in the Contract or incorporated herein. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

22.15 NO THIRD-PARTY RIGHTS OR ENFORCEMENT

No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

22.16 EFFECT OF INVALIDITY OF CLAUSES

If any clause or provision of this Contract is in conflict with any Federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

22.17 APPLICABLE LAW

The term "applicable law," as used in this Contract, means, without limitation, all Federal and State law, and the regulations, policies, procedures, and instructions of CMS and DMAS all as existing now or during the term of this Contract.

22.18 SOVEREIGN IMMUNITY

Nothing in this Contract will be construed to be a waiver by the Commonwealth of Virginia of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

22.19 WAIVER OF RIGHTS

The Contractor or DMAS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor or DMAS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of

any right or remedy on any future occasion. The acceptance or approval by the Department of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

22.20 INSPECTION

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the Federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

22.21 DEBARMENT STATUS

By signing this Contract the Contractor certifies that they are not currently debarred by the Commonwealth of Virginia or any other Federal, State or local government from entering into contracts for the type of services covered herein, nor are they an agent of any person or entity that is currently so debarred.

22.22 ANTITRUST

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said Contract.

22.23 DRUG-FREE WORKPLACE

For the purposes of this section, “drug-free workplace” means a site for the performance of work done in connection with this Contract, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the Contract. During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor’s employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Business Associate maintains a drug-free workplace; and, (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that the provisions will be binding upon each subcontractor or Vendor.

22.24 COVID-19

The Contractor will work with the Department on COVID-19 activities for Members and providers in accordance with MCO Guidance dated March 19, 2020 issued by the Department, as referenced in Attachment 20 of this Contract, and any subsequent COVID-19 response memorandum issued by the Department.

SECTION 23.0 DEFINITIONS AND ACRONYMS

Listed below are the Definitions and Acronyms used in this CCC Plus Contract. These terms utilize the meaning used in the CCC Plus program rules and regulations. However, the following terms, when used in this Contract, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other sections of this Contract, the specific language in the Contract shall govern.

23.1 DEFINITIONS

Abuse – Either: (1) Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid program; or, (2) the suspected or known physical or mental mistreatment of a Member which must be reported immediately upon discovery.

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

Activities of Daily Living (ADLs) - Personal care tasks such as bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining the appropriate level of care and service needs. Also see Instrumental Activities of Daily Living (IADLs).

Acute Care - Preventive care, primary care, and other inpatient and outpatient medical care and behavioral health care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital – Includes an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

Addiction and Recovery Treatment Services (ARTS) – A comprehensive continuum of addiction and recovery treatment services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. This includes: (i) inpatient services to include withdrawal management services; (ii) residential treatment services; (iii) partial hospitalization; (iv) intensive outpatient treatment; (v) outpatient treatment including Medication Assisted Treatment (MAT); (vi) substance use case management; (vii) opioid use treatment service and (viii) peer recovery support services. Providers will be credentialed and trained to deliver these services consistent with ASAM's published criteria and the Department's medical necessity criteria using evidence-based best practices including Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

Adjudicated Claim – A clean claim that has been paid in full, denied in full or denied in part by the Contractor or its subcontractors. Clean claims are considered to be paid on the date the payment is made via EFT or the date the check has been postmarked. Pended clean claims shall not be considered adjudicated.

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

Administrative Dismissal – means:

- 1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
- 2) A Member appeal dismissal made on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the Contractor.

Adult Day Health Care (ADHC) – Long term maintenance or supportive services offered by a community-based day program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those individuals enrolled in the CCC Plus Waiver who are older adults or who have a disability and who are at risk of placement in a Nursing Facility (NF). The program shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC). The services offered by the ADCC shall be required by the individual receiving the CCC Plus Waiver in order to permit the individual to remain in his/her home rather than entering a NF.

Adverse Action – means, for providers that have already rendered a service, a denial in whole or in part, of a service authorization; or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – For Members, pursuant to 42 CFR § 438.400, means any of the following: (i) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner, as defined by the State; (v) the failure of the Contractor to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (vi) for a resident of a rural area with only one MCO, the denial of a Member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Agency-Directed Services - A model of service delivery where an agency is responsible for providing direct support staff, for maintaining individuals' records, and for scheduling the dates and times of the direct support staff's presence in the individuals' homes.

Agency Provider - A public or private organization or entity that holds a Medicaid provider agreement and furnishes services to individuals using its own employees or subcontractors.

Alzheimer's Assisted Living (AAL) Waiver – A former CMS-approved home and community-based services (HCBS) waiver that covered a range of community support services offered to individuals who have a diagnosis of Alzheimer's or related dementia (without a diagnosis of intellectual disability or serious mental illness), are over age 55, who meet Nursing Facility level of care, and were receiving an Auxiliary Grant. The AAL waiver was discontinued on June 30, 2018. At that time, individuals who were enrolled in the AAL Waiver may have become enrolled in the CCC Plus program if they met the eligibility requirements of the program.

Appeal – means:

- 1) For Members, in accordance with 42 C.F.R. § 438.400, a Member appeal is defined as a request to DMAS for a State fair hearing of a Contractor's internal appeal decision to uphold the Contractor's adverse benefit determination. After a Member exhausts the Contractor's one-step internal appeal process, the Member may appeal to DMAS. Member appeals to DMAS shall be conducted in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
- 2) For providers, a provider appeal is a request made by a provider (in-network or out-of-network) to review the Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the Contractor's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) with DMAS in accordance with the Virginia Administrative Process Act, Code of Virginia § 2.2-4000 *et seq.*, and Virginia Medicaid's provider appeal regulations, 12 VAC 30-20-500 *et seq.*

Assess - To evaluate an individual's condition, including social supports, health status, functional status, psychosocial history, and environment. Information is collected from the individual, family, significant others, and medical professionals, as well as the assessor's observation of the individual.

Assessment - Processes used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status, and other factors to determine which services, if any, should be authorized and provided. Assessment information supports the development of the person-centered Individualized Care Plan (ICP) and the determination of whether an individual requires HCBS waiver services.

Assistive Technology - Specialized medical equipment and supplies including those devices, controls, or appliances specified in the ICP, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform ADLs/IADLs and/or to perceive, control, or communicate with the environment in which they live or that are necessary for the proper functioning of the specialized equipment and are cost-effective and appropriate for the individual's assessed medical needs and deficits.

Attendant - An individual who provides consumer-directed personal assistance, respite or companion services through a consumer-directed model.

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

Authorized Representative - A person who is authorized to conduct the personal or financial affairs for an individual who is eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

Behavioral Health Home – A team based services delivery model that provides comprehensive and continuous care to patients, including care coordination, with the goal of maximizing health outcomes. For this Contract, Health Homes will not need to meet the standards set forth in §2703 of the Patient Protection and Affordable Care Act.

Behavioral Health Inpatient Services – Acute psychiatric services provided to Members in a secured facility setting.

Behavioral Health Outpatient Services – Non-acute psychiatric services that are provided to Members in a variety of non-facility based settings including community settings.

Behavioral Health Services - An array of therapeutic services provided in inpatient and outpatient psychiatric and community mental health settings. Services are designed to provide necessary support and address mental health and behavioral needs in order to diagnose, prevent, correct, or minimize the adverse effect of a psychiatric or substance use disorder.

Behavioral Health Services Administrator (BHSA) - An entity that is contracted to manage or direct a behavioral health benefits program. The BHSA is currently responsible for administering the Department’s behavioral health benefits for Medicaid recipients enrolled in Fee for Service and for Residential Treatment Services and Treatment Foster Care Case Management described in the Summary of Covered Service chart in Attachment 5, Part 2B for CCC Plus Members, including care coordination, provider management, and reimbursement of such behavioral health services.

Birth Injury Fund - Virginia Birth-Related Neurological Injury Compensation Fund is commonly known as the Birth Injury Fund. More information can be found at: <https://www.vabirthinjury.com/why-the-birth-injury-program>.

Building Independence (BI) Waiver – The CMS-approved HCBS § 1915 (c) waiver whose purpose is to provide support in the community for individuals 18 years of age or older who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by DMAS and DBHDS.

Business Associate – Any entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for or provide medical services, or to enhance the Department’s capability for effective administration of the program. A Business Associate includes, but is not limited to, those applicable parties referenced in 45 CFR §160.103.

Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Time, except for State holidays and unless otherwise stated.

Capitation Payment - A payment the Department makes periodically to the Contractor on behalf of each Member enrolled under the Contract for the provision of services under the State Plan or waivers regardless of whether the Member receives services during the period covered by the payment. Any and all costs incurred by the Contractor in excess of the capitation payment shall be borne in full by the Contractor.

Capitation Rate – The monthly amount, payable to the Contractor, per Member, for the provision of contract services as defined herein. The Contractor shall accept the annually established capitation rates paid each month by the Department as payment in full for all Medicaid services to be provided pursuant to the Contract and all administrative costs associated therewith, pending final recoupment, reconciliation, sanctions, or payment of quality withhold amounts.

Caregiver - A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends, or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

Care Coordination (also known as Care Management) – The Contractor’s responsibility of assessing and planning of services; linking the Member to services and supports identified in the individualized care plan (ICP); assisting the Member directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services and service planning with other agencies, providers and family individuals involved with the Member; making collateral contacts to promote the implementation of the ICP and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and training, education, and counseling that guides the Member and develops a supportive relationship that promotes the ICP (also see *Targeted Case Management*).

Carved-Out Services - The subset of Medicaid covered services for which the Contractor shall not be responsible under the CCC Plus program.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency of the United States Department of Health and Human Services that is responsible for the administration of Titles XVIII, XIX, and Title XXI of the Social Security Act.

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

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

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

Clinical Laboratory Improvement Amendments (CLIA) – A laboratory testing program regulated by the Centers for Medicare & Medicaid Services and implemented by the Division of Laboratory Services under the Center for Clinical Standards and Quality. CLIA covers approximately 254,000 laboratory entities. CLIA defines a clinical laboratory as any facility which performs laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention, or treatment of disease or impairment.

Cold Call Marketing – Any unsolicited personal contact by the Contractor with a potential Member for the purpose marketing.

Common Core –Refers to the subset of the Contractor’s formulary that includes all the preferred drugs from the Department’s Preferred Drug List (PDL).

Commonwealth Coordinated Care (CCC) Program – The Department’s capitated, managed care, financial alignment demonstration model, administered under the Center for Medicare & Medicaid Innovation authority. Virginia operates the CCC program with CMS under a Memorandum of Understanding (MOU) and a three-way contract between DMAS, CMS and contracted Medicare-Medicaid Plans (MMPs). The CCC program ended on December 31, 2017.

Commonwealth Coordinated Care Plus (CCC Plus) Program – The Department’s mandatory integrated care initiative for certain qualifying individuals, including dual eligible individuals and individuals receiving long term services or supports (LTSS). The CCC Plus program includes individuals who receive services through Nursing Facility (NF) care, or from the Department’s home and community-based services (HCBS) 1915(c) waivers.

Commonwealth Coordinated Care Plus (CCC Plus) Waiver – The Department’s Home and Community Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care. Individuals in this waiver are eligible to participate in the CCC Plus program.

Community-Based Organizations (CBOs) – Organizations such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) that have historically formed the backbone of the HCBS delivery system for seniors and adults with physical disabilities. CBOs provide long-term services and supports (LTSS), care planning, and care coordination using a variety of funding sources including Federal funds and State appropriations, and frequently local funds.

Community-Based Team (or CBT): Community based screening team. A nurse, social worker or other assessors designated by DMAS and a physician who are employees of, or contracted with, VDH or the LDSS. CBTs conduct screenings for adults and children who live in the community and are not currently inpatients.

Community Living (CL) Waiver – The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to 6 years of age who are at developmental risk and individuals age 6 and older who have Developmental Disability (DD) and meet the ICF/IID level of care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver.

Community Service Board (CSB)/Behavioral Health Authority (BHA) - A citizens' board established pursuant to Virginia Code §37.2-500 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-500>) and §37.2-600 (<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-600>) that provides mental health, developmental disability and substance use disorder programs and services within the political subdivision or political subdivisions participating on the board. In all cases, the term CSB also includes Behavioral Health Authority (BHA).

Complaint - means an expression of provider dissatisfaction about any matter other than an “adverse action.” Possible subjects for complaints include, but are not limited to, claims or service authorization processing time, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Contractor staff or employee, or failure to respect the Member’s grievance.

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

Consumer-Directed (CD) Employee/Attendant - A person who is employed by a CCC Plus Waiver individual who is receiving services through the consumer-directed model or their representative to provide approved personal care, companion services, or respite care, or any combination of these three services, and who is exempt in Virginia from Workers’ Compensation.

Consumer-Directed (CD) Services – HCBS (personal care and respite services) for which the CCC Plus Waiver individual or his or her representative, as appropriate, is responsible for directing their own care and hiring, training, supervising, and firing of staff.

Consumer-Directed (CD) Services Facilitator (SF) - The Medicaid enrolled provider who is responsible for supporting the CCC Plus Waiver Member or his or her representative, as appropriate, by ensuring the development and monitoring of the ICP, providing attendant management training, and completing ongoing review activities as required by DMAS for CCC Plus Waiver Members who are consumer-directing personal care and respite services.

Contract - This signed and executed CCC Plus program document resulting from the RFP, issued and awarded, including all attachments or documents incorporated by reference.

Contract Amendment or Contract Modification – Any changes, modifications or amendments to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.

Contractor - A managed care health plan selected by the Department and contracted by execution of this Contract to participate in the CCC Plus program in accordance with the RFP award.

Cost Sharing – Coinsurance and deductibles. Also see definition for “Patient Pay.”

Covered Services – Services as outlined in this Contract that the Contractor shall cover for its enrolled Members.

Cover Virginia – Virginia’s telephonic customer service center and online portal providing statewide eligibility information and assistance for Medicaid FAMIS, newborns, Department of Corrections, Plan First, Fee-for-service, and other insurance options. Cover Virginia’s website www.coverva.org provides easy access to information about Virginia’s FAMIS and Medicaid programs, including eligibility and how to apply. Staff at the Cover Virginia statewide customer service center at 1-855-242-8282 provide confidential application assistance and program information. Individuals can apply, report changes or renew an individual’s coverage by calling Cover Virginia.

Credentialing - The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver covered services.

Critical Incident - A critical incident is any incident that threatens or impacts the well-being of the Member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member.

Crisis Intervention Services – Immediate mental health care, available 24 hours per day, seven (7) days per week, to assist Members who are experiencing acute psychiatric dysfunction requiring immediate clinical attention.

Crisis Stabilization Services – Direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current

community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize Members in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

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

Days – Business days, unless otherwise specified.

Day Support Services - Training, assistance, and specialized supervision in the acquisition, retention, or improvement of self-help, socialization, and adaptive skills, which typically take place outside the home in which the individual resides. Day support services shall focus on enabling the individual to attain or maintain his maximum functional level. This is different from Adult Day Health Care (ADHC).

Day Treatment/Partial Hospitalization – Time limited interventions that are more intensive than outpatient services and are required to stabilize a Member's psychiatric condition. The services are delivered when a Member is at risk of psychiatric hospitalization or is transitioning from a psychiatric hospitalization to the community. Services consist of diagnostic, medical, psychiatric, psychosocial, and psycho-educational treatment modalities designed for Members with serious mental health disorders.

Default Enrollment- An enrollment process that permits automatic enrollment of a dually-eligible beneficiary in a Medicaid Managed Care Organization into a D-SNP offered under the same Medicare Advantage Organization, under certain circumstances, when the beneficiary is first eligible for Medicare.

Department of Behavioral Health and Developmental Services (DBHDS) – DBHDS is the state agency responsible for coordination of behavioral health, developmental disabilities, and substance use services through the local community services boards (CSBs). This agency has responsibility for the day-to-day operations of the Community Living Waiver, Family and Individual Supports Waiver, and the Building Independence Waiver. DBHDS also serves as the state Lead Agency for Virginia’s early intervention system and is responsible for certification of early intervention providers and service coordinators/case managers.

Department of Health Professions (DHP) – Agency that issues licenses, registrations, certifications, and permits to healthcare practitioner applicants that meet qualifications established by law and regulation. In addition to the Board of Health Professions, the following applicable boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Long-Term Care

Administrators, Board of Medicine, Board of Nursing, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, and Board of Social Work.

Department of Medical Assistance Services (DMAS or Department) – The single State Agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the Children’s Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act.

Developmental Disability (DD) Waivers – The CMS-approved HCBS §1915(c) waivers for individuals with developmental disabilities. The individuals are enrolled in either the Building Independence (BI), Community Living (CL), or the Family and Individual Supports (FIS) Waivers.

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

Disenrollment - The process of changing enrollment from one Contractor to another. This term does not refer to termination of eligibility in a Medicaid program.

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

Dual Eligible Individuals – A Medicare beneficiary who receives Medicare Part A, B, and/or D benefits and who also receives full Medicaid benefits. Individuals who receive both Medicare and Medicaid coverage but who are NOT eligible for full Medicaid benefits (e.g., individuals who qualify as Specified Low-Income Medicare Member (SLMBs), Qualified Medicare Member (QMBs), Qualified Disabled and Working Individuals (QDWIs), or Qualifying Individuals (QIs)) are not included in the CCC Plus program.

Dual Eligible Special Needs Plan (D-SNP) - A type of Medicare Advantage (MA) plan that enrolls only dual eligible individuals in Medicare and Medicaid.

Durable Medical Equipment (DME) - Medical equipment, supplies, and appliances consistent with 42 CFR § 440.70(b)(3) and prescribed by the attending physician, generally recognized by the medical community as serving a diagnostic or therapeutic purpose to assist the waiver individual in the completion of everyday activities, and as being a medically necessary element of the service plan without regard to whether those items are covered by the State Plan for Medical Assistance.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under 21 years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same

service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

Early Intervention (EI) - Early Intervention (EI) services are provided through Part C Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth to age three years who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Early intervention services provided in the child's natural environment to the maximum extent appropriate. EI services are covered by this Contract.

Early Intervention Assistive Technology Services - Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

Early Intervention Individualized Family Service Plan (IFSP) - A written plan developed by the Member's interdisciplinary team for providing early intervention supports and services to eligible children and families that: 1) Is based on evaluation for eligibility determination and assessment for service planning; 2) Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and 3) Is implemented as soon as possible once parental consent is obtained.

Electronic Visit Verification (EVV) - Verifies visit activity for in-home and in-community care services delivered and offers a measure of accountability to ensure that individuals receive the care and services they need and are authorized to receive.

Emergency Custody Order (ECO) – Judicial intervention to order law enforcement personnel to take into custody and transport for needed mental health evaluation and care or medical evaluation and care a person who is unwilling or unable to volunteer for such care pursuant to 42 CFR § 441.150 and *Code of Virginia*, § 16.1- 335 et seq, § 37.2-808, § 16.1-340 (Juvenile), § 37.2-1103 (Medical), and § 16-1.340 (Court). A magistrate is authorized to order such custody on an emergency basis for short periods. Different emergency custody statutes apply to adults than to juveniles.

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

Emergency Services - Those health care services that are rendered by participating or non-participating providers qualified to furnish these services, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the Member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior, and these services are needed to evaluate or stabilize an emergency medical condition pursuant to 42 CFR § 438.114.

Emerging Vulnerable Subpopulation– Includes Members identified in items a-m in Section 5.1.1, *CCC Plus Vulnerable and Emerging Vulnerable Populations* of this Contract, who have well managed complex medical needs and do not meet the criteria for the CCC Plus waiver, NF, or other high need subpopulations. These Members could be enrolled in one of the DD waivers unless they meet high risk criteria per Section 5.3.4.3, *Initial HRAs for High Risk Populations*.

Employer of Record (EOR) - The individual who directs their own care and receives consumer-directed services from a CD attendant who is hired, trained, and supervised by the individual or the individual's representative.

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

Encounter Data – Data collected by the Contractor that documents all of the health care and related services provided to a Member. These services include, but are not limited to, professional services, medical supplies or equipment, and medications. Encounter data is collected on an individual Member level and includes the person's Medicaid ID number. It is also specific in terms of the provider, the medical procedure, and the date the service was provided. DMAS and the Federal government require plans to collect and report this data. Encounter data is a critical element of measuring managed care plan's performance and holding them accountable to specific standards for health care quality, access, and administrative procedures.

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

Enhanced Benefits - Benefits that the Contractor may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor's capitation rate.

Enrollment (CCC Plus Program) - Assignment of an individual to a health plan by the Department in accordance with the terms of this Contract. This does not include attaining eligibility for the Medicaid program.

Enrollment (Waiver) - The process whereby an individual has been determined to meet the eligibility requirements (financial and functional and medical/nursing) for a service and the approving entity has verified the availability of services for that individual. It is used to define

the entry of an individual into a HCBS waiver, effective the first day a waiver service is rendered. This does not include attaining eligibility for the Medicaid program.

Enrollment Broker - An independent entity that is the beneficiary support system used to enroll individuals in the Contractor's health plan and is responsible for the operation and documentation of a toll-free helpline. The responsibilities of the Enrollment Broker include, but are not limited to, education and enrollment, assistance with and tracking of individuals' grievance resolutions, and may include marketing and outreach.

Enrollment Period – The period of time that a Member is enrolled with a health plan.

Electronic Pre-Admission Screening (ePAS) – DMAS web portal that streamlines submission and payment for screening activities. The ePAS system has the capacity to upload fillable UAI and other screening forms. Screening teams may access ePAS via the Internet and enter the information directly into the system while the screening is being conducted. Reference the DMAS Screening Manual for Medicaid Funded Long-Term Services and Supports (LTSS) available on the Virginia Medicaid Web Portal at: <https://www.virginiamedicaid.dmas.virginia.gov>.

Excluded Entity – Any provider or subcontractor that is excluded from participating in the Contractor's health plan as defined by Federal requirements set forth in 42 CFR § 438.610.

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

External Appeal - An appeal, subsequent to the Contractor's appeal decision, to the State Fair Hearing process for Medicaid-based adverse decisions.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354 and performs external quality review, and other EQR related activities as set forth in 42 CFR§ 438.358.

Family and Individual Supports (FIS) Waiver – The CMS-approved home and community-based §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to 6 years of age who are at developmental risk and individuals age 6 and older who have a Developmental Disability (DD) and meet the ICF/IID level of care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs.

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

Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 CFR § 405.2401(b), as amended.

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

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

First Tier, Down Stream, and Related Entities - Any party that enters into a written arrangement, acceptable to DMAS, with the Contractor to provide administrative services or health care services to a CCC Plus program Member; or any party that enters into a written arrangement, acceptable to DMAS, with persons or entities involved with providing CCC Plus benefits, below the level of a first tier entity; or, a related entity by ownership and control. A sub-contractor relationship or related entity that could impact the Contractor’s ability to comply with the requirements of this Contract.

Fiscal/Employer Agent (F/EA) - An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 that has a separate Federal Employer Identification Number used for the sole purpose of filing Federal employment tax forms and payments on behalf of program individuals who are receiving CD services.

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

Formal Support – Services provided by professional, trained employees, typically paid for their work, such as the personal care attendant who helps with bathing.

Formulary – A list of drugs that the Contractor has approved. Dispensing some of the drugs may require a service authorization for reimbursement.

Former Foster Care and Fostering Futures – For the purposes of this Contract, these individuals are enrolled in Aid Category 70. Depending on which group (Title IV-E or Non IV-E), their eligibility ranges from age 18 to 26. These individuals were formerly covered under a Foster Care designation. Refer to Section 3.2.7, *Enrollment Process for Foster Care and Adoption Assistance Children*.

Foster Care - Pursuant to 45 CFR §1355.20, a “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility.” Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The Federal definition is predicated upon the child being placed outside of the home and with an individual who has “placement and care” responsibility for the child. The term “placement and care” means that Local Department of Social Services (LDSS) is legally accountable for the day-to-day care and protection of the child

through either a court order or a voluntary placement agreement. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the Federal government considers the child to be in foster care.

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

Grievance - In accordance with 42 CFR § 438.400, a grievance means an expression of dissatisfaction about any matter other than an “adverse action” or “adverse benefit determination.” Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member’s rights.

Healthcare Effectiveness Data and Information Set (HEDIS) – A tool developed and maintained by the National Committee for Quality Assurance (NCQA) that is used to measure performance on dimensions of care and service in order to maintain and/or improve quality.

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

Health Risk Assessment - A comprehensive assessment of a Member’s medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, long-term services and supports (LTSS), and social needs.

High Risk Population – A Member is considered high risk if at least one of the following applies: 1) he or she is homeless; 2) has had a combination of five (5) or more ED visits or hospitalizations related to their chronic medical, physical, and/or behavioral health condition in the past ninety (90) calendar days; 3) for Members 18 (eighteen) years of age or older, has had three (3) or more falls resulting in an ED visit, hospitalization, or physician office visit within the past ninety (90) calendar days; 4) or is covered under the CCC Plus Waiver with Technology Assistance (Indicator A) waiver or Private Duty Nursing covered through EPSDT.

Home and Community-Based Services (HCBS) Waivers - A variety of home and community-based services authorized under a §1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be authorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutional (Nursing Facility) placement. The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid program. States can offer a variety of services under a HCBS waiver. Waivers can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of

services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

Homeless – In accordance with 42 U.S.C., 254b, a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Hospice – As defined § 32.1-162.1 of the *Code of Virginia*, a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. Children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services. A hospice utilizes a medically directed interdisciplinary team. A hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care shall be available twenty-four (24) hours a day, seven (7) days a week.

Hospital Team – Hospital screening team. Persons designated by an acute care hospital, rehabilitation hospital, or a rehabilitation unit in an acute care hospital who are responsible for conducting and submitting the screening for individuals that are inpatients to DMAS' automated system (electronic Pre-Admission Screening; ePAS) or other approved system. Hospital teams conduct screening for adults and children who are inpatients.

Indian – An individual, defined at Title 25 of the U.S.C. Sections 1603(c), 1603(f), 1679(b) who has been determined eligible, as an Indian, pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services. Also refer to definition of Native American

Indian Health Care Provider (IHCP) –A health care program, including providers of contract health services (CHS), operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603. Also refer to definition of Native American.

Individualized (Person-Centered) Care Plan (ICP) – The Contractor's comprehensive written document developed with a Member that specifies the Member's services and supports (both formal and informal). The ICP is developed through a person-centered planning process that incorporates the Member's strengths, skills, needs, preferences, and goals. The ICP includes all aspects of an individual's care needs including, but not limited to, medical, behavioral, social, and long term services and supports, as appropriate.

Individualized Education Program (IEP) – A written statement for a child receiving special education services that is developed, reviewed and revised in a team meeting in accordance with 34 CFR § 300.22. The IEP specifies the individual educational needs of the child and what special education and related services are necessary to meet the child’s educational needs.

Informal Support – The support provided by a Member’s social network and community, such as family, friends, faith-based organizations, etc., and is typically unpaid.

Infant and Toddler Online Tracking System (ITOTS) – Data system that collects early intervention eligibility information from the 40 local lead agencies; meets Section 618 Federal reporting requirements for Part C of the Individuals with Disabilities Education Act (IDEA).

Institution for Mental Disease (IMD) - A hospital, Nursing Facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, and whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental disease. An IMD may be private or state-run. A State Institution for Mental Disease or State Mental Hospital is a hospital, psychiatric institute, or other institution operated by the DBHDS that provides care and treatment for persons with mental illness.

Instrumental Activities of Daily Living (IADLs) - Activities such as meal preparation, shopping, housekeeping, laundry, and money management. The extent to which an individual requires assistance in performing these activities is assessed in conjunction with the evaluation of level of care and service needs. Also see Activities of Daily Living (ADLs).

Intensive Community Treatment Services – An array of mental health services for Members with significant mental illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Services are designed to be provided through a designated multi-disciplinary team of mental health professionals. Services are available either directly or on call 24 hours per day, seven days per week and 365 days per year.

Intensive In-Home Services (IIH) for Children/Adolescents Under Age 21 – Time-limited interventions provided in the Member's residence and when clinically necessary in community settings. IIH services are designed to specifically improve family dynamics, provide modeling, and the clinically necessary interventions that increase functional and therapeutic interpersonal relations between family members in the home. IIH services are designed to promote psychoeducational benefits in the home setting of a Member who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the Member.

Intensive Outpatient (IOP) Substance Use Disorder Services – Services shall include the major psychiatric, psychological and psycho-educational modalities: individual and group counseling; family therapy; education about the effects of alcohol and other drugs on the

physical, emotional, and social functioning of the Member; relapse prevention; occupational and recreational therapy, or other therapies. Intensive outpatient services for Members are provided in a non-residential setting.

Interdisciplinary Care Team (ICT) - A team of professionals that collaborate, either in person or through other means, to develop and implement a person-centered Individualized Care Plan (ICP) built on the individual's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity and meets the medical, behavioral, LTSS, early intervention, and social needs of Members. ICTs include the MCO Care Coordinator and may include physicians, physician assistants, LTSS providers, nurses, specialists, pharmacists, behavior health specialists, early intervention Care Coordinators/providers, social workers and other appropriate entities for the individual's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

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

Internal Appeal – means a request to the Contractor by a Member, a Member's authorized representative or provider, acting on behalf of the Member and with the Member's written consent, for review of a Contractor's adverse benefit determination as defined in this Contract. The internal appeal is the only level of appeal with the Contractor and must be exhausted by a Member or deemed exhausted according to 42 CFR § 438.408(c)(3) before the Member may initiate a State fair hearing.

Investigation – As used in this Contract related to program integrity activities, an investigation is a review of the documentation of a billed claim or other attestation by a provider to assess appropriateness or compliance with contractual requirements. Most investigations involve the review of medical records to determine if the service was correctly documented and appropriately billed. The Department reserves the right to expand upon any investigation.

Laboratory - A place performing tests for the purpose of providing information for the diagnosis, prevention, or treatment of disease or impairment, or the assessment of the health of human beings, and which meets the requirements of 42 CFR § 493.3, as amended.

Level of Care (LOC) – The specification of the minimum amount of assistance that an individual requires in order to receive services in a community or institutional setting under the State Plan for Medical Assistance or to receive CCC Plus Waiver services.

Level of Care Review – The periodic, but at least annual, review of a Member's condition and service needs to determine whether the Member continues to need a level of care specified by a waiver. Also referred to as Level of Care Review Instrument (LOCERI). Also see the definition

for nursing facility annual reassessment. For more information about LOCERI, including the Level of Care User Guide and Tutorial, is available on the Virginia Medicaid Web Portal, Provider Resources tab, at: <https://www.virginiamedicaid.dmas.virginia.gov>.

List of Excluded Individuals and Entities (LEIE) - When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs, information about the provider is entered into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Local Lead Agency - An entity that, under contract with the DBHDS, administers a local early intervention system. The DBHDS contracts with forty (40) local lead agencies to facilitate implementation of local early intervention services statewide.

Long Distance Trip – A trip at least 21 miles or greater from the point of pick up.

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

Long Term Acute Care Hospitals (LTAC) – A Medicare facility designation as determined by the U.S. Secretary of Health and Human Services that specializes in treating patients with serious and often complex medical conditions. DMAS recognizes these facilities as acute care facilities and are covered under this Contract.

Long Term Services and Supports (LTSS) – Includes hospice, nursing facility, and CCC Plus Waiver covered services.

Low Risk Population – A Member is considered low risk if he or she is Aged, Blind, or Disabled, is not in a Medicaid expansion aid category, and does not meet the moderate or high risk category.

Managed Care Plan or Managed Care Organization (MCO) – An organization which offers managed care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in Va. Code § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined

in Va. Code § 38.2-3407 or preferred provider subscription contracts as defined in Va. Code § 38.2-4209 shall be deemed to be offering one or more MCHIPs. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks. Additionally, for the purposes of this Contract, and in accordance with 42 CFR § 438.2, an entity that has qualified to provide the services covered under this Contract to qualifying Members must be as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other individuals within the area served, and meets the solvency standards of 42 CFR § 438.116.

Managed Long Term Services and Supports (MLTSS) Manuals – Documents developed by the Department that provide the specifications for the submission of provider networks, encounters, and other contract deliverables, including monthly, quarterly, annual, and other required reports. In addition, the Manuals provide information on enrollment files, payment files, and DMAS-generated files.

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

Marketing – In accordance with 42 CFR § 438.104 means any communication, from an MCO to a Medicaid Member who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the Member to enroll in that particular MCO's Medicaid product, or either to not enroll in or to disenroll from another MCO's Medicaid product.

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

Marketing, Outreach, and Member Communications – Any informational materials targeted to Members that are consistent with the definition of marketing materials at 42 CFR § 438.104.

Medallion – (aka, Medallion 3.0, Medallion 4.0) - The Department's statewide mandatory Medicaid program which operates under a CMS §1915(b) waiver and utilizes contracted managed care organizations (MCOs) to provide medical services to qualified individuals. Medallion serves over 600,000 individuals: children, care taker parents, and pregnant women.

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

Medicaid Covered Services - Services reimbursed by DMAS as defined in the Virginia Medicaid State Plan for Medical Assistance or State regulations.

Medicaid Enterprise System (MES) – The Department’s modernized technology system which will replace the current Medicaid Management Information System (MMIS).

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

Medicaid Management Information System (MMIS) – The medical assistance and payment information system of the Department. This system will be replaced with the MES upon completion of the redesign.

Medicaid Works Program - A voluntary Medicaid plan option that enables workers with disabilities to earn higher income and retain more in savings or resources than is usually allowed by Medicaid.

Medically Necessary or Medical Necessity – Per Virginia Medicaid, an item or service provided for the diagnosis or treatment of an enrollee’s condition consistent with standards of medical practice and in accordance with Virginia Medicaid policy (12 VAC 30-130-600) and EPSDT criteria (for those under age 21), and federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Medication Monitoring - An electronic device only available in conjunction with Personal Emergency Response Systems (PERS) that enables certain waiver individuals who are at risk of institutionalization to be reminded to take their medications at the correct dosages and times.

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

Medicare Advantage - (Medicare “Part C”) - Sometimes referred to as “MA Plans,” includes all of an individual’s Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).

Medicare Part A – Insurance that helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care.

Medicare Part B – Insurance that helps cover medically-necessary services like doctors’ services, outpatient care, durable medical equipment (DME), home health services, and other medical services. Part B also covers some preventive services.

Medicare Part D – Medicare prescription drug coverage.

Member, Individual, Recipient, Enrollee, Participant, or Client – Any person having current Medicaid eligibility and authorized by the Department to participate in the CCC Plus program.

Member Handbook – Document required by the Contract to be provided by the Contractor to the Member prior to the first day of the month in which their enrollment starts. Refer to *Member Outreach and Marketing* for more information.

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

Mental Health Parity Addiction Equality Act (MHPAEA) – Requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

Mental Health Professional – In accordance with the Virginia Department of Health Professions (DHP), a Mental Health Professional is a person who by education and experience is professionally qualified and licensed by the Commonwealth to provide counseling interventions designed to facilitate an individual’s achievement of human development goals and remediate mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development. Refer to:

<https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2400.1/>.

Mental Health Skill-Building Services – Goal directed training to enable Members to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services shall include goal directed training in the following areas in order to qualify for reimbursement: functional skills and appropriate behavior related to the Member’s health and safety; activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

Minimal Need Subpopulation – A Member is considered minimal need if he or she meets all of the following criteria:

- 1) Is a CCC Plus ABD or expansion Member;
- 2) Is not a CCC Plus Waiver or Nursing Facility Member;
- 3) Is an Other Vulnerable or Emerging Vulnerable subpopulation Member who is unable to be contacted by the Contractor to conduct the HRA reassessment.

Note that the “Minimal Need Subpopulation” is distinct from the “Minimal Risk Populations”. See below.

Minimal Risk Population – A Member is considered minimal risk if he or she meets the criteria for placement in the Minimal Risk populations as determined through the MMHS.

Minimum Data Set (MDS) - Part of the federally-mandated process for assessing individuals receiving care in Certified Nursing Facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for Nursing Facility residents to return to community settings. All Medicare and Medicaid certified nursing facilities were required to use the MDS 3.0.

Model of Care – A comprehensive plan that describes the Contractor's population; identifies measurable goals for providing high quality care and improving the health of the enrolled population; describes the Contractor's staff structure and care coordination roles; describes the interdisciplinary care team; system of disseminating the Model to Contractor staff and network providers; and, provides other information designed to ensure that the Contractor provides services that meet the needs of Members.

Moderate Risk Population – A Member is considered moderate risk if at least one of the following applies: 1) he or she has had a combination of three to four (3-4) ED visits or hospitalizations related to his or her chronic medical, physical, and/or behavioral health condition in the past ninety (90) calendar days; 2) for Members eighteen (18) years of age or older has had one to two (1-2) falls resulting in an ED visit, hospitalization, or physician office visit within the past ninety (90) calendar days; 3) needs assistance with ADLs, his or her ability to perform daily tasks is impacted by SMI/SUD condition; 4) is under Foster Care (if not High Risk); or 5) is covered under the CCC Plus Waiver (Indicator 9) (if not high risk) or is covered under the CCC Plus Waiver without Private Duty Nursing covered through EPSDT.

Money Follows the Person (MFP) – A former demonstration project designed to create a system of long term services and supports that better enable individuals to transition from certain institutions into the community. To participate in MFP, individuals must: 1) have lived for at least ninety (90) consecutive days in a Nursing Facility, an intermediate care facility for persons with intellectual disabilities (ICF/ID), a long-stay hospital licensed in Virginia, institute for mental disorders (IMD), psychiatric residential treatment facility (PRTF), or a combination thereof; and, 2) move to a qualified community-based residence. The MFP program ceased effective December 31, 2017. Individuals enrolled in MFP were not eligible for the CCC Plus program.

Monitoring - The ongoing oversight to determine that services are administered according to the individual's ICP and effectively meet his or her needs, thereby assuring health, safety and welfare. Monitoring activities may include, but are not limited to, telephone contact; observation; interviewing the Member and/or the Member's family, as appropriate, in person or by telephone; and/or interviewing service providers.

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

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

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

National Provider Identifier (NPI) - NPI is a national health identifier for all health care providers, as defined by CMS. The NPI is a numeric 10-digit identifier, consisting of nine (9) numbers plus a check-digit. It is accommodated in all electronic standard transactions and many paper transactions. The assigned NPI does not expire. All providers who provide services to individuals enrolled in CCC Plus program will be required to have and use an NPI.

Native American – For the purposes of this Contract, this terminology is used interchangeably with the population referenced in 42 CFR § 438.14, and who is recognized as an Indian (as that term is defined in Section 4(c) of the Indian Health Care Improvement Act of 1976 (25 USC 1603(c)).

Network Provider - The health care entity or health care professional who is either employed by or has executed a contract with the Contractor or its subcontractor to render covered services to Members as defined in this Contract.

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

Notice – A written statement that meets the requirements of 42 CFR § 438.404.

Nursing Facility (NF)– Any licensed skilled nursing facility, skilled care facility, intermediate care facility, nursing care facility, or nursing facility, whether freestanding or a portion of a freestanding medical care facility. This includes, but is not limited to, a facility that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and the *Code of Virginia*, §32.1-137.

Nursing Facility Annual Reassessments - Annual reassessments (functional and medical/nursing needs) for continued Nursing Facility placement, including the incorporation of all MDS guidelines.

Nursing Facility Population - For the purpose of determining when an HRA is needed, the Nursing facility population is any Member who resides in a Nursing Facility as defined in this Contract who has not otherwise been determined to be high or moderate risk. Refer to *Nursing Facility Populations*. A Member is categorized as Nursing Facility if he or she resides in a Nursing Facility and is not categorized as high, moderate, or low risk.

Nursing Facility LTSS Screening Team - Nursing facility staff trained and certified in the use of the LTSS screening tool who are responsible for performing LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. Nursing facility LTSS screening staff must include at least one registered nurse and physician, but may include social worker or other members of the interdisciplinary team. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

Office Based Opioid Treatment Providers – Also known as “Preferred OBOTS”, deliver addiction treatment services to Members with moderate to severe opioid use disorders provided by buprenorphine-waivered practitioners working in collaboration and co-located with licensed Credentialed Addiction Treatment Practitioners providing psychosocial treatment in public and private practice settings (12VAC30-5020).

Ombudsman – The independent State entity that will provide advocacy and problem-resolution support for CCC Plus program participants, and serve as an early and consistent means of identifying systemic problems. Contact information: Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services, 1-800-552-5019, ombudsman@dars.virginia.gov.

Open Enrollment – The time frame in which Members are allowed to change from one MCO to another, without cause, is at least once every 12 months per 42 CFR § 438.56 (c)(2) and (f)(1). Open enrollment will occur from October 1st – December 18th for a January 1 effective date. Individuals eligible through Medicaid expansion will have an open enrollment period from November 1 – December 18th for a January 1 effective date. Within sixty (60) calendar days prior to the open enrollment begin date, the Department will inform Members of the opportunity to remain with the current plan or change to another plan without cause. Those Members who do not choose a new health plan during the open enrollment period shall remain in his or her current health plan selection until their next open enrollment period.

Other Vulnerable Subpopulation – Includes Members identified in items a-l of Section 5.1.1, *CCC Plus Vulnerable and Emerging Vulnerable Populations* whose conditions are not well managed. DD waiver Members could be included if they meet high risk criteria, per Section 5.3.4.3, *Initial HRAs for High Risk Populations*.

Out-of-Network – Coverage provided outside of the established MCO network. Medical care rendered to a Member by a provider not affiliated with the Contractor or its subcontractors.

Patient Pay - When an individual’s income exceeds an allowable amount, the Member must contribute toward the cost of their LTSS. This contribution, known as the patient pay amount, is required for individuals residing in a NF (skilled or custodial) and for those enrolled in waivers.

Patient pay is required to be calculated for every individual (including Native Americans) although not every eligible individual will end up having to pay each month. The process for collecting patient pay amounts will be the responsibility of the Contractor and shall be outlined in the Contractor's provider agreement.

Person with Ownership or Control Interest – In accordance with 42 CFR §455 Subpart B, a person or corporation that owns, directly or indirectly, five (5) percent or more of the Contractor's capital or stock or received five (5) percent of the total assets of the Contractor in any mortgage, deed of trust, note or other obligation secured in whole or in part by the Contractor or by its property or assets, or is an officer, director, or partner of the Contractor. See Section 2.11, *Prohibited Affiliations With Entities Debarred by Federal Agencies* of this Contract for more information.

Person-Centered Planning - A process, directed by an enrolled Member and/or his or her family/caregiver, as appropriate, intended to identify the needs, strengths, capacities, preferences, expectations, and desired outcomes of the Member.

Personal Care Provider – A provider that renders personal care services to an eligible Member in order to prevent or reduce institutional care.

Personal Care Services - A range of support services that includes assistance with ADLs/IADLs, access to the community, and self-administration of medication or other medical needs, and the monitoring of health status and physical condition provided through the agency-directed or consumer-directed model of service. Personal care services shall be provided by PCAs or attendants within the scope of their licenses or certifications, as appropriate.

Personal Emergency Response System (PERS) - An electronic device and monitoring service that enables certain individuals at risk of institutionalization to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

PERS Provider - An entity that meets the standards and requirements set forth by DMAS to provide PERS equipment, direct services, and PERS monitoring. PERS providers may also provide medication monitoring.

Pharmacy Benefits Management – Means the administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals.

Pharmacy Benefit Manager (PBM) – An entity responsible for the provision and administration of pharmacy services.

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 of Safe Care - A guide developed by the Contractor with their Members to ensure mothers and others have the necessary resources to safely care for the unique challenges of an infant who is exposed to substances during pregnancy. Each woman and infant's needs vary.

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

Post Stabilization Services – Covered services related to the Member's underlying condition that are provided after a Member's Emergency Medical Condition has been stabilized and/or under the circumstances described in 42 CFR § 438.114(e).

Potential Member – A Medicaid Member who is subject to mandatory enrollment (42 CFR § 438.10(a))

Pre-Payment Review - A type of program integrity activity that requires a provider to submit additional documentation to support a billed claim before that claim is processed for payment. Pre-payment review is often focused on a claim type, a provider type, or a specific provider based on an indication that additional scrutiny is needed. It may be used after identifying an area/provider that presents a program integrity risk, or prior to evidence of risk, in order to mitigate potential issues.

Prevalent Language – When five (5) percent or more of the Contractor's enrolled population in any participating region is non-English speaking and speaks a common language other than English.

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

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

Primary Caregiver - The primary person who consistently assumes the role of providing direct care and support of the Member to live successfully in the community without compensation for providing such care.

Privacy – Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing Medicaid regulations, including 42 CFR §§ 431.300 through 431.307, as well as relevant Virginia privacy laws.

Private Duty Nursing – Nursing care services available for children under age 21 under EPSDT that consist of medically necessary skilled interventions, assessment, medically necessary monitoring and teaching of those who are or will be involved in nursing care for the individual. Private duty nursing differs from both skilled nursing and home health nursing because the nursing is provided continuously as opposed to the intermittent care provided under either skilled nursing or home health nursing services.

Program of All-inclusive Care for the Elderly (PACE) - PACE provides the entire spectrum of medical (preventive, primary, acute) and long term services and supports to their enrollees without limit as to duration or dollars. PACE participants are excluded from the CCC Plus program.

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

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

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

Provider Preventable Condition – (also called Provider Preventable Event) - A condition that (1) meets the requirements of an “Other Provider Preventable Condition” pursuant to 42 CFR § 447.26(b); and/or (2) a hospital acquired condition or a condition occurring in any health care setting that has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the beneficiary, and is auditable. The Department’s policy regarding Provider Preventable Conditions is set out in 12 VAC 30-70-201 and 12 VAC 30-70-221.

Psychosocial Rehabilitation Services – A treatment program of two or more consecutive hours per day provided to groups of adults in a non-residential setting. Members must demonstrate a clinical need for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. This service provides education to teach the Member about mental illness, substance use disorders (SUD), and appropriate medication to avoid complication and relapse and opportunities to learn and use

independent skills and to enhance social and interpersonal skills within a consistent program structure and environment.

Qualifying CCC Plus Waiver Services – Qualifying Services can be authorized as *stand-alone* services. Qualifying services include: ADHC, personal care, respite, and private duty nursing services. The following CCC Plus Waiver services are not qualifying waiver services: AT, EM, and PERS, and must be authorized in conjunction with at least one *qualifying* CCC Plus Waiver service.

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

Quality Incentive – The portion of a Contractor’s capitation payments at-risk in a given Contract period based on performance on quality metrics, population-based performance targets and VBP requirements as designated by the Department.

Quality Management Review (QMR) – An on-site visit and/or desk review of the Contractor conducted by the Department to assure the health and safety of waiver participants and compliance with Federal waiver assurances.

Quarterly – For the purpose of Contract reporting requirements, quarterly shall be defined as within thirty (30) calendar days after the end of each calendar quarter. Calendar quarters begin on January 1, April 1, July 1, and October 1 of each year.

Reassessment – For Members enrolled in a waiver or a Nursing Facility, the periodic (in accordance with waiver requirements), face-to-face review of a Member’s condition and service needs.

Reconsideration – A provider’s request for review of an adverse action as defined in this Contract. The Contractor’s reconsideration decision is a pre-requisite to a provider’s filing of an appeal to the DMAS Appeals Division.

Remand – The return of a case by the DMAS hearing office to the Contractor for further review, evaluation, and action.

Psychiatric Residential Treatment Facilities (PRTF) – Means the same as defined in 42 CFR 483.352 and are a 24-hour, supervised, clinically and medically necessary, out-of-home active treatment program designed to provide necessary support and address mental health, behavioral, substance abuse, cognitive, and training needs of an individual younger than 21 years of age in order to prevent or minimize the need for more intensive treatment.

Resource Utilization Groups (RUGS) – Based on information acquired from the Nursing Minimum Data Set, the RUGS score is developed. RUGS reflects the exclusive categories of a Nursing Facility resident’s level of resource need (based on their functional and cognitive status)

which are used to facilitate payment. For the purposes of this contract, RUGS refers to the version in use by the Department on the date of service.

Respite Care Provider - Agency provider that renders respite services designed to provide periodic or routine relief for unpaid primary caregivers under the CCC Plus Waiver.

Respite Services - Services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of unpaid caregivers who normally provide the care. Respite services may refer to skilled nursing respite or unskilled respite.

Rural Area - DMAS will follow the CMS MA HSD reference guide, available at: https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/MA_Network_Adequacy_Criteria_Guidance_Document_1-10-17.pdf. DMAS defines rural as micro, rural, and CEAC areas. DMAS posted the CMS reference guide that identifies VA rural and urban localities at: <http://www.dmas.virginia.gov/#/cccplushealthplans>.

Rural Exception - A rural area, as defined within this Contract (see Rural Area definition), and as designated in the 1915(b) managed care waiver, pursuant to 1935(a)(3)(B) of the Social Security Act and 42 CFR § 438.52(b) and recognized by the Centers for Medicare and Medicaid Services, wherein qualifying Members are mandated to enroll in the one available contracted MCO.

Rural Health Clinic - A facility as defined in 42 CFR § 491.2, as amended.

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

Screening - The process to: (i) evaluate the functional, nursing, and social supports of individuals referred for screening for certain long term services requiring Nursing Facility eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual’s needs; and, (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facility or home and community-based care for those individuals who meet Nursing Facility level of care.

Screening Team - The Medicaid MLTSS Screening Team contracted with DMAS that is responsible for performing screenings for Nursing Facilities or, if qualified, waiver services pursuant to the *Code of Virginia* § 32.1-330. Screening teams include: (1) “Community-based team” (CBT) means a nurse, social worker or other assessors designated by the Department and a physician who are employees of, or contracted with, the Virginia Department of Health or the local Department of Social Services; (2) “Hospital Team” means persons designated by the

hospital who are responsible for conducting and submitting the screenings for inpatients to DMAS automated system; and, (3) “DMAS designee” means the public or private entity with an agreement with the Department to complete screenings.

Serious Mental Illness (SMI) – Used to refer to individuals ages 18 and older, who have serious mental illness diagnosed under the DSM in the following major diagnostic categories: schizoprenias and other psychotic disorders, bipolar disorders, and major depressive disorders.

Serious Emotional Disturbance – Used to refer to children from birth through seventeen (17), who have had a serious mental health problem diagnosed under the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or who exhibit all of the following: problems in personality development and social functioning that have been exhibited over at least one year’s time, problems that are significantly disabling based upon the social functioning of most children of the child’s age, problems that have become more disabling over time, and service needs that require significant intervention by one or more agency (see <http://www.dbhds.virginia.gov> for additional information).

Service Authorization (SA)/Prior Authorization (PA) - A type of program integrity activity that requires a provider to submit documentation to support the medical necessity of services before that service is performed and the claim is billed and processed for payment. Pre-payment review is often focused on controlling utilization of specific services by a pre-determination that the service is medically necessary for a Member.

Service Facilitator (SF) - Entity designated by the DMAS MCO contractor or one who is employed or contracted by a DMAS-enrolled provider responsible for supporting the individual, individual’s family/caregiver, or Employer of Record, as appropriate, by ensuring the development and monitoring of the CD services Plans of Care, providing employee management training, and completing ongoing review activities as required by the Department for CD personal care and respite services.

Significant Change - A change (decline or improvement) in a Member’s status that: 1) will not normally resolve itself without intervention or by implementing standard disease-related clinical interventions, is not “self-limiting” (for declines only); 2) impacts more than one area of the individual’s health status; and, 3) requires interdisciplinary review and/or revision of the ICP.

Skilled Private Duty Nursing Services (Skilled PDN) – Skilled in-home nursing services listed in the person-centered Individualized Care Plan that are (i) not otherwise covered under the State Plan for Medical Assistance Services home health benefit; (ii) required to prevent institutionalization; (iii) provided within the scope of the Commonwealth's Nurse Practice Act and Drug Control Act (Chapters 30 (§ 54.1-3000 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the *Code of Virginia*, respectively); and (iv) provided by a licensed RN, or by an LPN under the supervision of an RN, to CCC Plus Waiver Members who have serious medical conditions or complex health care needs. Skilled nursing services are to be used as hands-on Member care, training, consultation, as appropriate, and oversight of direct care staff, as appropriate.

Social Determinants – Economic and social conditions that affect health risk and outcomes.

Specialist - A doctor who specializes in treating certain diseases, health problems, or conditions. For the purposes of this contract, not a primary care or pediatric doctor.

Spend Down –When a Medicaid applicant meets all Medicaid eligibility requirements other than income, Medicaid eligibility staff conduct a “medically needy” calculation which compares the individual’s income to a medically needy income limit for a specific period of time referred to as the “budget period” (not to exceed 6 months). When a Medicaid applicant’s incurred medical expenses are equal to the spend down amount, the individual is eligible for full benefit Medicaid for the remainder of the spend down budget period. Individuals with short-term and retroactive coverage only, including certain medically needy (spend down) individuals, will not be eligible to participate in the CCC Plus program.

Spread Pricing - Means the model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

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

State Fair Hearing – DMAS’ evidentiary hearing process for Member appeals. Any adverse internal appeal decision rendered by the Contractor may be appealed by the Member to the DMAS Appeals Division. DMAS conducts evidentiary hearings in accordance with regulations at 42 CFR§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

State Holidays – Twelve specific (12) days of any calendar year that State offices are closed. Contractors may elect to be closed for State holidays; however, it is not required. State holidays do not include any additional time off that may be appropriated to State employees by the Governor or legislature.

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

State Plan Substituted Services (In Lieu of Services) – Alternative services or services in a setting that are not included in the state plan or not normally covered by this Contract but are medically appropriate, cost effective substitutes for state plan services are included within this Contract (for example, a service provided in an ambulatory surgical center or sub-acute care facility, rather than an inpatient hospital). However, the Contractor shall not require a Member to use a state plan substituted service/“in lieu of” arrangement as a substitute for a state plan

covered service or setting, but may offer and cover such services or settings as a means of ensuring that appropriate care is provided in a cost efficient manner. For individuals 21 through 64 years of age, an Institution for Mental Disease (IMD) may be an “in lieu of” service; however, shall be limited to **no more than** fifteen (15) calendar days in any calendar month. Reference 42 CFR §§438.3 and 438.6(e).

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

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

Substance Abuse Case Management – Assists children, adults, and their families with accessing needed medical, psychiatric, SUD, social, educational, vocational services and other supports essential to meeting basic needs for the individuals assessed to have a substance-related disorder as defined in the current DSM. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Crisis Intervention – Immediate mental health care, available twenty-four (24) hours a day, seven (7) days a week, to assist individuals who are experiencing acute mental dysfunction requiring immediate clinical attention. This service’s objective is to prevent exacerbation of a condition, to prevent injury to the Member or others, and to provide treatment in the context of the least restrictive setting. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Day Treatment – Services of two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is 20 hours with a maximum of 30 hours per week. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Day Treatment for Pregnant Women – Comprehensive and intensive intervention services in a central location lasting two or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Intensive Outpatient Services – Services two or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is 19 hours. This service should be provided to those Members who do not require the intensive level of care of

inpatient, residential, or day treatment services, but require more intensive services than outpatient services. May also be referenced as a Substance Use Disorder Service.

Substance Abuse Residential Treatment for Pregnant Women – Comprehensive and intensive services in residential facilities, other than inpatient facilities, for pregnant and postpartum women with serious substance use disorder problems for the purposes of improving the pregnancy outcome, treating the substance use disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. May also be referenced as a Substance Use Disorder Service.

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

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

Target Amount – An amount equal to the total capitation payments for benefit costs for services allowed under 42 CFR § 438.3(c)(1)(ii) paid by DMAS for the twelve (12) month period from July 1 through June 30 to the Contractor based on the actuarially determined projected benefit cost PMPM. The target amount will be determined by DMAS and will not be affected by any service level agreement penalties described in Section 8.0, *Provider Network Management* of this Contract.

Targeted Case Management (TCM) – Services that will assist individuals with specific conditions in gaining access to needed medical, social, educational and other services. These services include but are not limited to assessment, development of a specific care plan, referral and related activities, monitoring and follow-up activities. Services are designed to assist social, educational, vocational, housing, and other services. TCM services include: ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high risk prenatal and infant case management services. Refer to the *CCC Plus Coverage Chart*.

Telehealth – The use of telecommunications and information technology to support remote or long-distance physical and behavioral health care services. Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth incorporates technologies such as telephone, facsimile machines, electronic,

email systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Telemedicine – A service delivery model that uses real time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered Member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment to link the Member at an approved originating site to an enrolled provider approved to provide telemedicine services at a distant (remote) site.

Temporary Detention Order (TDO) – An involuntary detention order by sworn petition to any magistrate to take into custody and transport for needed mental health evaluation and care or medical evaluation and care of a person who is unwilling or unable to volunteer for such care. A magistrate is authorized to order such involuntary detention on an emergency basis for short periods, pursuant to 42 CFR § 441.150 and *Code of Virginia* § 16.1-336 et seq and § 37.2-809 et seq. Different temporary detention statutes apply for adults than for juveniles.

Therapeutic Group Home (TGH) – Means a congregate residential service providing 24-hour supervision in a community-based home having eight or fewer residents.

Therapeutic Day Treatment (TDT) for Children and Adolescents – A combination of psychotherapeutic interventions combined with evaluation, medication education and management, opportunities to learn and use daily skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.) and individual, group, and family counseling offered in treatment programs of two or more hours per day.

Third-Party Liability (TPL) - Any entity (including other government programs or insurance) that is or may be liable to pay all or part of the medical cost for injury, disease, or disability of a Medicaid Member.

Transition Services - Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. For the purposes of transition services, an institution means a NF, or a specialized care facility/hospital as defined at 42 CFR § 435.1009. Transition services do not apply to an acute care admission to a hospital.

Transmit – Send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Transportation Network Companies (TNC) - Provides prearranged rides for compensation using a digital platform that connects passengers with drivers using a personal vehicle. TNC drivers are referred to as TNC partners; reference additional information at <https://www.dmv.virginia.gov/commercial/tnc/intro.asp>.

Treatment Foster Care (TFC) Case Management (CM) – Serves children under age 21 in treatment foster care who are seriously emotionally disturbed (SED) or children with behavioral disorders who in the absence of such programs would be at risk for placement into more restrictive residential settings such as psychiatric hospitals, correctional facilities, residential treatment programs or group homes. TFC case management focuses on a continuity of services, is goal directed and results oriented.

Unable to Contact (UTC) for Initial HRA and HRA Reassessment – The Contractor’s reasonable efforts to contact the non-LTSS Member in person, by telephone, or by mail immediately upon completion of the MCO Member Health Screening without success places the Member in the “UTC” category for the Initial HRA. “Reasonable efforts” for individuals who must be contacted to conduct the Initial HRA are defined as at least three (3) documented attempts (six (6) documented attempts for high risk non-LTSS Members only), with more than one method of contact being employed, including a home visit.

Unable to Contact (UTC) for MMHS – The Contractor’s reasonable efforts to contact the Member in person, by telephone, or by mail in order to conduct the MMHS without success places the Member in the “UTC” category for the MMHS. “Reasonable efforts” or “good faith efforts” as referred to in Section 5.2.2, *MCO Member Health Screening (MMHS)* for individuals who must be contacted to conduct the MMHS, are defined as at least three (3) documented attempts, with more than one method of contact being employed.

Urban Area - DMAS will follow the CMS MA HSD reference guide, available at: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>. DMAS defines urban as metro and large metro. DMAS posted the CMS reference guide that identifies VA rural and urban localities at: <http://www.dmas.virginia.gov/#/cccplushealthplans>.

Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical/behavioral health condition, but that are the result of an unforeseen illness, injury, or condition for which medical/behavioral health services are immediately required. Urgent care is appropriately provided in a clinic, physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.

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

Virginia Administrative Code (VAC) – Contains regulations of all of the Virginia State Agencies.

Value-Based Payments Purchasing (VBP) - A broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures. Public and private payers use VBP strategies in an effort to drive improvements in quality and to slow the growth in health care spending.

Virginia Department of Health Office of Emergency Medical Services (OEMS) – The governing state sister agency that ensures ambulance companies maintain employee, vehicle compliance, and licensing requirements. If OEMS finds the ambulance company out of compliance, OEMS is the governing authority that takes action.

Virginia Uniform Assessment Instrument (UAI) - The standardized multidimensional assessment instrument that is completed by the Screening Team that assesses an individual's physical health, mental health, psychosocial and functional abilities to determine if an individual meets the Nursing Facility level of care.

Waste - The rendering of unnecessary, redundant, or inappropriate services and medical errors and/or incorrect claim submissions. Generally, waste is not considered a criminally negligent action but rather misuse of resources. However, patterns of repetitive waste, particularly when the activity persists after the provider has been notified that the practice is inappropriate, may be considered fraud or abuse.

23.2 ACRONYMS

AA -- Adoption Assistance
AAA -- Area Agencies on Aging
ABD -- Aged, Blind, and Disabled Population
ACA -- Patient Protection and Affordable Care Act
ACIP -- Advisory Committee on Immunization Practice
ADCC -- Adult Day Care Center
ADHC -- Adult Day Health Care
ADHD -- Attention-Deficit/Hyperactivity Disorder
ADL -- Activities of Daily Living
AHRQ -- Agency for Healthcare Research and Quality
ALS -- Amyotrophic Lateral Sclerosis
ANSI -- American National Standards Institute
APIN -- Administrative Provider Identification Number
APM -- Alternate Payment Model
ARTS -- Addiction and Recovery Treatment Services
ASAM -- American Society of Addiction Medicine
ASP -- Application Service Provider
BAA -- Business Associate Agreement
BBA -- Balanced Budget Act of 1997
BHA -- Behavioral Health Authority
BHSA -- Behavioral Health Services Administrator
BMI -- Body Mass Index
BOI -- Bureau of Insurance of the Virginia State Corporation Commission
CAD -- Coronary Artery Disease
CAHPS® -- Consumer Assessment of Healthcare Providers and Systems
CAP -- Corrective Action Plan
CBO -- Community-Based Organizations
CCC -- Commonwealth Coordinated Care
CCM -- Chronic Care Management
CD -- Consumer-Directed
CDSMP -- Chronic Disease Self-Management Program
CFR -- Code of Federal Regulations
CHF -- Congestive Heart Failure
CHIPRA -- Children's Health Insurance Program Reauthorization Act
CIL -- Center for Independent Living
CLIA -- Clinical Laboratory Improvement Amendments
CMR -- Comprehensive Medication Review
CMS -- Centers for Medicare and Medicaid Services
CMS 1500 -- Standard Professional Paper Claim Form
CMHRS -- Community Mental Health Rehabilitative Services
CON -- Certificate of Need
COPD -- Chronic Obstructive Pulmonary Disease
CORFs -- Comprehensive Outpatient Rehabilitation Facilities
CPT -- Current Procedural Terminology
CQI -- Continuous Quality Improvement

CSB -- Community Service Board
CY -- Calendar Year
CYSHCN -- Children and Youth with Special Health Care Needs
DARS -- Virginia Department for Aging and Rehabilitative Services
DBA -- Dental Benefits Administrator
DBHDS -- Department of Behavioral Health and Developmental Services
DD -- Developmental Disability
DESI -- Drug Efficacy Study Implementation
DHHS -- Department of Health and Human Services
DMAS -- Department of Medical Assistance Services
DME -- Durable Medical Equipment
DOB -- Date of Birth
DOD -- Date of Death
DRG -- Diagnosis Relative Grouping
DSM -- Diagnostic and Statistical Manual of Mental Disorders
DSMP -- Diabetes Self-Management Program
D-SNP -- Dual Eligible Special Needs Plan
DSP -- Data Security Plan
DSS -- Department of Social Services
ECO -- Emergency Custody Order
EDI -- Electronic Data Interchange
EI -- Early Intervention
EMR -- Emergency Medical Record
EN -- Enteral Nutrition
EOL -- End-of-Life
EOM -- End of Month
EOR -- Employer of Record
EPA -- Environmental Protection Agency
ePAS -- Electronic Pre-Admission Screening
EPSDT -- Early and Periodic Screening, Diagnostic, and Treatment
EQR -- External Quality Review
EQRO -- External Quality Review Organization
ER -- Emergency Room
ESRD -- End Stage Renal Disease
EVV -- Electronic Visit Verification
FAMIS -- Family Access to Medical Insurance Security
FC -- Foster Care
F/EA -- Fiscal/Employer Agent
FFS -- Fee-for-Service
FIPS -- Federal Information Processing Standards
FOIA -- Freedom of Information Act
FQHC -- Federally Qualified Health Centers
FTE -- Full-Time Equivalent
FTP -- File Transfer Protocol
FY-- Fiscal Year
GAAP -- Generally Accepted Accounting Principles
HCBS -- Home and Community-Based Care Services

HCPCS -- Healthcare Common Procedure Coding System
 HEDIS -- Healthcare Effectiveness Data and Information Set
 HIPAA -- Health Insurance Portability and Accountability Act of 1996
 HIV/AIDS -- Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
 HPMS -- Health Plan Management System
 HRA -- Health Risk Assessment
 HRR -- Hospital Referral Region
 IADL -- Instrumental Activities of Daily Living
 IBNR -- Incurred But Not Reported
 ICF/ID -- Intermediate Care Facility/Individuals with Intellectual Disabilities
 ICP -- Individualized Care Plan
 ICT -- Interdisciplinary Care Team
 ID -- Identification
 ID -- Intellectual Disability
 IDEA -- Individuals with Disabilities Education Act.
 IDEA-EIS -- Individuals with Disabilities Education Act - Early Intervention Services
 IEP -- Individual Education Plan
 IFSP -- Individual Family Service Plan
 IHCP -- Indian Health Care Provider
 IHS -- Indian Health Services
 IOP -- Intensive Outpatient
 I/T/U -- Indian Tribe, Tribal Organization, or Urban Indian Organization
 IMD -- Institution for Mental Disease
 ITOTS—Infant and Toddler Online Tracking System (Early Intervention tracking system)
 LARC -- Long Acting Reversible Contraceptive
 LCSW -- Licensed Clinical Social Worker
 LDSS -- Local Department of Social Services
 LEIE -- Listing of Excluded Individuals and Entities
 LIFC -- Low Income Families and Children
 LOC -- Level of Care
 LOCERI -- Level of Care Review Instrument
 LSH -- Long-Stay Hospital
 LTAC -- Long Term Acute Care
 LTSS -- Long Term Services & Supports
 MA -- Medicare Advantage
 MAO -- Medicare Advantage Organization
 MATE -- Medical Assistance to Employment
 MCHIP -- Managed Care Health Insurance Plans
 MCO -- Managed Care Organization
 MDS -- Minimum Data Set
 MES -- Medicaid Enterprise System
 MFCU -- Medicaid Fraud Control Unit
 MHPAEA -- Mental Health Parity Addiction Equality Act
 MLTSS -- Managed Long Term Services and Supports
 MMHS -- MCO Member Health Screening
 MMIS -- Medicaid Management Information System (also known as VAMMIS)
 MMP -- Medicare-Medicaid Plan

MOB – Matter of Balance
MOC -- Model of Care
MOU -- Memorandum of Understanding
MTM -- Medication Therapy Management
MTR -- Medical Transition Reports
NCPDP -- National Council for Prescription Drug Programs
NCQA -- National Committee for Quality Assurance
NDC -- National Drug Code
NEMT -- Non-Emergency Medical Transportation
NF -- Nursing Facility
NIST -- National Institute of Standards and Technology
NPDB -- National Practitioner Data Bank
NPI -- National Provider Identifier
NRSM -- Network Requirements Submission Manual
OB/GYN -- Obstetrician and Gynecologist
OIG -- Office of Inspector General
OSR -- Operational Systems Review
OT -- Occupational Therapy
PA -- Prior Authorization (also known as Service Authorization)
PACE -- Program of All-inclusive Care for the Elderly
PCP -- Primary Care Provider
PHI -- Protected Health Information
PIP -- Physician Incentive Plan
PIRS -- Patient Intensity Rating Survey
PDSA -- Plan Do Study Act
PMV -- Performance Measure Validation
POC -- Plan of Care
PPE -- Provider Preventable Event (refer to Provider Preventable Condition)
PRTF -- Psychiatric Residential Treatment Facility
PSA -- Prostate Specific Antigen
PT -- Physical Therapy
PUMS -- Patient Utilization Management & Safety Program
QI -- Quality Improvement
QIP -- Quality Improvement Program
RFP -- Request for Proposal
RHC -- Rural Health Clinics
RN -- Registered Nurse
RTF -- Residential Treatment Facility
RUGS -- Resource Utilization Groups
SA -- Service Authorization (formally known as Prior Authorization)
SAMHSA -- Substance Abuse and Mental Health Services Administration
SED -- Serious Emotional Disturbance
SLP -- Speech-Language Pathology
SMI -- Serious Mental Illness
SPO -- State Plan Options
SSI -- Social Security Income
SSN -- Social Security Number

SUD -- Substance Use Disorder
TB -- Tuberculosis
TBI -- Traumatic Brain Injury
TDO -- Temporary Detention Order
TFCCM -- Treatment Foster Care Case Management
TGH -- Therapeutic Group Home
TMJ -- Temporomandibular Joint (disorder)
TNC -- Transportation Network Company
TPL -- Third-Party Liability
TPN -- Total Parenteral Nutrition
TTY/TDD -- Teletype/Telecommunication Device for the Deaf
UAI -- Uniform Assessment Instrument
UB-92 -- Universal Billing 1992 claim form
UM -- Utilization Management
USC -- United States Code
VAC -- Virginia Administrative Code
VAMMIS -- Virginia Medicaid Management Information System
VAN -- Value Added Network
VBP -- Value Based Payment
VICAP -- Virginia Independent Clinical Assessment Process
VPN -- Virtual Private Network
VVFC -- Virginia Vaccines for Children Program
XYZ -- Any Named Entity

ATTACHMENTS

ATTACHMENT 1 - CCC PLUS CONTRACTOR SPECIFIC CONTRACT TERMS

Effective Dates: July 1, 2020 – June 30, 2021

Contract Name: Commonwealth Coordinated Care Plus

Issued By: Commonwealth of Virginia
Department of Medical Assistance Services

Contractor: <Health Plan>

This Contract is effective July 1, 2020 and shall continue through June 30, 2021.

1. The Contractor shall accept the established capitation rates, effective July 1, 2020 (see Exhibit A) paid monthly by the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith, pending final recoupments, reconciliation, or sanctions. The capitation payments to the Contractor shall be paid retrospectively by the Department for the previous month's enrollment (e.g., payment for January enrollment will occur in February, February payment will be made in March, etc.) as further explained in Section 19.0, *Contractor Payment and Financial Provisions* of the CCC Plus Contract.
2. By signature of this Contract, the Contractor agrees to adhere to all CCC Plus MCO Contract provisions, including network adequacy. The Contractor shall operate in all six (6) regions of the Commonwealth and in accordance with the Department's standards for network sufficiency as detailed in this Contract. The Department reserves the right to delay or deny the Contractor's receipt of enrollment for any region or locality within a region, contingent on the Contractor's ability to meet the network adequacy standards set forth and described in this Contract.
3. Maximum enrollment level: A limit of 70% of enrolled lives within an operational region may be placed on any Contractor participating within that region. Should a Contractor's monthly enrollment within an operational region exceed 70%, the Department reserves the right to suspend random assignments to that Contractor until the enrolled lives are reflected at 70% or below. The enrollment cap may be exceeded due to Member-choice assignment changes, for continuity of care, or other reasons as the Department deems necessary. Operational regions consist of the areas reflected in the CCC Plus contract, Attachment 7, *CCC Plus Program Regions and Localities* chart.
4. This contract is contingent upon receipt of final approval from the Centers for Medicare and Medicaid Services (CMS), including all provisions of the Federal regulations in 42 CFR § 438. Any revisions needed shall be completed through a subsequent contract Amendment.
5. By signature of this Contract, the Contractor agrees to adhere to all CCC Plus program 2019 Contract provisions, including compliance with Federal conflict of interest provisions and compliance with requirements in 42 CFR § 438.610 prohibiting Contractor affiliations with individuals debarred by Federal agencies.

CCC PLUS CONTRACTOR SIGNATURE PAGE
(Continued)

6. With signature of this Contract, the Contractor shall attach all of the following documentation:
- a. A copy of its valid license issued with “Health Maintenance Organization” Lines of Authority by the State Corporation Commission (see Section 2.3, *Licensure* of the Contract); and,
 - b. A copy of its MCHIP certification issued by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection (see Section 2.4, *Certification of Quality* of the Contract); and,
 - c. The required information reflected in the Disclosure of Ownership and Control Interest Statement (DMAS-1513).
 - d. In accordance with 42 CFR §455 Subpart B, the names and social security numbers of managing employees. DMAS currently defines managing employees as those individuals that hold positions reflected in Section 2.1.8, *Key Personnel* of this contract.
7. The Contractor agrees to submit claims (encounter) data, along with the Contractor’s subcontractor data, to the Department or its designated Consultant(s) in accordance with the terms specified in this Contract and the CCC Plus Encounter Technical Manual. These data will be used to ensure services were administered to the Contractor’s Members as well as to support future Contract rate calculations.

IN WITNESS HEREOF, the parties have caused this Contract Amendment to be duly executed intending to be bound thereby.

CONTRACTOR:
<Health Plan Name>

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services

BY: _____

BY: _____

NAME: _____

NAME: Karen Kimsey

TITLE: _____

TITLE: Director

DATE: _____

DATE: _____

ATTACHMENT 2 - BUSINESS ASSOCIATE AGREEMENT

*This BAA is only required if there are changes from the original submission. The Contractor shall highlight any changes to the BAA.

THIS ATTACHMENT supplements and is made a part of the Business Associate Agreement (herein referred to as “Agreement”) by and between the Department of Medical Assistance Services (herein referred to as “Covered Entity”) and [name Business Associate] (herein referred to as “Business Associate”).

General Conditions

This BAA (“Agreement” or “BAA”) is made as of December 1, 2016 by the Department of Medical Assistance Services (“Covered Entity”), with offices at 600 East Broad Street, Richmond, Virginia, 23219, and [redacted] (“Business Associate”), with an office at [redacted]. This is a non-exclusive agreement between the Covered Entity, which administers Medical Assistance, and the Business Associate named above.

The Covered Entity and Business Associate, as defined in 45 CFR § 160.103, have entered into this Business Associate Agreement to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the current and future Privacy and Security requirements for such an Agreement, the Health Information Technology for Economic and Clinical Health (HITECH) Act, (P.L. 111-5) Section 13402, requirements for business associates regarding breach notification, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements.

DMAS and Business Associate (“parties”) shall fully comply with all current and future provisions of the Privacy and Security Rules and regulations implementing HIPAA and HITECH, as well as Medicaid requirements regarding Safeguarding Information on Applicants and Recipients of 42 CFR § 431, Subpart F, and *Virginia Code* § 32.1-325.3. The parties desire to facilitate the provision of or transfer of electronic PHI in agreed formats and to assure that such transactions comply with relevant laws and regulations. The parties intending to be legally bound agree as follows:

Definitions. As used in this agreement, the terms below will have the following meanings:

- a. Business Associate has the meaning given such term as defined in 45 CFR § 160.103.
- b. Covered Entity has the meaning given such term as defined in 45 CFR § 160.103.
- c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.
- d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain recipient (*Member*), provider, and claims data for administration of the Medicaid program.
- e. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 CFR § 160.103.
- f. Breach has the meaning as that term is defined at 45 CFR § 164.402.
- g. Required by law shall have the meaning as that term is defined at 45 CFR § 160.103.
- h. Unsecured Protected Health Information has the meaning as that term is defined at 45 CFR § 164.402.
- i. Transport Layer Security (TLS): A protocol (standard) that ensures privacy between communicating applications and their users on the Internet. When a server and client communicate, TLS ensures that no third party may eavesdrop or tamper with any message. TLS is the successor to the Secure Sockets Layer (SSL).

Terms used, but not otherwise defined, in this Agreement shall have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

II. Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate shall be sent via email or general mail to the DMAS Privacy Officer (with a copy to the DMAS contract administrator in II.2) at:

DMAS Privacy Officer, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
CCCPlus@dmass.virginia.gov

2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:

Contact: DMAS Division of Integrated Care
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
CCCPlus@dmass.virginia.gov

III. Special Provisions to General Conditions

1. Uses and Disclosure of PHI by Business Associate. The Business Associate
 - a. May use or disclose PHI received from the Covered Entity, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business.
 - b. Shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law.
 - c. Shall have a signed confidentiality agreement with all individuals of its workforce who have access to PHI.
 - d. Shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, and who have signed a confidentiality agreement.
 - e. Shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agree in writing to all the same restrictions, terms, special provisions and general conditions in this BAA that apply to Business Associate. In addition, Business Associate shall ensure that any such subcontractor or agent agrees to implement reasonable and appropriate safeguards to protect Covered Entity's PHI. In instances where one DMAS Business Associate is required to access DMAS PHI from another DMAS Business Associate, the first DMAS Business Associate shall enter into a business associate agreement with the second DMAS Business Associate.
 - f. Shall provide Covered Entity access to its facilities used for the maintenance and processing of PHI, for inspection of its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI, for purpose of determining Business Associate's compliance with this BAA.
 - g. Shall make its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of Department of Health and Human Services (DHHS) or its designee and provide Covered Entity with copies of any information it has made available to DHHS under this section of this BAA.
 - h. Shall not directly or indirectly receive remuneration in exchange for the provision of any of Covered Entity's PHI, except with the Covered Entity's consent and in accordance with 45 CFR§ 164.502.

Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use, disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.

- i. Shall comply with 45 CFR § 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall

- a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the HITECH Act.
- b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.
- c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.
- d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 CFR § 164.312(e).
- e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall

- a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
 - i. the date made,
 - ii. the name of the person or organization receiving the PHI,
 - iii. the recipient's (Member) address, if known,
 - iv. a description of the PHI disclosed, and the reason for the disclosure.
- b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

4. Sanctions - Business Associate shall

- a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
- b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:

- a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer.
 - i. Initial notification regarding any impermissible use or disclosure by the Business Associate must be immediate or as soon as possible after discovery. Formal notification shall be delivered within five (5) business days from the first day on which such breach is known or reasonably should be known by Business Associate or an employee, officer or agent of Business Associate other than the person committing the breach, and

ii. Written notification to DMAS Privacy Officer shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Business Associate shall confer with DMAS prior to providing any notifications to the public or to the Secretary of HHS.

b. Breach Notification requirements.

- i. In addition to requirements in 5.a above, in the event of a breach or other impermissible use or disclosure by Business Associate of PHI or unsecured PHI, the Business Associate shall be required to notify in writing all affected individuals to include,
 - a) a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
 - b) a description of the types of unsecured PHI that were involved in the breach;
 - c) any steps the individuals should take to protect themselves from potential harm resulting from the breach;
 - d) a brief description of what Business Associate is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches, and, if necessary,
 - e) Establishing and staffing a toll-free telephone line to respond to questions.
- ii. Business Associate shall be responsible for all costs associated with breach notification requirements in 5b, above.
- iii. Written notices to all individuals and entities shall comply with 45 CFR § 164.404(c)(2), 164.404(d)(1), 164.406, 164.408 and 164.412.

6. Amendment and Access to PHI - Business Associate shall

- a. Make an individual's PHI available to Covered Entity within ten (10) days of an individual's request for such information as notified by Covered Entity.
- b. Make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within ten (10) days of notification by Covered Entity per 45 CFR § 164.526.
- c. Provide access to PHI contained in a designated record set to the Covered Entity, in the time and manner designated by the Covered Entity, or at the request of the Covered Entity, to an individual in order to meet the requirements of 45 CFR § 164.524.

7. Termination

- a. Covered Entity may immediately terminate this agreement if Covered Entity determines that Business Associate has violated a material term of the Agreement.
- b. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination.
- c. Within thirty (30) days of expiration or earlier termination of this agreement, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI.
- d. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate by the Covered Entity. If such return or destruction is

infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this agreement shall survive with respect to such PHI.

8. Amendment

- a. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement in such manner as Covered Entity determines necessary to comply with such law or regulation.
- b. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.

9. Indemnification. Business Associate shall indemnify and hold Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

10. This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

- a. The names and contact information for at least one primary contact individual from each party to this Agreement.
- b. A complete list of all individuals, whether employees or direct contractors of Business Associate, who shall be authorized to access Covered Entity's PHI
- c. A list of the specific data elements required by Business Associate in order to carry out the purposes of this Agreement.
- d. The purposes for which such data is required.
- e. A description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Business Associate agrees to update the above noted information as needed in order to keep the information current. Covered Entity may request to review the above-referenced information at any time, including for audit purposes, during the term of this Agreement.

11. Disclaimer. COVERED ENTITY MAKES NO WARRANTY OR REPRESENTATION THAT COMPLIANCE BY BUSINESS ASSOCIATE WITH THIS AGREEMENT OR THE HIPAA REGULATIONS WILL BE ADEQUATE OR SATISFACTORY FOR BUSINESS ASSOCIATE'S OWN PURPOSES OR THAT ANY INFORMATION IN BUSINESS ASSOCIATE'S POSSESSION OR CONTROL, OR TRANSMITTED OR RECEIVED BY BUSINESS ASSOCIATE, IS OR WILL BE SECURE FROM UNAUTHORIZED USE OR DISCLOSURE, NOR SHALL COVERED ENTITY BE LIABLE TO BUSINESS ASSOCIATE FOR ANY CLAIM, LOSS OR DAMAGE RELATED TO THE UNAUTHORIZED USE OR DISCLOSURE OF ANY INFORMATION RECEIVED BY BUSINESS ASSOCIATE FROM COVERED ENTITY OR FROM ANY OTHER SOURCE. BUSINESS ASSOCIATE IS SOLELY RESPONSIBLE FOR ALL DECISIONS MADE BY BUSINESS ASSOCIATE REGARDING THE SAFEGUARDING OF PHI.

(To be completed by Business Associate)

Department of Medical Assistance Services/Contractor Name

Reference Section III - Special Provisions to General Conditions

This Agreement shall have a document, attached hereto and made a part hereof, containing the following:

- a. The names and contact information for at least one primary contact individual from each party to this Agreement.

Contact: DMAS Integrated Care Division Director
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
Phone Number : (804) 371-7983
Email Address: CCCPlus@dmas.virginia.gov

Contractor Contact:

Address:

Phone Number:

Email Address:

- b. Complete list of all individuals, whether employees or direct contactors, of Business Associate who shall be authorized to access Covered Entity's PHI.
- c. List of the specific data elements required by Business Associate in order to carry out the purpose of this Agreement.
- d. Purposes for which such data is required.
- e. Description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

ATTACHMENT 3 - BHSA/CCC PLUS MCO COORDINATION AGREEMENT

This Mutual Cooperation and Coordination Agreement (the “Agreement”) is entered into this ___ day of June, 2017, by and between Magellan of Virginia (Magellan), and-
_____ (“MCO”).

WHEREAS, Magellan has entered into a contract with the Department to provide behavioral health services to beneficiaries (“Members”) of the Medicaid Program (the “Program”); and

WHEREAS, <MCO> intends to Contract with the Department to provide coverage for primary, acute, long term services and supports, pharmacy, and behavioral health services, except for the subset of behavioral health services currently carved out of managed care as described in the Summary of Covered Services chart in Attachment 5, Part 2(B) to Members covered under the CCC Plus Program; and

WHEREAS, Magellan and MCO are required by the terms of their respective contracts with the Department to cooperate with each other and to coordinate care provided to Members, including, but not limited to, (i) support service delivery approaches that integrate behavioral health and primary care services, (ii) address and attempt to resolve coordination of care issues concerning behavioral health care and physical health care, and (iii) share data for purposes of coordinating care for Members; and

WHEREAS, Magellan and MCO, at the direction of the Department, desire to formalize the understanding they have reached with respect to such cooperation and coordination, as set forth in this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants contained herein, BHSA and CCC Plus MCO agree as follows:

Magellan and MCO shall cooperate to coordinate care in a manner that meets the requirements of their respective contracts with the Department, subject to any restrictions relating to confidentiality of patient information, and further subject to the written approval of the Department.

With respect to the sharing of patient information, Magellan and MCO shall adhere to the following:

- a) All collaborative activities shall adhere to state and federal confidentiality laws and regulations; including, without limitation the Health Insurance Portability and Accountability Act (“HIPAA”) and regulations promulgated there under, 45 CFR Parts 160 – 164 (the “Regulations”).
- b) Magellan and MCO may share among each other clinically relevant information, such as periodic treatment updates, subject to all state and federal confidentiality laws and regulations, including but not limited to HIPAA and the Regulations. The parties hereto acknowledge their individual obligations, as covered entities, to comply with HIPAA and the Regulations. Each party shall employ reasonable efforts to implement HIPAA privacy requirements in a manner that allows for the effective exchange of clinical information for treatment, payment and healthcare operations purposes, as described in 45 CFR § 164.506(c), while complying with applicable confidentiality requirements. The parties agree that, upon request, their respective notices of privacy practices shall be exchanged

to facilitate such treatment, payment and healthcare operations purposes. The parties acknowledge that certain federal or state laws may take precedence over HIPAA

General

a) Magellan and MCO shall work together to coordinate and collaborate in the referral, diagnostic assessment and treatment, prescribing practices, the provision of emergency services and other treatment issues necessary for the prevention of disease and achieving optimal health of each Member.

b) All parties agree to meet on an as needed basis, as directed by the Department, and will identify a contact within each organization to facilitate communication throughout the term of the Agreement.

Contact for Magellan:

CEO, Magellan Behavioral Health of _____, Inc.

COO, Magellan Behavioral Health of _____, Inc.

Director of System Transformation, Magellan Behavioral Health of _____, Inc.

Clinical Director, Magellan Behavioral Health of _____, Inc.

Contacts for MCO:

Plan President

Medical Director

Director of Care Management

Director of Quality

c) Coordination of care by Magellan and MCO will include interaction, cooperation, problem identification, and problem resolution in order to reduce barriers or boundaries that impede appropriate health care delivery to Members.

Term. This Agreement shall become effective as of the day and date first written above. Either party may terminate this Agreement at any time upon thirty (30) days prior written notice to the other party, with approval by the Department.

Miscellaneous Provisions.

a) Amendment. This Agreement may be amended only in writing and the amendment must be signed by both parties.

b) Entire Agreement. This Agreement and amendments thereto constitute the entire understanding and agreement of the parties hereto and supersedes any prior written or oral agreement pertaining to the subject matter hereof, except for such written agreements which antedate this Agreement

c) Compliance with Terms. Failure to insist upon strict compliance with any of the terms of this Agreement (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.

d) Severability. If any portions of this Agreement shall, for any reason, be invalid or unenforceable, such portions shall be ineffective only to the extent of any such invalidity or unenforceability, and the remaining portion or portions shall nevertheless be valid, enforceable and of full force and effect;

provided however, that if the invalid provision is material to the overall purpose and operation of this Agreement, then this Agreement shall terminate upon the severance of such provision.

e) Independent Contractors. None of the provisions of this Agreement is intended to create, nor shall it be deemed or construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement.

f) Assignment. No party may assign this Agreement without the prior written consent of the other parties.

g) Governing Law. This Agreement shall be construed in accordance with the laws of the State of Virginia.

h) Counterparts. This Agreement may be signed in counterparts which, when taken together, shall be treated as a single document.

i) Headings. The headings and captions of the Sections of this Agreement are for the convenience of reference only and do not in any way modify, interpret or construe the intention of the parties or affect the provisions of the Agreement.

j) Notices. All notices, requests, demands and other communications regarding this Agreement shall be in writing and shall be deemed to have been duly given (a) on the date of delivery if delivered personally, or (b) on the date of receipt if sent by overnight national courier service or (c) on the date of receipt when mailed (registered or certified mail, postage prepaid, return receipt requested) addressed to a party at the address give above.

IN WITNESS WHEREOF, the forgoing Mutual Cooperation and Coordination Agreement has been duly executed by the parties hereto as of the day and date first written above.

BY: _____

BY: _____

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

ATTACHMENT 4 - SAMPLE CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR DRUG TREATMENT INFORMATION

I, _____, authorize
(Name of patient)

(Name or general designation of program making disclosure)

to disclose to _____ the
(Name of person or organization to which disclosure is to be made)

following information: _____
(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to: _____
(Specific purpose of disclosure)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____
Signature of patient

Signature of parent, guardian or authorized

representative when required

Source: This sample form is set forth in CSAT/SAMHSA's TAP 13, Page 17; TIP 7, Page 41

ATTACHMENT 5 - CCC PLUS COVERAGE CHART

The Contractor shall provide benefits as defined in this Contract within at least equal amount, duration, and scope as available under the State Medicaid fee-for-service program, and as further defined in the Medicaid State Plan, DMAS policy and guidance documents, and as described in the CCC Plus Coverage Chart below. Services listed as non-covered by Medicaid shall be covered by the Contractor when medically necessary for children under age 21 in accordance with Federal EPSDT requirements.

The CCC Plus Coverage Chart provides detailed information for covered benefits and includes information on how the Contractor can assist its CCC Plus Members in accessing services that are carved-out of this Contract and covered through fee-for-service or other DMAS Contractor. Services are presented in the chart in the following order: Part 1- Medical Benefits, Part 2A-Inpatient and Outpatient Mental Health Services, Part 2B – Community Mental Health Rehabilitation Services (CMHRS), Part 2C – Addiction and Recovery Treatment (ARTS), Part 3A – EPSDT Services, Part 3B – Early Intervention Services, Part 4A - Long Term Care Facility Based Services, Part 4 B- Long Term Services and Supports- Community Based, Part 4C- Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver Services.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40 Also See Hospital Manual Chapter IV, Exhibits for required forms.	Yes, limited	Yes, limited	The Contractor shall provide coverage for abortions in limited cases where there would be a substantial danger to life of the mother as referenced in Public Law 111-8, as written at the time of the execution of this contract, shall be reviewed to ensure compliance with State and Federal law. The Contractor shall be responsible for payment of abortion services meeting State and Federal requirements under the fee-for-service program.
Assisted Suicide	Assisted Suicide Funding Restriction Act of 1997 (42 USC § 14401, et. seq.)	No	No	The Contractor shall not cover services related to assisted suicide, euthanasia, or mercy killings, or any action that may secure, fund, cause, compel, or assert/advocate a legal right to such services.
Behavioral Health	See Part 2 of this Attachment			
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid covered service. <i>The Contractor is not required to cover this service except as medically necessary in accordance with EPSDT criteria.</i>
Christian Science Sanatoria Facilities and Nurses	12 VAC 30-50-300	Yes	No	The Contractor is not required to cover this service. Individuals will be excluded from CCC Plus program participation when admitted to a Christian Science Sanatoria and services shall be covered under the fee-for-service program with DMAS established criteria and guidelines. Christian Science Nursing Services are not covered.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor shall cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Community Intellectual Disability Case Management (T1017)	12 VAC 30-50-440	Yes	No	The Contractor shall provide information and referrals as appropriate to assist Members in accessing these services through the individual’s local community services board.
Court Ordered Services	<i>Code of Virginia</i> Section 37.1-67.4	Yes	Yes	The Contractor shall cover all medically necessary court ordered services. In the absence of a contract otherwise, out-of-network payments will be made in accordance with the Medicaid fee schedule.
Dental	12 VAC 30-50-190 See Dental Manual	Yes	Limited coverage	DMAS’ contracted dental benefits administrator (DBA) will cover routine dental services for children under 21 and for adult pregnant women; therefore, these services are carved out of CCC Plus program. However, the Contractor shall be responsible for transportation and medication related to covered dental services. The Contractor shall cover CPT codes billed by an MD as a result of an accident, and CPT and “non-CDT” procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor shall also cover medically necessary anesthesia and hospitalization services for its Members when determined to be medically necessary by the Department’s Dental Benefits Administrator.
Developmental Disability Support Coordination (T2023)	12 VAC 30-50-490	Yes	No	These services will be covered through Medicaid fee-for-service until completion of the Community Living and Family and Individual Supports system redesign.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Dietary Counseling Medicaid Works (Also see EPSDT and Pregnancy related services)	12VAC30-60-200	Yes	Limited Coverage	<p>The Contractor shall cover medically necessary Dietary Counseling Services, for Medicaid Works enrolled Members. For example, if they have hyperlipidemia (high cholesterol) and/or other known risk factors for cardiovascular and diet-related chronic disease (for example, heart disease, diabetes, kidney disease, obesity).</p> <p>DMAS FFS reimburses for Dietary Counseling services for Medicaid Works individuals (aid category 59) as follows:</p> <ol style="list-style-type: none"> 1. Medical Nutrition Therapy; Initial Assessment CPT code 97802: \$28.10 per unit for inpatient and \$29.93 per unit for outpatient with a maximum of four (4) units per day in either setting; and 2. Medical Nutrition Therapy; Re-Assessment and Intervention, CPT code 97803: \$23.82 per unit for inpatient and \$25.96 per unit for outpatient with a maximum of two (2) units per day in either setting.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services - See Part 3A of this Attachment				
Early Intervention Services - See Part 3B of this Attachment				
Emergency Services	42 CFR § 438.114 12 VAC 30-50-110 12 VAC 30-50-300	Yes	Yes	The Contractor shall cover all emergency services without service authorization. The Contractor shall also cover services needed to ascertain whether an emergency exists. The Contractor shall not restrict a Member's choice of provider for emergency services.
Emergency Services - Post Stabilization Care	42 CFR § 422.100(b)(1)(iv)	Yes	Yes	The Contractor shall cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary until AFTER an emergency condition has been stabilized.
End Stage Renal Disease (ESRD)	12 VAC 30-50-270 and 12 VAC 30-60-130	Yes	Yes	Individuals diagnosed with ESRD at time of enrollment will be auto-enrolled in CCC Plus but may request to be disenrolled within the first 90 days of CCC Plus enrollment and remain in FFS. CCC Plus Members who are diagnosed with ESRD after enrollment will remain in CCC Plus program for ESRD services.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Enhanced Services	CCC Plus Contract	No	Yes	Enhanced benefits are services offered by the Contractor to Members in excess of CCC Plus program covered services. Enhanced benefits do not have to be offered to individuals in every category of eligibility; however, must be available to all individuals if placed on the CCC Plus comparison chart. See contract section ‘Enhanced Benefits’ for more information.
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	Experimental and investigational procedures as defined in 12 VAC 30-50-140 are not covered. <i>For those Members <21, clinical trials are not always considered to be experimental or investigational and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.</i>
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover all family planning services and supplies for Members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor shall not restrict a Member’s choice of provider or method for family planning services or supplies, and the Contractor shall cover all family planning services and supplies provided to its Members by network and out-of-network providers. Individuals enrolled in Plan First are excluded from CCC Plus program participation.
HIV Testing and Treatment Counseling	<i>Code of Virginia</i> Section 54.1-2403.01 12 VAC 30-50-510 Chapter IV of the Physician Manual	Yes	Yes	The Contractor shall comply with the State requirements governing HIV testing and treatment counseling for pregnant women. The Contractor shall ensure that, as a routine component of prenatal care, every pregnant Member shall be advised of the value of testing for HIV infection. Any pregnant Member shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the Member’s Medical Record.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Home Health Services	12VAC30-10-220 12VAC30-50-160 12VAC30-50-200 12 VAC 30-60-70 42 CFR § 440.70 41 CFR § 441.15	Yes	Yes	<p>The Contractor shall cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits per year shall be allowed. Skilled home health visits are limited based upon medical necessity. The Contractor shall manage conditions, where medically necessary and regardless of whether the need is long or short-term, including in instances where the Member cannot perform the services; where there is no responsible party willing and able to perform the services; and where the service cannot be performed in the PCP office/outpatient clinic, etc. The Contractor may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option.</p> <p>Medicaid home health services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy participants determined to be eligible for assistance. Home health services for Medicaid must not be of any less or greater duration, scope, or quality than that provided participants not receiving State and/or Federal assistance for those home health services. For the purpose of the Virginia Medical Assistance Program, a home health agency is an agency or distinct unit that is primarily engaged in providing licensed nursing services and other therapeutic services outside an institutional setting.</p> <p>0550 Skilled Nursing Assessment 0551 Skilled Nursing Care, Follow-Up Care 0559 Skilled Nursing Care, Comprehensive Visit 0571 Home Health Aide Visit 0424 Physical Therapy, Home Health Assessment 0421 Physical Therapy, Home Health Follow-Up Visit 0434 Occupational Therapy, Home Health Assessment 0431 Occupational Therapy, Home Health Follow-Up Visit 0444 Speech-Language Services, Home Health Assessment 0441 Speech Language Services, Home Health Follow-Up Visit 0542 Non-Emergency Transportation, Per Mile</p> <p><i>Additional information can be found in the Home Health provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</i></p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Hospice Services - See Part 4 (LTSS) of this Attachment.				
Hysterectomies	42 CFR Part 441 Subpart F as amended See Hospital Manual Chapter IV, Exhibits For required forms.	Yes, limited.	Yes, limited.	The Contractor may not impose a 30-day waiting period for hysterectomies that are not performed for rendering sterility. The Contractor shall inform the patient that the hysterectomy will result in sterility and must have the patient acknowledge her understanding. Patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization form (DMAS-3004) or adhere to the waiting period. Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid. The Contractor shall comply with State and Federal reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or upon request.
ID/DD/DS Waivers (known Community Living Waiver, Family and Individual Supports Waiver, and Building Independence Waiver) See Part 4C of this Attachment.				
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor shall cover immunizations within the most current Center for Disease Control (CDC) guidelines for EPSDT populations and Medicaid Expansion populations as an ACA Minimum Essential Benefit only. The Contractor shall educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates. See EPSDT in part 3B for immunizations for children, and Section 4.17, <i>ACA Minimal Essential Benefits for the Medicaid Expansion Population</i> .

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 12 VAC 30-50-225 12 VAC 30-60-20 12 VAC 30-60-120 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor shall cover inpatient stays in general acute care and rehabilitation hospitals for all Members; shall comply with maternity length of stay requirements; shall comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements; and shall cover an early discharge follow-up visit in maternity cases where the Member is discharged earlier than 48 hours after the day of delivery. Notwithstanding these requirements, the attending physician and the patient can determine that a shorter stay in the hospital is appropriate in accordance with Chapter 631 of 1998 Virginia Acts of Assembly, § 32.1-325(a)(1) through § 32.1-325(a)25 of the <i>Code of Virginia</i> .
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID); state or private. - See Part 4 of this Attachment.				
Laboratory, Radiology and Anesthesia Services	12 VAC 30-50-120	Yes	Yes	The Contractor shall cover all medically necessary laboratory, radiology and anesthesia services directed and performed within the scope of the license of the practitioner. In accordance with 42 CFR §§ 493.1 and 493.3, all laboratory testing sites providing services under this Contract are required to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.
Lung Cancer Screening with Low Dose Computed Tomography (LDCT)	12VAC30-50-220	Yes	Yes	Screenings will be covered for Members who meet all of the following criteria: 55-80 years of age; asymptomatic (no signs or symptoms of lung cancer); tobacco smoking history of at least one pack per day for 30 or more years; current smoker or former smoker who has quit smoking within the last 15 years; and, receive a written order furnished by a licensed provider or a qualified non-physician practitioner for lung cancer screening with LDCT that meets the requirements described above. Prior authorization may be required. Providers use G0297 for billing. Diagnosis codes Z87.891, F17.210, F17.211, F17.213, F17.218, or F17.219
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor shall cover low-dose screening mammograms for determining presence of occult breast cancer. Screening mammograms for age 40 and over shall be covered consistent with the guidelines published by the American Cancer Society.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Medical Supplies and Equipment	12 VAC 30-50-165 12 VAC 30-60-75 12 VAC 30-80-30	Yes	Yes	<p>The Contractor shall cover medical supplies and equipment at least to the extent covered by DMAS. The Contractor’s DME benefits shall be limited based upon medical necessity. There are no maximum benefit limits on DME. The Contractor shall cover nutritional supplements and supplies for children and adults. The Contractor shall cover specially manufactured DME equipment that was prior authorized by the Contractor per requirements specified in the DME supplies manual. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the plan, even if the Member is no longer enrolled with the plan or with Medicaid. Retraction of the payment for specialized equipment can only be made if the Member is retro-disenrolled for any reason by the Department and the effective date of the retro-disenrollment precedes the date the equipment was authorized by the plan. The Contractor must use the valid preauthorization begin date as the invoice date.</p> <p>Additional information can be found in the Durable Medical Equipment & Supplies provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p> <p><u>The MCOs shall work with the Member to receive/replace DME supplies that have been lost or destroyed, or the current DME provider is not available, as a result of a disaster or emergency in accordance with Code of Virginia § 44.146.16.</u></p>
Mental Health Services - See Part 2 of this Attachment				
Certified Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor shall cover certified nurse-midwife services as allowed under State licensure requirements and Federal law.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Organ Transplantation	12 VAC 30-50-540 12 VAC 30-50-550 12-VAC 30-50-560 12 VAC 30-50-580, 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	The Contractor shall cover organ transplants for children and adults in accordance with 12 VAC 30-10-280, 12 VAC 30-50-540, VAC 30-50-550, VAC 30-50-560 and 12 VAC 30-50-580 within at least equal amount, duration, and scope as Medicaid fee-for-service. Transplant services for kidneys, corneas, hearts, lungs, livers (from living or cadaver donors), and bone marrow/stem cell shall be covered for all eligible persons as medically necessary and based on evidenced-based clinical standards of care. Experimental or investigational transplants are not covered. Contractor shall cover necessary procurement/donor related services. Transplant services shall be covered for children (under 21 years of age) per EPSDT guidelines.
Outpatient Hospital Services	12 VAC 30-50-110	Yes	Yes	The Contractor shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. 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. Outpatient services include emergency services, surgical services, diagnostic, and professional provider services. Facility charges are also covered.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor shall cover annual pap smears consistent with the guidelines published by the American Cancer Society.
Personal Care; EPSDT	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR § 441.50 1905(a) of Social Security Act	EPSDT	EPSDT	The Contractor shall cover medically necessary personal care services for children under age 21 consistent with the Department’s criteria described in the EPSDT Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. Personal care coverage is also available for Members through HCBS waiver programs. See Section 4 of this coverage chart.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
<p>Personal Care Medicaid Works</p> <p>See CCC Plus Waiver services in Section 4b.</p>	<p>12VAC30-60-200 12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	<p>Yes</p>	<p>Yes</p>	<p>The Contractor shall provide coverage for personal care services for Medicaid works individuals using the same coverage criteria as the personal care coverage criteria under the CCC Plus HCBS waiver, however, Medicaid Works individuals are not required to have a Medicaid LTSS screening. In order to receive personal care services, Medicaid Works individuals who meet coverage criteria must be enrolled with the Medicaid Works (MW) exception indicator. Medicaid Works individuals also have no patient pay responsibility for the personal care services. Criteria information regarding personal care can be found in the Commonwealth Coordinated Care Plus Waiver Provider Manual, Chapter IV, beginning on page 10. The manual is available on the web portal at www.virginiamedicaid.dmas.virginia.gov under the Provider Resources; Provider Manuals link.</p>
<p>Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services</p>	<p>12 VAC 30-50-200 12 VAC 30-50-225 12 VAC 30-60-150</p>	<p>Yes</p>	<p>Yes</p>	<p>The Contractor shall cover physical therapy, occupational therapy, speech pathology, and audiology services that are provided as an inpatient, outpatient hospital service, outpatient rehabilitation agencies, or home health service. The Contractor’s benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity. There are no maximum benefit limits on PT, OT, SLP, and audiology services. These services are covered regardless of where they are provided, The plan shall also cover all Medically Necessary, intensive physical rehabilitation services in facilities which are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Physician Services	12 VAC 30-50-140 12 VAC 30-50-130 42 CFR §438.206	Yes	Yes	<p>The Contractor shall cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT. The Contractor shall permit any female Member of age thirteen (13) or older direct access, as provided in subsection B of § 38.2-3407.11 of the <i>Code of Virginia</i>, to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.</p> <p>The Contractor shall provide for a second opinion from a network provider, or arrange for the Member to obtain one outside the network, at no cost to the Member.</p>
Podiatry	12 VAC 30-50-150	Yes	Yes	<p>The Contractor shall cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot. The Contractor is not required to cover preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; or acupuncture.</p>

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Pregnancy-Related Services	12 VAC 30-50-510 12 VAC 30-50-410 12 VAC 30-50-280 12 VAC 30-50-290	Yes	Yes	The Contractor shall cover prenatal and postpartum services to pregnant enrollees. The Contractor shall cover case management services for its high risk pregnant women. The Contractor shall provide to qualified Members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. The Contractor shall cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends for the Contractor’s enrolled Members. In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, the plan shall cover at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists. As set forth in 12 VAC 30-50-220, the early discharge follow-up visit shall be provided to all mothers who meet the Department’s criteria and the follow-up visit shall be provided within forty-eight (48) hours of discharge and meet minimum requirements.
Prescription Drugs	12 VAC 30-50-210 Chapter IV of the Pharmacy Manual	Yes	Yes	The Contractor shall cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits. Refer to the Contract Section 4.8, <i>Pharmacy Services</i> .
Private Duty Nursing (PDN)	https://www.virginiamedicaid.dmas.virginia.gov/wps/portal 42 CFR § 441.50 1905(a) of Social Security Act	EPSDT only	EPSDT only	The Contractor shall cover medically necessary private duty nursing services for children under age 21 consistent with the Department’s criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal (Also see Technology Assisted Program in Part 4 of this Attachment) Not a State Plan covered benefit for Adults. Coverage is available for children under age 21 under EPSDT. PDN Coverage is also available for Members in the Technology Assisted Program.
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male Members for prostate cancer.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120 Chapter IV of the Prosthetic Devices Manual	Yes	Yes	The Contractor shall cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12 VAC 30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor shall cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	The Contractor shall cover reconstructive breast surgery.
School Health Services	12 VAC 30-50-130	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department’s criteria will continue to be covered as a carve-out service through the DMAS fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Local Education Agency school provider manual. The Contractor shall cover EPSDT screenings for the general Medicaid student population. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. Private duty nursing and personal care services provided through EPSDT, Technology Assisted Program, Community Living Waiver, or Family and Individual Supports Waiver are not considered school health services, including when provided in the school setting or provided before or after school.
Skilled Nursing Facility Care - See Part 4A (LTC Facility Services) of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Sterilizations	42 CFR§ 441, Subpart F, as amended <i>Code of Virginia</i> § 54.1-2974	Yes, limited.	Yes, limited.	The Contractor shall not perform sterilization for a Member under age twenty-one (21). The Contractor shall comply with State and Federal requirements and shall comply with the thirty (30) calendar day waiting period requirement as specified in <i>Code of Virginia</i> § 54.1-2974. The Contractor shall ensure that the consent form DMAS-3004 of 42 CFR § 441.258 is both obtained and documented prior to the performance of any sterilization under this Contract. Specifically, there must be documentation of the Member being informed, the Member giving written consent, and the interpreter, if applicable, signing and dating the consent form prior to the procedure being performed. The Contractor shall comply with State and Federal reporting and compliance requirements for sterilizations and hysterectomies, reporting the policy and processes used to monitor compliance to the Department prior to signing the initial contract, upon revision or upon request.
Substance Use Disorder Treatment - See Part 2C of this Attachment.				
Telemedicine Services	Chapter IV of the DMAS Physician Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The plan shall provide coverage for telemedicine services. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Department recognizes physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors for medical telemedicine services and requires one of these types of providers at the main (hub) and satellite (spoke) sites for a telemedicine service to be reimbursed. Federal and state laws and regulations apply, including laws that prohibit debarred or suspended providers from participating in the Medicaid program. All telemedicine activities shall be compliant with HIPAA requirements.

SUMMARY OF COVERED SERVICES - PART 1 – MEDICAL BENEFITS				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Transportation	12 VAC 30-50-530 12 VAC 30-50-300 42 CFR §440.170(a) Chapter IV of the Transportation Manual	Yes	Yes	The Contractor shall provide urgent and emergency transportation as well as non-emergency transportation to all Medicaid covered services, including those Medicaid services covered by Medicare or another third party payer and to services provided by subcontractors. These modes shall include, but shall not be limited to, non-emergency air travel, non-emergency ground ambulance, stretcher vans, wheelchair vans, common user bus (intra-city and inter-city), volunteer/registered drivers, and taxicabs. The Contractor shall cover air travel for critical needs. The Contractor shall cover travel expenses determined to be necessary to secure medical examinations and treatment as set forth in CFR § 440.170(a). The Contractor shall cover transportation to all Medicaid covered services, even if those Medicaid covered services are reimbursed by an out-of-network payer or are carved-out services. The Contractor shall cover transportation to and from Medicaid covered community mental health rehabilitation services. Community Living, Family and Individual Supports, and Building Independence Waiver Members shall receive acute and primary medical services via the Contractor and shall receive waiver services and related medical transportation to waiver services via the fee-for-service program.
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	The Contractor shall cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy for Members covered through Medicaid Expansion and Members covered through EPSDT, in accordance with the Affordable Care Act. 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.
Vision Services	12 VAC 30-50-210 Chapter IV of the Vision Services Manual	Yes	Yes	The Contractor shall cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. The Contractor shall also cover eyeglasses for children under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based) - See Part 4 B (LTSS) of this Attachment.				

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES*				
*Coverage must comply with Federal Mental Health Parity law. (See Section 4.2.7, Mental Health Parity)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
INPATIENT MENTAL HEALTH TREATMENT SERVICES				
Inpatient Psychiatric Hospitalization in Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 12VAC30-50-130 12VAC30-50-100 12VAC30-50-105 Manual-Psychiatric Services Chapter 4 Final Rule: 42 CFR Part 438.6 page 27861 and pages 27557 and 27558	Yes	Yes	The Contractor shall cover medically necessary inpatient psychiatric hospital stays in free standing psychiatric hospitals for covered Members over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an “in lieu of” service to Medicaid Members between the ages of 21 and 64. Coverage must comply with Federal Mental Health Parity law and Federal provisions for IMDs. For Members aged 21-64, the Contractor may provide services through an IMD (Institute of Mental Disease) for no more than 15 days in a calendar month, consistent with the Federal regulations described in 42 CFR § 438.6 and section 4.12 <i>State Plan Substituted (In Lieu Of) Services</i> of this contract.
Inpatient Psychiatric Hospitalization in General Hospital	12 VAC 30-50-100 12VAC30-50-130 12VAC30-50-105 12 VAC 30-50-230 12 VAC 30-50-250 12VAC30-60-25 Manual-Psychiatric Services, Chapter 4	Yes	Yes	The Contractor shall provide coverage for medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital for all Members, regardless of age. Coverage must comply with Federal Mental Health Parity law.
State Geriatric Hospital Placements (Piedmont, Catawba, Hiram Davis, and Hancock)		Yes	No	Individuals in Piedmont, Catawba, Hiram Davis, and Hancock state geriatric facilities are excluded from CCC Plus program participation.
Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO)	<i>Code of Virginia</i> § 16.1-340 and 340.1 and §§ 37.2-808 through 810	Yes	Yes	Pursuant to 42 CFR § 441.150 and the <i>Code of Virginia</i> , § 16.1-335 et seq., § 37.2-800 et. seq., and the 2014 Virginia Acts of Assembly, Chapter 691, the Contractor shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services. The

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES*

*Coverage must comply with Federal Mental Health Parity law. ([See Section 4.2.7, Mental Health Parity](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
(Revenue Codes for TDOs and Service Code 0450 for ECOs)	Appendix B of the Hospital Manual			<p>Contractor is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the Contractor may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the Member is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. The duration of temporary detention shall be in accordance with the <i>Code of Virginia</i>, as follows:</p> <p>For Individuals under age 18 (Minors) – Pursuant to §16.1-340.1.G of the <i>Code of Virginia</i>, 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.</p> <p>For Adults age 18 and over – Pursuant to § 37.2-809.H of the <i>Code of Virginia</i>, 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.</p>

OUTPATIENT MENTAL HEALTH SERVICES – Psychiatric Services Manual for All

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES*

*Coverage must comply with Federal Mental Health Parity law. ([See Section 4.2.7, Mental Health Parity](#))

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Electroconvulsive Therapy	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180	Yes	Yes	The Contractor shall cover medically necessary electroconvulsive therapy services. Coverage must comply with Federal Mental Health Parity law.
Pharmacological Management, including prescription and review of medication, when performed with psychotherapy services	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary pharmacological management services. (CPT 90863)
Psychiatric Diagnostic Evaluation	12 VAC 30-50-180 12 VAC 30-50-140 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Psychiatric Diagnostic Evaluation ; with Medical Service (CPT 90792 alone or GT)
Psychological/ Neuropsychological Testing	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary psychological and neuropsychological testing services. Coverage must comply with Federal Mental Health Parity law. The former psychological testing CPT codes (96101-96103) and neuropsychological testing CPT codes (96118-96120) are retired, and have been replaced with the following codes, effective Jan. 1, 2019: Psychological Testing administered by Computer (CPT: computer:96146) Neurobehavioral Status Exam (CPT: 96116 and 96121 for Each Add'l Hour) Neuropsychological Testing Administered by Psychologist/Physician (CPT: 96132 and 96133 for Each Add'l Hour; 96136 and 96137 for Each Add'l 30 minutes) Neuropsychological Testing Administered by Technician (CPT: 96138 and 96139 for Each Add'l 30 minutes) Neuropsychological Testing Administered by Computer(CPT: 96146)

SUMMARY OF COVERED SERVICES - PART 2A – MENTAL HEALTH TREATMENT SERVICES*				
*Coverage must comply with Federal Mental Health Parity law. (See Section 4.2.7, Mental Health Parity)				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Tobacco Cessation	State Medicaid Director Letter, June 24, 2011 – page 4	Yes	Yes	The Contractor shall cover medically necessary tobacco cessation services, including both counseling and pharmacotherapy. The EPSDT benefit includes the provision of anticipatory guidance and risk-reduction counseling with regard to tobacco use during routine well-child visits. In addition to routine visits, additional counseling and tobacco cessation drug therapy must be provided when medically necessary for individuals under age 21.
Psychotherapy (Individual, Family, and Group)	12 VAC 30-50-140 12 VAC 30-50-150 12 VAC 30-50-180 Psychiatric Services Manual	Yes	Yes	The Contractor shall cover medically necessary outpatient individual, family, and group mental health treatment services. Coverage must comply with Federal Mental Health Parity law. Use the most up-to-date version of the CPT codes

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES				
*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)				
<i>The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.</i>				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Behavioral Therapy Services	12 VAC 30-50-130; 12 VAC 30-50-150; 12 VAC 30-60-61; 12 VAC 30-80-97; 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]	Yes	Yes	The Contractor is required to provide coverage for Behavioral Therapy (BT) Services as defined by 12 VAC 30-50-130 and the DMAS Behavioral Therapy Program Supplement to the CMHRS Manual available at https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal . Behavioral Therapy (Service Code: H2033) Behavioral Therapy Comprehensive Needs Assessment (Service Code: H0032-UA)

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	EPSDT Manual			
Crisis Intervention Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 Community Mental-Health Rehabilitation Services Manual - CMHRS Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary crisis intervention services. Defined as immediate behavioral health care, available twenty-four (24) hours a day, seven (7) days a week, to assist Enrollees who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as Enrollees who are a danger to themselves or others. This service’s objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the Enrollee, providing access to further immediate assessment and follow-up, and linking the Enrollee and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, screenings, telephone contacts, and other client-related activities for the prevention of institutionalization. Service Code: H0036 alone or GT; or H0036 GT alone or 32
Crisis Stabilization Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary crisis stabilization services. Includes services provided to non-hospitalized Enrollees experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation. Service Code: H2019

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Day Treatment/Partial Hospitalization	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary day treatment/partial hospitalization assessment and treatment services. Includes sessions of two (2) or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for Enrollees with serious behavioral disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for Enrollees with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital. SSPI Service Code: H0032-U7 Treatment Service Code: H0035HB
Intensive Community Treatment Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary Intensive Community Treatment Assessment and Treatment services. Includes an array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Intensive Community Treatment is provided through a designated multi-disciplinary team of behavioral health professionals. It is available twenty-four (24) hours per day. Comprehensive Needs Assessment Service Code: H0032-U9 Treatment Service Code: H0039
Intensive In-Home Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143	Yes	Yes	The Contractor shall cover medically necessary Intensive In-Home Assessment and Treatment services.

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6			Comprehensive Needs Assessment Service Code: H0031 Treatment Service Code: H2012
Mental Health Case Management	12 VAC 30-50-420 through 12 VAC 30-50-430 12 VAC 30-60-143 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary Mental Health Case Management services. Service Code: H0023
Mental Health Skill-building Assessment and Treatment Services	12 VAC 30-50-226 12 VAC 30-60-143 12 VAC 30-50-130 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5	Yes	Yes	The Contractor shall cover medically necessary Mental Health Skill-building Assessment and Treatment Services. Comprehensive Needs Assessment Service Code: H0032-U8 Treatment Service Code: H0046

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	CMHRS Manual Chapters 2, 4 & 6			
Psychosocial Rehabilitation Assessment and Treatment Services	12 VAC 30-50-130 12 VAC 30-50-226 12 VAC 30-60-5 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-143 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary Intensive Psychosocial Rehabilitation Assessment and Treatment Services. Includes services for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a nonresidential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications. These services are limited to 936 units annually. Comprehensive Needs Assessment Service Code: H0032-U6. Treatment Service Code: H2017* Not an excluded service for Members in one of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation.
Therapeutic Group Home Children and Adolescents under 21 – Group Home (Formerly known as Levels A&B)	12 VAC 30-50-130 and 12 VAC 30-60-61 VAC 30-60-5 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)]	Yes	Not at this time.	The Contractor shall cover medically necessary Residential Services (Community-Based) for children and Adolescents under 21 – Therapeutic Group Home (formerly Levels A&B). Level A Service Code: H2022 HW or HK (Level A will cease to be reimbursed on 5/1/2018) TGH Service Code: H2020 HW or HK <i>TGH will transition later than the CMHRS.</i>

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	Residential Treatment Services Manual			
Psychiatric Residential Treatment Facility – (PRTF) for children under age 21 years – (Formerly known as Level C)	12 VAC 30-10-540 12 VAC 30-60-61 12 VAC 30-50-130 12 VAC 30-60-5 Residential Treatment Services; Manual	Yes	Not at this time.	The Contractor is not responsible for covering Psychiatric Residential Treatment Facility (PRTF) services. DMAS authorization into a PRTF program will result in disenrollment of the Member from the CCC Plus program. The PRTF provider must contact the DMAS BHSA for authorization and payment through the fee-for-service program. The Contractor must work closely with the Department’s BHSA to ensure against unnecessary institutional placement; i.e., including where treatment in a community level of care is a timely and safe and effective treatment alternative. Revenue codes and Service code 1001 <i>PRTF will transition later than the CMHRS.</i>
Therapeutic Day Treatment (TDT) for Children and Adolescents	12 VAC 30-50-130 12 VAC 30-60-61 12 VAC 30-60-143 12 VAC 30-50-226 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] 12 VAC 30-60-5 CMHRS Manual Chapters 2, 4 & 6	Yes	Yes	The Contractor shall cover medically necessary Therapeutic Day Treatment (TDT) for Children and Adolescents. Comprehensive Needs Assessment Service Code: H0032 Service Code: H0035 HA Modifiers: School Based TDT must be billed as H0035HA After School TDT must be billed as H0035HA-UG Summer TDT must be billed as H0035HA-U7

SUMMARY OF COVERED SERVICES - PART 2B – COMMUNITY MENTAL HEALTH REHABILITATION SERVICES (CMHRS) * & RESIDENTIAL TREATMENT SERVICES

*Coverage must comply with Federal Mental Health Parity law. (See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001)

The Contractor shall provide coverage for CMHRS within the Department’s coverage criteria and guidelines and consistent with Mental Health Parity law. CMHRS Providers shall have the appropriate licensure and qualifications. Refer to Medicaid provider manuals listed under each service for full descriptions, provider qualifications, and service limitations. Exceptions are noted below.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years.	12 VAC 30-60-170 12 VAC 30-50-480 12 VAC 30-130-900 to 950 12 VAC 30-80-111 CMHRS Manual Chapters 2, 4 & 6	Yes	Not at this time.	The Contractor shall cover medically necessary Treatment Foster Care (TFC) Case Management (CM) for children under age 21 years. Service Code T1016. <i>TFC-CM will transition later than the CMHRS.</i>
MH Peer Recovery Support Services	Regulations: 12 VAC 30-50-226 12 VAC 30-50-130 12 VAC 30-130-5160 through 12 VAC 30-130-5210 12 VAC 30-130-2000 [excluding C.4, D.2(d) and E(i)] Manual: CMHRS – Peer Recovery Support Services Manual Supplement	Yes	Yes	The Contractor shall cover medically necessary MH Peer Support Services for adults and MH Family Support Partners for youth under 21. Service Code H0024 (Individual) H0025 (Group)

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))
[See ARTS website for forms, credentialing requirements and coverage updates: http://www.dmas.virginia.gov/#/arts](#)

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
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INPATIENT AND RESIDENTIAL SUD TREATMENT SERVICES - The Contractor shall provide coverage in IMD settings as appropriate based on the ASAM Criteria for adults who are 21 through 64 years of age.

Medically Managed Intensive Inpatient	ASAM Level 4.0	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0011 or Rev. 1002
Medically Monitored Intensive Inpatient Services	ASAM Level 3.7	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2036 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed High Intensity Residential Services	ASAM Level 3.5	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier(s) HB-Adult or HA-Adolescent
Clinically Managed Population-Specific High Intensity Residential Services	ASAM Level 3.3	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0010 / Rev 1002 and Modifier TG
Clinically Managed Low Intensity Residential Services	ASAM Level 3.1	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H2034

OUTPATIENT WITHDRAWAL MANAGEMENT

ARTS Partial Hospitalization	ASAM Level 2.5	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes S0201 Rev 0913 and S0201
ARTS Intensive Outpatient	ASAM Level 2.1	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. Service Codes H0015 Rev 0906 and H0015
Ambulatory Withdrawal Management With	ASAM Level 2WM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))
 See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities	
Extended On- Site Monitoring					
Ambulatory Withdrawal Management Without Extended On- Site Monitoring	ASAM Level 1 WM	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. CPT codes	
Medication Assisted Treatment (MAT)					
Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Medication Administration Care Coordination Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance	H0004 – individual and family counseling H0005 - group counseling S0109 Methadone 5 mg oral billed by provider H0020 G9012 Substance Use Care Coordination H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Methadone Clinics)	ASAM Opioid Treatment Programs	Yes	Yes	Counseling Medication Care Coordination	H0004 – individual and family counseling H0005 - group counseling J0572, J0573, J0574, J0575 Buprenorphine/Naloxone Oral billed by provider J0571 Buprenorphine Oral billed by provider J2315 Naltrexone, Injection, depot form, billed by provider G9012 Substance Use Care Coordination

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. (See the [CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))
 See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
				Physician Visit – Induction Day 1 Urine Drug Screen Labs Physician Visit – Maintenance H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
Buprenorphine/Naloxone in ASAM Office Based Opioid Treatment and ASAM Level 1.0	ASAM Office Based Opioid Treatment	Yes	Yes	Counseling and Medication Oversight Care Coordination Physician Visit – Induction Day 1 Drug Screen Labs Physician Visit – Maintenance H0004 – individual and family counseling H0005 - group counseling G9012 Substance Use Care Coordination H0014 80305 to 80307 and G0480- G0483 CPT codes Use CPT E&M Established patient
ARTS CASE MANAGEMENT, OUTPATIENT, AND PEER RECOVERY SUPPORT SERVICES				
Substance Use Case Management	12 VAC 30-60-185 12 VAC 30-50-491	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria. (H0006)
Outpatient ARTS Individual, Family, and Group Counseling Services	ASAM Level 1.0	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria (CPT Codes)
ARTS Peer Recovery Support Services	Regulations: 12VAC30-50-226 12VAC30-50-130 12VAC30-130-5160 through 12VAC30-130-5210	Yes	Yes	The Contractor shall cover ARTS Peer Support Services for Adults and ARTS Family Support Partners for youth under 21. Group – S9445 Individual – T1012

SUMMARY OF COVERED SERVICES - Part 2 C - ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)*

*Coverage must comply with Federal Mental Health Parity law. ([See the CMS State Official Letter, dated January 16, 2013; SHO # 13-001](#))
 See ARTS website for forms, credentialing requirements and coverage updates: <http://www.dmas.virginia.gov/#/arts>

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities
	http://townhall.virginia.gov/L/ViewXML.cfm?textid=11723 To Be Determined; New Service Manual: ARTS - Peer Services Manual Supplement			
Screening, Brief Intervention and Referral to Treatment (SBIRT)	ASAM Level 0.5 12VAC30-50-180	Yes	Yes	The Contractor shall cover SUD services within ASAM criteria (99408/99409)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
EPSDT Benefit Global Coverage Guidelines	<p>12 VAC 30-50-130 42 CFR § 440.40(b)(2) and 42 CFR § 441 Subpart B (Sections 50-62) Omnibus Budget Reconciliation Act of 1989 (OBRA89) Section 1905(r)(5) of the Social Security Act http://www.dmas.virginia.gov/files/links/914/EPSDT%20Specialized%20Services%20-%20Guide%20to%20Providers.pdf https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p>	Yes	Yes	<p>EPSDT includes periodic screening, vision, dental and hearing services for Medicaid beneficiaries under 21 years of age. EPSDT also includes a federal requirement which compels state Medicaid agencies to cover services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. Refer to the following for more information: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html</p> <p>Ameliorate is defined as necessary to improve or to prevent the condition from getting worse.</p> <p>For individuals under 21 years of age EPSDT services will be provided before Technology Assisted Program services are offered.</p> <p>The Contractor shall screen and assess all children; cover immunizations; educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal to increase immunization rates.</p> <p>EPSDT Assistive Technology (T5999) is a covered EPSDT benefit. The Contractor shall provide assistive technology as specified in the EPSDT Manual, Supplement B Chapter.</p>
Behavioral Therapy Services	Same as EPSDT Global Coverage Guidelines			

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
See CMHRS Services Part 2B of this Coverage Chart				
Case Management for High Risk Infants (up to age 2)	12 VAC 30-50-410	Yes	Yes	The Contractor shall reimburse case management services for high risk Medicaid eligible children up to age 2.
Clinical Trials	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Clinical trials are not always considered to be experimental or investigational, and must be evaluated on a case-by-case basis using EPSDT criteria as appropriate.
Dental Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>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.</p> <p>Contracted PCPs or other screening providers must make an initial direct referral to a dentist when the child receives his or her one-year screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. When any screening, even as early as the neonatal examination, indicates a need for dental services at any earlier age, referral must be made for needed dental services.</p> <p>The Contractor is not required to cover testing of fluoridation levels in well water.</p>
Dental Varnish	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form shall be covered.

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Hearing Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>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.</p> <p>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.</p>
Immunizations	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>According to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines, immunizations shall be reviewed at each screening examination, and necessary immunizations should be administered at the time of the examination. Coverage shall also be within CDC guidelines. The Contractor shall coordinate coverage within the Virginia Vaccines for Children (VVFC) program. See the EPSDT Supplement Manual and the VVFC website at: http://www.vdh.virginia.gov/immunization/vvfc</p>
Laboratory Tests	Same as EPSDT Global Coverage Guidelines	Yes	Yes	<p>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:</p> <ul style="list-style-type: none"> ○ hemoglobin/hematocrit ○ tuberculin test (for high risk groups) ○ blood lead testing (see below section on Lead Testing)

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Lead Investigations	12 VAC 30-50-227 EPSDT Supplement	Yes	Yes	<p>The Contractor shall provide coverage for investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of Medicaid-eligible children who have been diagnosed with elevated blood lead levels. Environmental investigations are coordinated by local health departments. Coverage includes costs that are eligible for Federal funding participation in accordance with current Federal regulations and does not include the testing of environmental substances such as water, paint, or soil which are sent to a laboratory for analysis. Contact the Member’s local health department to see if a Member qualifies for a risk assessment. More information is available at http://www.vdh.virginia.gov/environmental-epidemiology/fact-sheets-for-public-health/elevated-blood-lead-levels-in-children Payments for environmental investigations shall be limited to no more than two visits per residence.</p>
Lead Testing	EPSDT Guidelines 12VAC5-90-215	Yes	Yes	<p>All Medicaid children are required to receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. Testing may be performed by venipuncture or capillary. Filter paper methods are also acceptable and can be performed at the provider’s office. Tests of venous blood are considered confirmatory. The providers need to use the code 83655 for Lead blood testing and one of the following:</p> <ul style="list-style-type: none"> • 36416 for the collection of capillary blood specimen (finger, heel, ear stick) • 36415 for the collection of venous blood by venipuncture. <p>A blood lead test result equal to or greater than 5 ug/dL (or consistent with the most current CDC guidelines) obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. All testing shall be done through a blood lead level determination. Results of lead testing, both positive and negative results, shall be reported to the Virginia Department of Health, Office of Epidemiology.</p>
Private Duty Nursing	42 CFR §§ 441.50, 440.80,	Yes	Yes	<p>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.</p>

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	Social Security Act §1905(a) and 1905(r) I.			<p>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.</p> <p>Skilled PDN is also covered for Members who are enrolled in Technology Assisted Program who require continuous nursing that cannot be met through home health. Technology Assisted Program uses form 108& 109 to determine the hours of service needed. Under EPSDT or Skilled PDN, the Member’s condition warrants continuous nursing care including but not limited to, nursing level assessment, monitoring, and skilled interventions. EPSDT and Skilled PDN differ from home health nursing which provides for short-term intermittent care where the emphasis is on Member or caregiver teaching. Examples of Members that may qualify for PDN coverage include but are not limited to those with health conditions requiring: tube feedings or total parenteral nutrition (TPN); suctioning; oxygen monitoring for unstable saturations; catheterizations; blood pressure monitoring (i.e., for autonomic dysreflexia); monitoring/intervention for uncontrolled seizures; or nursing for other conditions requiring continuous nursing care, assessment, monitoring, and intervention.</p> <p>Payment by the Contractor for services provided by any network or out-of-network provider for EPSDT or Skilled Private Duty Nursing shall be reimbursed no less than the Department’s fee-for-service rate.</p>
Screenings	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Comprehensive, periodic health assessments (or screenings) from birth through age 20 at intervals specified by the American Academy of Pediatrics (AAP). AAP recommends surveillance (assessing for risk) at all well-child visits, and screening using a standardized tool routinely. Developmental screenings should be documented in the medical record using a standardized screening tool. The Contractor shall not require any

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				SA associated with the appropriate billing of these developmental screening services (e.g., CPT96110) in accordance with AAP recommendations. The medical screening shall include: (1) a comprehensive health and developmental history, including assessments of both physical and mental health development, including reimbursement for developmental screens rendered by providers other than the primary care provider; and, (2) a comprehensive unclothed physical examination including vision and hearing screening, dental inspection, nutritional assessment, height/weight, and BMI assessment.
Vision Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	Periodic vision assessments appropriate to age, health history and risk, which includes assessments by observation (subjective) and/or standardized tests (objective), provided according to the Department’s EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.
Other Medically Necessary Services	Same as EPSDT Global Coverage Guidelines	Yes	Yes	EPSDT includes medically necessary health care, diagnostic services, treatment, and measures as needed to correct or treat defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child’s (under 21 years of age) current level of functioning or to prevent the child’s medical condition from getting worse. CMS EPSDT Guidance: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf NHHelp - http://www.healthlaw.org/ State Medicaid Manual: https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html

SUMMARY OF COVERED SERVICES - PART 3A – EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization shall not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov, under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Early Intervention Services	20USC § 1471 34 CFR§ 303.12 <i>Code of Virginia</i> § 2.2-5300 12 VAC 30-50-131 12 VAC 30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	<p>The Contractor shall provide coverage for Early Intervention services as defined in 12 VAC 30-50-131, 12 VAC 30-50-415, and 12VAC35-225 et. seq., and within the Department’s coverage criteria and guidelines. The DMAS Early Intervention billing codes, reimbursement methodology, and coverage criteria shall be used and are described in the Department’s Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.</p> <p>Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, including in terms of amount, duration, and scope. Service authorization shall not be required.</p> <p>The Contractor shall also cover other medically necessary rehabilitative and developmental therapies, when medically necessary, including for EI enrolled children where appropriate.</p> <p>For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:</p> <ol style="list-style-type: none"> 1) Those services federally required to be provided at public expense as is the case for <ol style="list-style-type: none"> a) assessment/EI evaluation, b) development or review of the Individual Family Service Plan (IFSP); and, c) targeted case management/service coordination; 2) Developmental services; and, 3) Any covered early intervention services where the family has declined access to their private health/medical insurance; See Section 12.4.12.3 <i>Comprehensive Health Coverage</i>

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization shall not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov, under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
Early Intervention Targeted Case Management/Service Coordination	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 et. seq.	Yes	Yes	The Contractor shall provide coverage for EI Targeted Case Management (also referred to as EI Service Coordination). EI service coordination is a service that will assist the child and family in gaining access to needed and appropriate medical, social, educational, and other services. EI Service Coordination is designed to ensure that families are receiving the supports and services that will help them achieve their goals on their child’s Individual Family Service Plan (IFSP), through monthly monitoring, quarterly family contacts, and on-going supportive communication with the family. The Service Coordinator can serve in a “blended” role; in other words, a single practitioner can provide both Early Intervention Targeted Case Management/Service Coordination and an IFSP service, such as physical therapy, developmental services, etc. to a child and his or her family.		
				Billing Code	Description	Limits
				T2022	Service Coordination	1 charge/child/month
Early Intervention Initial Assessments for Service Planning and Development and Annual Review of the Individual Family Services Plan (IFSP)	12VAC30-50-131 12VAC30-50-415 12 VAC 35-225 120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention initial and subsequent assessments for service planning in the child’s natural environment or in a center based program.		
				Billing Code	Description	Limits
				T1023 (RC 2) T1023 U1(RC 1)	Initial assessment, development of initial IFSP, Annual IFSP	24 units/day and 36 units/year
IFSP Team Treatment Activities (more than one professional)	12VAC30-50-131 12 VAC 35-225-120 – 12VAC35-225-160	Yes	Yes	The Contractor is required to provide coverage for Early Intervention team treatment activities where more than one professional is providing services during same session for an individual child/family. These services may be provided in the child’s natural environments for team treatment activities; or the natural environment or center for IFSP reviews and assessment.		
				Billing Code	Description	Limits

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization shall not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov, under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
providing services during same session for an individual child/family); IFSP Review meetings; Assessments performed after the initial assessment for service planning				T1024* (RC 2) T1024 U1* (RC 1)	<ul style="list-style-type: none"> •Team Treatment activities (more than one professional providing services during same session for an individual child/family) •IFSP Review Meetings (must be in person) •Assessments that are done after the initial Assessment for Service Planning 	The maximum daily units/per child/ per (service) code/ per individual practitioner is 6 units with a maximum of 18 units per day per child for all agency/providers combined. Applies to all codes in this section with “*”.
Developmental Services; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention developmental services for an individual child or for more than one child, in a group (congregate) in the child’s natural environment.		
				Billing Code	Description	Limits
				T1027* (RC 2)	Developmental Services and other early intervention services provided for more than one child, in a group (congregate).	RC 2 only. See above for limits *.
				Billing Code	Description	Limits
T1027 U1* (RC 2)	Developmental Services and other early intervention services provided for one child	RC 2 only. See above for limits *.				
Center-Based Early Intervention Services;	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention center-based individual and group (congregate) services.		
				Billing Code	Description	Limits

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization shall not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov, under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
individual and/or group				T1026* (RC 1)	Center-based group (congregate) early intervention services	See above for limits*.
				T1026 U1* (RC 1)	Center-based individual early intervention services	
				T1015* (RC 2)	Center-based group (congregate) early intervention services	
				T1015 U1* (RC 2)	Center-based individual early intervention services	
Early Intervention Physical Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Physical Therapy in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0151* (RC 1)	Group (congregate) PT	See above for limits*.
G0151 U1* (RC 1)	Individual PT					
Early Intervention Occupational Therapy; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Occupational Therapy in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0152* (RC 1)	Group (congregate) OT	See above for limits*.

SUMMARY OF COVERED SERVICES - PART 3B – EARLY INTERVENTION SERVICES

Medical necessity for Early Intervention services shall be defined by the Member’s IFSP, approved by a physician, physician’s assistant, or nurse practitioner, including in terms of amount, duration, and scope. Service authorization shall not be required. Appendix G to the Early Intervention Services Manual describes early intervention providers, qualifications and reimbursement types. All individual practitioners providing Early Intervention services must be certified to provide Early Intervention services through the Department of Behavioral Health and Developmental Services (DBHDS). Providers of Early Intervention Care Management/Service Coordination must be certified through DBHDS as a Service Coordinator. For information about certification through DBHDS, contact Infant and Toddler Connection at 804-786-3710 or visit www.infantva.org. The DMAS Early Intervention Services manual is located online at: www.virginia.medicaid.dmas.virginia.gov, under Provider Services / Provider Manuals.

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable		
				G0152 U1* (RC 1)	Individual OT	
Early Intervention Speech Language Pathology; individual and/or group	12VAC30-50-131 12 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention Speech Language Pathology in an individual or group (congregate) setting, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0153 (RC 1)	Group (congregate) SLP	See above for limits*.
G0153 U1 (RC 1)	Individual SLP					
Developmental Nursing; individual and/or group	12VAC30-50-13112 VAC 35-225-120	Yes	Yes	The Contractor is required to provide coverage for Early Intervention individual and group (congregate) Nursing Services or Developmental Services provided by a nurse, in the child’s natural environment.		
				Billing Code	Description	Limits
				G0495* (RC 1)	Group (congregate) RN Training and Education Services;	See above for limits*.
G0495 U1* (RC 1)	RN Individual Training and Education Services.					

SUMMARY OF COVERED SERVICES - PART 4A – LONG TERM SERVICES AND SUPPORTS (LTSS) FACILITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
Nursing Facility	12VAC5-215-10 12 VAC 30-50-130 Chapter IV of the Nursing Facilities Manual (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)	Yes	Yes	The Contractor shall cover this service. The Contractor shall also be responsible for non-nursing facility services and shall work with the NF on discharge planning if appropriate. The Contractor shall establish strong relationships with NFs to ensure that Members in NFs receive high quality care, maintain good health, and to reduce avoidable hospital admissions among NF residents. Contractors shall help facilitate Members returning to community settings when possible and desired by the Member. The Contractor may provide additional health care improvement services or other services not specified in this contract, including but not limited to step down nursing care as long as these services are available, as needed or desired by Members.
Long Stay Hospital State Plan Only Service	12 VAC 30-60-30; 12 VAC 30-130-100 through 12 VAC 30-130-130 Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	The Contractor shall provide information and referrals as appropriate to assist Members in accessing services. The Contractor shall cover all services associated with the provision of long stay hospital services. Long Stay Hospital services are a state plan only service which covers individuals requiring mechanical ventilation, individuals with communicable diseases requiring universal or respiratory precautions, individuals requiring ongoing intravenous medication or nutrition administration, and individuals requiring comprehensive rehabilitative therapy services. The Contractor shall make provisions for the collection and distribution of the individual Member's monthly patient pay for long stay hospital services. Hospitals recognized as LSH are Lake Taylor Hospital (Norfolk) and Hospital for Sick Children (Washington, DC).
Specialized Care State Plan Only Service	12 VAC 30-60-40; 12 VAC 30-60-320 (ADULTS)	Yes	Yes	The Contractor shall cover all services associated with the provision of specialized care services for adults and children. Specialized care services are a state plan only service which covers complex trach and ventilator dependent nursing facility residents at a higher reimbursement rate. The Contractor shall make provisions for the collection and

SUMMARY OF COVERED SERVICES - PART 4A – LONG TERM SERVICES AND SUPPORTS (LTSS) FACILITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	<p>12 VAC 30-60-340 (CHILDREN)</p> <p>Additional information can be found in the Nursing Facility provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>			distribution of the individual Member’s monthly patient pay for specialized care services. Transition services are covered for those individuals seeking services in the community through the Contractor.
Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)	<p>http://www.dbhds.virginia.gov/library/developmental%20services/ods-voluntaryadmission2011.pdf</p> <p>http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/training-centers</p>	Yes	No	The Contractor is not required to cover ICF-IID services. Individuals receiving services in an ICF-ID will be excluded from MLTSS participation.

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
CCC Plus HCBS Waiver <i>(formerly Elderly or Disabled with Consumer-Directed Services EDCD and Technology Assisted Waivers)</i> General Requirements	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.viriniamedicaid.dmas.virginia.gov	Yes	Yes	<p>The Contractor shall provide care coordination, information and referrals as appropriate to assist Members in accessing these services. The Contractor shall cover personal care, respite care, adult day health care, personal emergency response systems, skilled private duty nursing, assistive technology, environmental modifications, services facilitation, transition services. The Contractor shall cover both agency directed and consumer-directed services as a service delivery model for personal care and respite care services. Personal emergency response systems may include medication monitoring as well. Transition services are covered for those individuals seeking services in the community after transition from a qualified institution. The Contractor shall make provisions for the collection and distribution of the Member’s monthly patient pay for Program services (if appropriate). The Contractor shall cover transportation services for the CCC Plus Waiver program Members.</p> <p>Rates for all CCC Plus Waiver services have both a Northern Virginia and Rest of State rate structure with the exceptions of Assistive Technology and Environmental Modifications. Rates are paid based upon the Member FIPS except for Adult Day Health Care. (See additional details below for specifics regarding AT and EM.)</p>
CCC Plus Waiver Personal Care	Same as General Requirements	Yes	Yes	<p>Agency-or consumer-directed personal care services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Personal Care A range of support services necessary to enable an individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with ADLs and IADLs, access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized. Personal care shall not be a replacement for private duty nursing services performed by a RN. Service Codes AD = T1019 CD = S5126 Services are billed as hourly.
CCC Plus Waiver Respite Care	Same as General Requirements	Yes	Yes	<p>Respite is for the relief of the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the Member.</p> <p>Agency- or consumer-directed respite care services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Respite coverage in children's residential facilities.</p> <p>A. Individuals with special needs who are enrolled in the CCC Plus Waiver and who have a diagnosis of developmental disability (DD) shall be eligible to receive respite services in children's residential facilities that are licensed for respite services for children with DD.</p> <p>B. These respite services shall be covered consistent with the requirements of 12VAC30-120-924, 12VAC30-120-930, and 12VAC30-120-935, whichever is in effect at the time of service delivery.</p> <p>Service Definition - Respite Care</p> <p>Respite services are unskilled services (agency-directed or consumer-directed) or skilled services of a nurse (AD-skilled respite) that provide temporary relief for the unpaid primary caregiver due to the physical burden and emotional stress of providing support and care to the individual.</p> <p>Skilled Private Duty Nursing Respite Care (Agency-Directed Only)</p> <p>Providers may be reimbursed for respite services provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) with a current, active license and able to</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual’s skilled needs. Respite care can be authorized as a sole program service, or it can be offered in conjunction with other services.</p> <p>Congregate Private Duty Nursing Respite Care (Agency-Directed Only) Congregate respite nursing provided to three or fewer Program individuals who reside in the same primary residence. Service Codes AD = T1005 CD = S5150</p> <p>PDN RN Respite Services = S9125 TD PDN LPN Respite Services = S9125 TE Congregate Respite RN Nursing Services = T1030 TD Congregate Respite LPN Nursing Services = T1031 TE Services are billed as hourly Respite is limited to 480 hours per fiscal year – regardless of the number of providers or whether the individual receives agency and consumer-directed respite services.</p>
CCC Plus Waiver Adult Day Health Care ADHC	Same as General Requirements	Yes	Yes	<p>Adult Day Health Care (ADHC) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Adult Day Health Care Long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those CCC Plus Waiver individuals who have been determined eligible for waiver services and who also require the level of care provided in either a nursing facility, specialized care nursing facility, or long-stay hospital. The program</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>shall be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC).</p> <p>ADHC may be offered either as the sole home- and community-based care service or in conjunction with other CCC Plus Waiver services.</p> <p>ADHC Service Codes = S5102 Transportation = A0120 Services are billed as a per diem. Transportation services are billed per trip.</p>
<p>CCC Plus Waiver</p> <p>Personal Emergency Response System (PERS)</p> <p>PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.</p>	Same as General Requirements	Yes	Yes	<p>Personal Emergency Response Systems (PERS) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Personal Emergency Response System (PERS) Electronic device capable of being activated by a remote wireless device that enables individuals to secure help in an emergency. PERS electronically monitors an individual’s safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual’s home telephone line or other two-way voice communication system. When appropriate, PERS may also include medication monitoring devices.</p> <p>PERS is not a stand-alone service. It must be authorized in conjunction with at least one qualifying CCC Plus Waiver service.</p> <p>Service Codes PERS nursing = H2021 TD (RN)</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>PERS nursing = H2021 TE (LPN) PERS installation = S5160 Person installation + medication monitoring = S5160 U1 PERS monitoring = S5161 PERS medication monitoring = S5185 PERS nursing services are billed in 30 minute increments. PERS installation (w/ or w/out medication monitoring) is billed as per visit.</p>
CCC Plus Waiver Services Facilitation	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Waiver provider manual available on the DMAS web portal at: www.viriniamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Services Facilitation shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924.</p> <p>Service Definition – Services Facilitation During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual’s current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual’s satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual’s needs, and document the review of the plan.</p> <p>The SF is responsible for completion of the following tasks related to service facilitation:</p> <ul style="list-style-type: none"> • Service Facilitation Comprehensive Visit: • Consumer (Individual) Training: • Management Training • Routine On-site Visits • Reassessment Visit <p>Service Codes SF Initial Comprehensive Visit = H2000 (billed as visit). SF Consumer Training Visit = S5109 (billed as visit). SF Management Training Visit = S5116 (billed as visit).</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				SF Routine Visit = 99509 (billed as visit). SF Reassessment Visit = T1028 (billed as a visit).
CCC Plus Waiver Transition Services	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Waiver provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Transition Services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-924. Service Definition – Transition Services Services that are “set-up” expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, where the person is directly responsible for his or her own living expenses. 12 VAC 30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service. Transition services do not apply to an acute care admission to a hospital. Transition Services Code T2038 (limited with a total cost regardless of the number of items to \$5,000.00 per lifetime)
CCC Plus Waiver Assistive Technology and Assistive Technology Maintenance	12 VAC 30-120-900 through 12 VAC 30-120-995 Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Service Definition – Assistive Technology (AT) Specialized medical equipment and supplies, including those devices, controls, or appliances, that are not available under the State Plan for Medical Assistance, that enable individuals to increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment necessary for the proper functioning of such items. AT shall not be authorized as a standalone service. Assistive technology devices, as defined in 12VAC30-120-924, shall be portable and shall be authorized per fiscal year. AT = T1999 (limited to per item with a set limit of \$5,000.00 per fiscal year) AT Maintenance = T1999 U5 (limited to per item with a set limit of \$5,000.00 per fiscal year)

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>AT and AT maintenance combined costs cannot exceed the \$5,000.00 limit.</p> <p>Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461</p>
<p>CCC Plus Waiver</p> <p>Environmental Modifications and Environmental Modification Maintenance</p>	<p>12 VAC 30-120-900 through 12 VAC 30-120-995</p> <p>Additional Information can be found in the CCC Plus Program provider manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov</p>	Yes	Yes	<p>Service Definition – Environmental Modifications (EMs) Physical adaptations to an individual’s primary residence or primary vehicle which are necessary to ensure the individual’s health, safety, or welfare or which enable the individual to function with greater independence and without which the individual would require institutionalization.</p> <p>EM = S5165 (limited to per item with a set limit of \$5,000.00 per fiscal year) EM Maintenance = 99199 U4 (limited to per item with a set limit of \$5,000.00 per fiscal year)</p> <p>EM must be provided in conjunction with at least one other qualifying CCC Plus Waiver service.</p> <p>EM and EM maintenance combined costs cannot exceed the \$5,000.00 limit</p> <p>Currently the program is operating under emergency regulations; these regulations are found on the Virginia Regulatory Town Hall website at http://register.dls.virginia.gov/details.aspx?id=6461</p>
<p>CCC Plus Waiver</p> <p>Skilled Private Duty Nursing</p>	Same as General Requirements	Yes	Yes	<p>Private Duty Nursing (PDN) services shall be offered to persons who meet the screening criteria, described at 12VAC30-60-303 and 12VAC30-60-313. Services shall be provided within <i>at least</i> equal amount, duration, and scope as available under Medicaid fee-for-service. Fee-for-service amount, duration, and scope provisions are described in 12VAC30-120-1720.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>Service Definition – Skilled Private Duty Nursing (Skilled PDN) In-home nursing services provided for individuals enrolled in the CCC Plus Waiver with a serious medical condition and/ or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse.</p> <p>Service Definition – Congregate Skilled PDN Skilled in-home nursing provided to three or fewer CCC Plus Waiver individuals who reside in the same primary residence. Congregate skilled PDN may be authorized in conjunction with skilled PDN in instances where individuals attend school or must be out of the home for part of the authorized PDN hours. Congregate skilled PDN hours will be determined and approved according to skilled nursing needs documented on the appropriate referral form.</p> <p>Coverage Limits – Up to 16 hours a day; 112 hours per week Service Codes PDN RN Nursing Services = T1002 (billed hourly) PDN LPN Nursing Services = T1003 (billed hourly) Congregate RN Nursing Services = T1000 U1 (billed hourly). Congregate LPN Nursing Services = T1001 U1 (billed hourly).</p>
Hospice Services	12 VAC 30-50-270 and 12 VAC 30-60-130 Additional information can be found in the Hospice provider manual available on the DMAS web portal at:	Yes	Yes*	<p>*Individuals receiving Hospice at time of enrollment will be excluded from CCC Plus program participation and will not be auto-enrolled. CCC Plus program enrolled Members who elect hospice will remain CCC Plus program enrolled.</p> <p>A Member may be in a waiver and also be receiving hospice services. The Contractor shall provide information and referrals as appropriate to assist Members in accessing services. The Contractor shall cover all services associated with the provision of hospice services. The Contractor shall ensure that children under 21 years of age are permitted to continue to receive curative medical services even if they also elect to receive hospice services.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
	www.virginiamedicaid.dmas.virginia.gov			<p>Non-institutional Hospice Services shall be paid by the Contractor based on the member FIPS. The DMAS hospice revenue codes and rates for non-insitutional claims are available at: http://www.dmas.virginia.gov/#/ratesetting.</p> <p>Categories of Care:</p> <p>0651- Routine Home Care: In-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016 a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter.</p> <p>0652 - Continuous Home Care: In-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)</p> <p>0655 - Inpatient Respite Care: Short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate.</p> <p>0656 - General Inpatient Care: May be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day)</p> <p>0658 - Nursing Facility: Beginning July 1, 2019, for Members who reside in a nursing facility and are enrolled in a Medicaid approved hospice program, the Contractor shall pay the nursing facilities their share of payment directly rather than paying the hospice provider. Payments made to the nursing facility shall be the full amount that would be paid to the nursing facility if the Member was not receiving hospice services.</p>

SUMMARY OF COVERED SERVICES - PART 4B – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities and Service Codes as Applicable
				<p>0551 - Skilled Nursing Visit – Used when submitting charges representative of a visit by a Registered Nurse within the Member’s last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 - Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.</p> <p>0561 - Medical Social Service Visit – Used to be used when submitting charges representative of a visit by a Clinical Social Worker within the Member’s last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.</p>

<p>Program of All-Inclusive Care for the Elderly (PACE)</p>	<p>12VAC30-50-320 http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx http://www.dmas.virginia.gov/Content_atchs/ltc/(11)%20Fact%20Sheet%20PACE%2011%2015.pdf</p>	<p>Yes</p>	<p>No</p>	<p>Individuals in PACE will be excluded from CCC Plus program participation. Individuals in CCC Plus program have the right to transition from CCC Plus program to PACE, including outside of their annual open enrollment. The Contractor shall ensure that Members are aware of PACE. PACE provides qualifying Members a fully integrated community alternative to nursing home care, and provides care/services covered by Medicare/Medicaid, and may include enhanced services not covered by Medicare/Medicaid. PACE coverage includes prescription medications, doctor care, transportation, home care, hospital visits, adult day services, respite care, restorative therapies, and nursing home stays, when necessary.</p> <p>In order to qualify for PACE, an individual must be 55+ years of age, live within a PACE service area, and be able to reside safely within the community at the time of enrollment. When a Member requests additional information about PACE, the contractor shall assist the Member with obtaining information and related referrals. This includes checking to see if there is a PACE site in the Member’s service area. This information is available via the DMAS website: http://www.dmas.virginia.gov/Content_pgs/ltc-pace.aspx (based upon the member’s zip code). The Contractor shall refer Members interested in enrolling in PACE to their Local Department of Social Services (LDSS) to request a Medicaid LTSS Screening.</p>
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				Meeting the functional criteria for nursing home level of care is a requirement for PACE enrollment and screening must be coordinated through the Member's LDSS.
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SUMMARY OF COVERED SERVICES - PART 4C – LONG TERM SERVICES AND SUPPORTS (LTSS) COMMUNITY BASED DD SERVICES				
Waiver Services for Individuals in the 3 Developmental Disabilities (DD) Waivers				
The Contractor is not required to cover DD Waiver Services (including when covered under EPSDT), DD targeted case management (T1017 & T2023), or transportation to/from DD Waiver Services. DD Waiver services covered through EPSDT include private duty nursing, personal care, and assistive technology.				
Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Coverage Details
Building Independence Waiver formerly Day Support (DS) Waiver	Regulations and Manual are currently in process.	Yes	No	The Day Support Waiver will become the Building Independence Waiver which will include supports for adults (18+) who live independently in their own homes. Services may be complemented by non-waiver funded rent subsidies and/or other types of support.
Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver	Regulations and Manual are currently in process.	Yes	No	The Individual and Family Developmental Disabilities Support (DD) Waiver will become the Family and Individual Supports Waiver which will include supports for children and adults living with their families, friends, or in their own homes, including supports for those with some medical or behavioral needs.
Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver	Regulations and Manual are currently in process.	Yes	No	The Intellectual Disability (ID) Waiver will become the Community Living Waiver , which will include residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs.
A description of all waiver services and a comparison of the services covered under each DD Waiver is available below				

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Shared Living = T1020 (billed as either full month or partial month)

This is a new service and is available under all 3 DD waivers.

An individual would live in an apartment, condominium, townhome, or other home in the community with a roommate of the Member's choice. The roommate acts as the individual's live-in companion. Individuals must be 18 years old or older and must be directly responsible for the residence (i.e., the individual must either rent or own it).

Individuals will be responsible for all expense associated with their housing, utilities and food as well as those for the live-in companion. Those expenses incurred by the individual and determined to be usual, reasonable and within the location's maximum reimbursement amount will be reimbursed by Medicaid consistent with the service authorization. These expenses may be covered when the live-in companion provides companionship supports, including fellowship and enhanced feelings of security, and may include limited Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL) supports as long as these account for no more than 20% of the anticipated companionship time on a weekly basis. The individual is responsible for his own living expenses. Designated Department of Behavioral Health and Developmental Services (DBHDS) licensed providers are eligible to bill and receive payment for administering this service. After retention of an allowable amount for administrative expenses, the provider will distribute payments to the individual to reimburse for expenses incurred per the service authorization.

Tiers do not apply to this service.

Size does not apply to this service.

Community Engagement = T2021 (billed as hourly)

This service applies to all 3 of the DD the waiver(s):

This is a new service that provides the individual with a wide variety of opportunities to build relationships and natural support systems, while utilizing the community as a learning environment. It supports and fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities and functions of community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities. These activities are conducted at naturally occurring times and in a variety of natural settings in which the individual actively interacts with persons without disabilities (other than those paid to support the individual). These services are provided to the individual at no more than a 1:3 staff to individual ratio.

Tiers 1-4 do apply to this service.

Size does not apply to this service.

Community Coaching = 97127 (billed as hourly)

This service applies to all 3 of the DD waivers

This is a new service designed to engage the individual in the community and to help the individual be supported to minimize a barrier from participating in activities of community engagement. This is a one-on-one service that occurs in a community setting.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Group Day Services = 97150 (billed as hourly)

This service applies to all 3 of the DD waivers

This includes skill building or supports for the acquisition, retention, or improvement of self-help, socialization, community integration, employability and adaptive skills. They provide opportunities for peer interactions, community integration, enhancement of social networks and assurance of an individual's health and safety. Skill building is a required component of this service unless the individual has a documented degenerative condition, in which case day services may focus on maintaining skills and functioning and preventing or slowing regression rather than acquiring new skills or improving existing skills. Group day services are delivered in a group setting of no more than 1:7 staff to individual ratio.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

Individual Supported Employment = H2023 (billed as hourly)

This service applies to all 3 of the DD waivers:

This is a service that is provided to an individual in work settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment.

Tiers do not apply to this service.

Size does not apply to this service.

Group Supported Employment = H2024 (billed as hourly using the modifier related to the size.)

This service applies to all 3 of the DD waivers

This is a service that provides continuous staff support in a naturally occurring place of employment to groups of two to eight individuals with disabilities and involves interactions with the public and coworkers without disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in the community. Group Supported Employment must be provided in a community setting that promotes integration into the workplace and interaction between participants and people without disabilities in the workplace. These supports enable an individual to obtain and maintain a job in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

- 2 or Fewer Individuals/Staff = Size 1 = UA
- 2+ TO 4 Individuals/Staff = Size 2 = U2
- 4+ Individuals/Staff = Size 3 = U3

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Electronic-Based Home Supports = A9279 (limited to \$5K per year)

This service applies to all 3 of the DD waiver

This is a new service designed to give individuals support to gain more independence and freedom at home by using electronic equipment. Electronic devices can be purchased and installed in the individual's home to help monitor and support greater autonomy. To qualify for reimbursement, purchases must substitute for other Medicaid services, promote integration into the community and increase the individual's safety in the home. Providers that bill and receive payment for this service are responsible for providing emergency assistance 24 hours a day and 365 or 366 days a year as well as furnishing, installing, maintaining, testing and providing user training of the services. Members receiving per diem residential services will not qualify to receive this service.

Tiers do not apply to this service.

Size does not apply to this service.

Assistive Technology (AT) = T1999 (limited to per item with a set limit of \$5,000.00 per year)

AT Maintenance = T1999 U5 (limited to per item with a set limit of \$5,000.00 per year)

This service applies to all 3 of the DD waivers.

AT and AT maintenance costs cannot exceed the \$5,000.00 limit.

This means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

Tiers do not apply to this service.

Size does not apply to this service.

Environmental Modifications (EM) = S5165 (limited to per item with a set limit of \$5,000.00 per year)

EM Maintenance = 99199 U4 (limited to per item with a set limit of \$5,000.00 per year)

This service applies to all 3 of the DD waiver.

EM and EM maintenance costs cannot exceed the \$5,000.00 limit.

This means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Personal Emergency Response System (PERS)

This service applies to all 3 of the DD waivers.

PERS NURSING = H2021 TD (RN)

PERS NURSING = H2021 TE (LPN)

PERS INSTALLATION = S5160

PERSON INSTALLATION + MEDICATION MONITORING = S5160 U1

PERS MONITORING = S5161

PERS MEDICATION MONITORING = S5185

PERS nursing services are billed in 30 minute increments.

PERS installation (w/ or w/out medication monitoring) is billed as per visit.

PERS monitoring (w/ or w/out medication monitoring) is billed as monthly.

Personal emergency response systems (PERS): an electronic device and monitoring service that enables certain individuals at high risk of institutionalization to secure help in an emergency. PERS services shall be limited to those individuals who live alone or are alone for significant parts of the day and who have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision.

Transition Services = T2038 (limited to per item with a total cost regardless of the number of items is a set limit of \$5,000.00)

This service applies to all 3 of the DD waivers.

This means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Peer Mentoring = H0038

This service applies to all 3 of the DD waivers.

Peer Mentor Supports provide information, resources, guidance, and support from an experienced, trained peer mentor to an individual receiving CL, FIS, or BI waiver supports. This service is delivered by individuals with developmental disabilities who are or have received services, have shared experiences with the individual, and provide support and guidance to him/her. The service is designed to foster connections and relationships which build individual resilience. Peer mentors share their successful strategies and experiences in navigating a broad range of community resources with waiver participants. Waiver participants become better able to advocate for and make a plan to achieve integrated opportunities and experiences in living, working, socializing, and staying healthy and safe in his/her own life. Peer mentoring is intended to assist with empowering the individual receiving the service. This service is provided based on the support needs of the individual as outlined in his/her person-centered plan. This service is designed to be a short-term, periodically intermittent, intense service associated with a specific outcome. Peer Mentor Supports may be authorized for up to six (6) consecutive months, and the cumulative total across that timeframe may be no more than 60 hours in a plan year.

For allowable activities, refer to Medicaid Memo located at

<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id={246BFF6F-99FB-43CE-97E9-74BFFD7AF24F}&vsId={C0FEA565-0A00-C194-AE0F-615F96FB34E1}&objectType=document&objectStoreName=VAPRODOS1>

Community Guide = H2015

This service applies to all 3 of the DD waivers.

Community Guide Services include direct assistance to promote individuals' self-determination through brokering community resources that lead to connection to and independent participation in integrated, independent housing or community activities so as to avoid isolation.

Includes the following components:

General Community Guide services: Utilizes an individual's existing assessment information regarding the individual's general interests in order to determine specific activities and venues that are available in the community (e.g., clubs, special interest groups, physical activities/sports teams, etc.) to promote inclusion and independent participation in community life.

Community Housing Guide services: Supports an individual's move to independent housing by helping with transition and tenancy sustaining activities. The community housing guide collaborates with the support coordinator, regional housing specialist, and others to enable the individual to achieve and sustain integrated, independent living.

For allowable activities, refer to Medicaid Memo located at

<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id={246BFF6F-99FB-43CE-97E9-74BFFD7AF24F}&vsId={C0FEA565-0A00-C194-AE0F-615F96FB34E1}&objectType=document&objectStoreName=VAPRODOS1>

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Benefits Planning = T1023 (billed as hourly)
This service applies to all 3 of the DD waivers.

Benefits planning is an individualized analysis and consultation service provided to assist individuals receiving waiver services and social security benefits (SSI, SSDI, SSI/SSDI) to understand their benefits and explore the possibility of work, to start work, and the effect of work on local, state, and federal benefits. This service includes education and analysis about current benefits status and implementation and management of state and federal work incentives as appropriate.

For allowable activities, refer to Medicaid Memo issued on 9/4/2018 located at
<https://www.ecm.viriniamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id={246BFF6F-99FB-43CE-97E9-74BFFD7AF24F}&vsId={C0FEA565-0A00-C194-AE0F-615F96FB34E1}&objectType=document&objectStoreName=VAPRODOS1>

Employment & Community Transportation = A0080, A0090, A0110, A0120 This service applies to all 3 of the DD waivers.

This service is offered in order to enable individuals to gain access to an individual's place of employment or volunteer activity, other community services or events, activities and resources, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the support plan and when no other means of access is available. The goal of this service is to promote the individual's independence and participation in the life of his/her community. Use of this services shall be related to the individual's desired outcomes as stated in the ISP. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Crisis Support Services = T2034 (billed as hourly)

This service applies to all 3 of the DD waivers.

Includes the following components:

Crisis Prevention: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis prevention may be authorized for up to 60 days per ISP year.

Crisis Intervention: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis intervention may be authorized in increments of no more than 15 days at a time for up to 90 days per ISP year.

Crisis Stabilization: unit of service = 1 hour and billing may occur up to 24 hours per day if necessary. Medically necessary crisis stabilization may be authorized in increments of no more than 15 days at a time for up to 60 days per ISP year.

Services may be authorized for an individual who has a history of at least one of the following: (i) previous psychiatric hospitalization or hospitalizations; (ii) previous incarceration; (iii) previous residential/day placement or placements were terminated; or (iv) behaviors that have significantly jeopardized placement.

Services include supports during the provision of any other waiver service and may be billed concurrently (same dates and times).

Tiers do not apply to this service.

Size does not apply to this service.

Center-Based Crisis Supports = H2011 UA and H2011 U1 (billed as hourly)

This service applies to the following waiver(s):

- 1) Building Independence Waiver formerly Day Support (DS) Waiver
- 2) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 3) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

The service includes crisis prevention and stabilization services in a residential setting (a crisis therapeutic home) using plan and emergency admissions. Services are approved for those individuals who will need ongoing crisis supports for long term. Services may be authorized for individuals who are at risk of at least one of the following: 1) psychiatric hospitalization; 2) emergency ICF/IID placement; 3) immediate threat of loss of community service due to severe situational reaction; or 4) causing harm to himself or others.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Community-Based Crisis Supports = H0040 and H0040 U1 (billed as hourly for up to 6 months per year in 30 day increments)

This service applies to the following waiver(s):

- 1) Building Independence Waiver formerly Day Support (DS) Waiver
- 2) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 3) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

In order to be approved to receive this service, the individual shall

1. have a history of at least one of the following:
 - a. previous psychiatric hospitalization or hospitalizations;
 - b. previous incarceration;
 - c. lost previous residential/day placement or placements; or
 - d. his behavior or behaviors have jeopardized his community placement.
2. meet at least one of the following:
 - a. is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
 - b. is experiencing an increase in extreme emotional distress;
 - c. needs continuous intervention to maintain stability; or
 - d. is actually causing harm to himself or others.
3. also:
 - a. be at risk of psychiatric hospitalization;
 - b. be at risk of emergency ICF/IID placement;
 - c. be at immediate threat of loss of community service due to a severe situational reaction; or
 - d. is actually causing harm to himself or others.

The service provides ongoing supports to individuals in their homes and community settings or both.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Supported Living Residential (formerly part of Congregate Residential Supports) = H0043 (billed as per diem with a maximum of 344 days/year)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This service provides access to 24 hour supports in an apartment setting operated by a DBHDS licensed provider. Services are provided to the individual in the form of ‘round the clock availability of paid staff who have the ability to respond in a timely manner. These supports may be provided individually or simultaneously to more than one individual living in the apartment, depending on the required support. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. The unit of service billed will be “daily” when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

In-Home Supports (formerly In-home Residential Supports) = H2014 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is a supplemental service that take place in an individual’s home, family’s home or community setting. Supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Usually, In-home supports involve one staff person to one individual, but now may include 1:2 or 1:3 as appropriate. The latter is a change from previous allowances. The unit of service billed remains “hourly.”

Tiers do not apply to this service.

Size applies to this service. Size is defined as:

2 or Fewer Individuals/Staff = Size 1 = UA

2+ TO 4 Individuals/Staff =Size 2 = U2

4+ Individuals/Staff = Size 3 = U3

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Skilled Nursing:

RN = S9123 (TD)

LPN = S9124 (TE)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Services are billed as 15 minute increments.

This is an existing service that will not change as part of the waiver redesign; however, individuals receiving this service may be assessed to determine whether private duty nursing is now the appropriate service.

Skilled nursing services: means both skilled and hands-on care, as rendered by either licensed RN or LPN, of either a supportive or health-related nature nursing services ordered by a physician and documented on the Plan for Supports, assistance with ADLs, administration of medications or other medical needs, and monitoring of the health status and physical condition of the individual enrolled in the waiver.

Tiers do not apply to this service.

Size does not apply to this service.

Private Duty Nursing:

RN = T1002 (TD)

LPN = T1003 (TE)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Services are billed as 15 minute increments.

This is a new service that is designed to provide individual and continuous medically necessary care as certified by a physician, physician assistant or nurse practitioner to individuals with a serious medical condition and/or complex health care need. It allows individuals to remain at home to receive care instead of in a nursing facility, hospital or ICF-IID. This service is provided to an individual at his place of residence or other community setting.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Therapeutic Consultation - Therapists/Behavior Analysts/Rehab Engineer = 97139 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

Therapeutic Consultation - Psychologist/Psychiatrist = H2017* (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

In the absence of a service authorization, billing is likely for Therapeutic Consultation (billed with procedure type I or M) and is excluded. Not an excluded CMHRS service for Members in one of the DD Waivers with an appropriate service authorization for Psychosocial Rehabilitation H2017. Refer to Coverage Chart Section 2B.

Therapeutic Consultation - Other Professionals = 97530 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

This is an existing service that provides support to the individual and his support team through expertise, training and technical assistance. This service has been updated to create three distinct therapeutic service rates according to the provider delivering the service.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Personal Assistance

AD = T1019 (billed as hourly)

CD = S5126 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Personal assistance: means assistance with ADL's, IADLs, access to the community, self-administration of medication or other medical needs, and the monitoring of health status and physical condition. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

Respite Services

AD = T1005 (billed as hourly)

CD = S5150 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Respite: means services provided to individuals who are unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those unpaid persons normally providing the care. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Workplace Assistance Services = H2025 (billed as hourly). Cannot exceed 40 hours/week. Cannot exceed 66 hours/week alone or in combination with 97150, T2021, H2023, H2024, 97127, and/or H2025.

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Workplace Assistance Services: supports provided to someone who has completed job development and completed or nearly completed and job placement training (i.e., supported employment) but requires more than typical job coach services to maintain stabilization in their employment. Workplace Assistance services are supplementary to the services rendered by the job coach services; the job coach still provides professional oversight and job coaching intervention. The provider provides on-site habilitative supports related to behavior, health, time management or other skills that otherwise would endanger the individual's continued employment. The provider is able to support the person related to personal care needs as well; however, this cannot be the sole use of Workplace Assistance services.

In order for an activity to qualify under Workplace Assistance services it must include all three of the following:

1. The activity must not be work skill training related which would normally be provided by a job coach
2. Services are delivered in their natural setting (where and when they are needed)
3. Services must facilitate the maintenance of and inclusion in an employment situation
4. The ratio is 1:1

Allowable activities include:

1. Skill building and supports around non-work skills necessary for the individual to maintain employment
2. Skill building and supports in the home, community, or workplace of employment maintenance related skills
3. Support to make and strengthen community connections
4. Safety supports to ensure the individual's health and safety.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Individual & Family Caregiver Training = S5111 (billed as hourly). Limited to 80 hours per ISP year.

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver

Individual & Family Caregiver Training: service that provides training and counseling services to individuals, families, or caregivers of individuals receiving waiver services. All individual and family/caregiver training must be included in the individual's written person-centered plan. "Family" does not include people who are employed to care for the individual.

Allowable activities:

Participation in educational opportunities designed to improve the family's or caregiver's ability to give care and support.

Participation in educational opportunities designed to enable the individual to gain a better understanding of his/her disability or increase his/her self-determination / self-advocacy abilities.

Travel expenses and room and board expenses are not covered.

Tiers do not apply to this service.

Size does not apply to this service.

Companion Services

AD Companion = S5135 (billed as hourly)

CD Companion = S5136 (billed as hourly)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Companion: means non-medical care, or support and socialization provided to an adult (ages 18 years and over). The provision of companion services does not entail (routine) hands-on care. It is provided in accordance with a therapeutic outcome in the Individual Support Plan and is not purely diversional in nature. Companions may assist or support the individual (enrolled in the waiver) with such tasks as meal preparation, community access and activities, laundry, and shopping but companions do not perform these activities as discrete services. Companions may also perform light housekeeping, tasks (such as bed-making, dusting, and vacuuming, laundry, grocery shopping, etc.) which such services are specified in the individual's Plan for Supports and essential to the individual's health and welfare in the context of providing nonmedical care, socialization or support, as may be needed in order to maintain the individual's home environment in an orderly and clean manner. These services may be agency-directed or consumer-directed.

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Services Facilitation (SF)

This service applies to the following waiver(s):

- 1) Family and Individual Support Waiver formerly the Individuals and Family Developmental Services (DD) Waiver
- 2) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

SF Initial Comprehensive Visit = H2000 (billed as visit).

SF Consumer Training Visit = S5109 (billed as visit).

SF Management Training Visit = S5116 (billed as visit).

SF Routine Visit = 99509 (billed as visit).

SF Reassessment Visit = T1028 (billed as a visit).

Service Definition – Services Facilitation

During visits with an individual, the Service Facilitator (SF) must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the consumer-directed services with regards to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan.

The SF is responsible for completion of the following tasks related to service facilitation:

- Service Facilitation Comprehensive Visit:
- Consumer (Individual) Training:
- Routine On-site Visits
- Reassessment Visit
- Management Training

Tiers do not apply to this service.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Group Home Residential (formerly part of Congregate Residential Supports) = H2022 (billed as per diem with a maximum of 344 days/year)

This service applies to the following waiver(s):

- 1) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Provides services in a home in which an individual lives with other individuals with developmental disabilities receiving supports from paid staff. These supports include skill building and ongoing supports with ADLs, IADLs, community access, physical and behavioral health, as well as general supports. Providers must be licensed by DBHDS and follow state and federal guidelines to participate in the service. The unit of service billed will be “daily” when the new waivers take effect.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size applies to this service. Size is defined as:

4 or Fewer Individuals/Staff = Size 1 = UA

5 individuals/staff = Size 2 = U2

6 individuals/staff = Size 3 = U3

7 individuals/staff = Size 4 = U4

8 individuals/staff = Size 5 = U5

9 individuals/staff = Size 6 = U6

10 individuals/staff = Size 7 = U7

11 individuals/staff = Size 8 = U8

12 individuals/staff = Size 9 = U9

Sponsored Residential (formerly part of Congregate Residential Supports) = T2033 (billed as per diem)

This service applies to the following waiver(s):

- 1) Community Living Waiver formerly the Intellectual Disabilities (ID) Waiver

Effective January 1, 2017:

Provides individuals the ability to live with a family or single “sponsor” in the community. No more than two individuals can live in the sponsor’s home. The supports provided by the sponsor may include skill building, supports with ADLs and IADLs, community access and recreation/social supports, as well as general supports. Sponsors are generally not related to the individual unless all other alternatives were investigated and found not to be appropriate for the individual. Sponsors are affiliated with a DBHDS licensed agency.

Tiers 1-4 do apply to this service and are stand-alone tiers.

Size does not apply to this service.

Services Available Under the DD Waivers (*Carved out of this contract and covered through fee-for-service.*)

Independent Living = T2032 (full month)
T2032 U1 (partial month)

This service applies to the following waiver(s):

1) Building Independence Waiver formerly Day Support (DS) Waiver

This is a new service provided to adults (18 and older) that offers skill building and supports necessary to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills. Individuals typically live alone or with a roommate in their own homes or apartments. The roommate may be paid (see Shared Living above) or unpaid. The unit of service billed is “monthly” or “partial month.”

Monthly services = no modifier

Partial Month services = U1 modifier

Tiers do apply to this services

There are only two Tiers for this service.

Tier 1 (stand-alone)

Tiers 2-4 (combined together)

Size does not apply to this service.

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Annual Adult Wellness Exams	<p>CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>US Preventive Services Task Force</p> <p>https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>42 U.S.C. § 300gg-13</p>	No	Yes	<p>Coverage in accordance with U.S. Preventive Task Force</p> <p>https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ul style="list-style-type: none"> • 99385 (New patient, 18-39 years); 1 per calendar year • 99386 (New patient, 40-64 years); 1 per calendar year • 99395 (Established patient, 18-39 years); 1 per calendar year • 99396 (Established patient, 40-64 years); 1 per calendar year <p>*CPT Code descriptions above subject to change</p>

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Individual and Group Smoking Cessation Counseling	<p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>42 U.S.C. § 300gg-13</p>	Limited	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ul style="list-style-type: none"> • 99406 (Individual counseling visit, 3-10 minutes); 6 units per calendar year; no preauthorization • 99704 (Individual counseling visit, >10 minutes); 6 units per calendar year; no preauthorization <p>S9446 (Group patient education, not otherwise classified, non-physician provider); 6 units per calendar year; no preauthorization</p> <p>*CPT Code descriptions above subject to change</p>

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
Nutritional Counseling for Individuals With Obesity or Chronic Disease	<p>CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf</p> <p>US Preventive Services Task Force</p> <p>https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>42 U.S.C. § 300gg–13</p>	Limited	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes and Limitations*:</p> <ul style="list-style-type: none"> • 97802 (Medical Nutrition Therapy, Initial Assessment and Intervention, Indiv., Face-to-Face with the patient, each 15 minutes; 12 units per calendar year; no prior authorization) • 97803 (Medical Nutrition Therapy Reassessment and Intervention, Indiv., Face-to-Face with the patient, each 15 minutes; 12 units per calendar year; no preauthorization) • 97804 (Medical Nutrition Therapy, Group (2 or more individual(s), each 30 minutes; 4 units per calendar year; no preauthorization) • G0270 (Medical Nutrition Therapy; Reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes; 8 units per calendar year; no prior authorization) • G0271 (Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes; 4 units per calendar year; no prior authorization) • S9470 (Nutritional Counseling, Dietician visit, 8 units per calendar year; no preauthorization) <p>*CPT Code Descriptions above subject to change</p>

SUMMARY OF COVERED SERVICES – PART 5 – EXTENDED BENEFITS FOR MEDICAID EXPANSION POPULATION

Service	State Plan Reference or Other Relevant Reference	Medicaid Covered?	CCC Plus MCO Covers?	Contractor Responsibilities, Scope of Coverage, and Service Codes as Applicable
ACIP Recommended Adult Vaccines	<p>12 VAC 30-50-130 CMS Bulletin 1/28/17</p> <p>https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf US Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>42 U.S.C. § 300gg–13</p>	Yes	Yes	<p>Coverage in accordance with U.S. Preventive Task Force https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations</p> <p>CPT Codes & Limitations*:</p> <ul style="list-style-type: none"> • 90714 (Td) • 90715 (Tdap) • 90736 (Singles zoster, > age 60) • 90750 (> age 50) • 90620 (Meningococcal, IM, 2 dose) • 90621 (Meningococcal, IM, 2-3 dose) • 90733 (Meningococcal, SQ) • 90734 (Meningococcal, IM) • 90707 (MMR) • 90649 (HPV, quadrivalent, 3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90650 (Bivalent, 3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90651 (Nonavalent, 2-3 dose schedule, Males through 21 years of age, Females through 26 years of age) • 90716 (Chickenpox) • 90632 (Hepatitis A) • 90739 (Hepatitis B, Adult, 2 dose) • 90746 (Hepatitis B, Adult, 3 dose) • 90647 (Hemophilus influenza, 3 dose) • 90648 (Hemophilus influenza, 4 dose) <p>*CPT Code Descriptions above subject to change</p>

*See Attachment 17 “Adult Preventive Services for Expansion Alternative Benefit Plan” for complete list including covered diagnoses.

ATTACHMENT 6 - DMAS DEVELOPMENTAL DISABILITY WAIVER SERVICES

SERVICES	Building Independence Waiver	Family and Individual Support Waiver	Community Living Waiver
Shared Living	X	X	X
Group Home Residential			X
Sponsored Residential			X
Supported Living Residential		X	X
In Home Supports		X	X
Independent Living Supports	X		
Community Engagement	X	X	X
Community Coaching	X	X	X
*Community Guide	X	X	X
*Peer Mentoring	X	X	X
Group Day Services	X	X	X
Individual Supported Employment	X	X	X
Group Supported Employment	X	X	X
Workplace Assistance Services		X	X
Private Duty Nursing Services		X	X
Skilled Nursing Services		X	X
Therapeutic Consultation		X	X
Crisis Support Services	X	X	X
Center-based Crisis supports	X	X	X
Community-based Crisis Supports	X	X	X
Personal Assistance Services		X	X
Respite Services		X	X
Companion Services		X	X
PERS	X	X	X
Assistive Technology	X	X	X
Environmental Modifications	X	X	X
Individual & Family/Caregiver Training		X	
Transition Services	X	X	X
Electronic Home-Based Supports	X	X	X
Services Facilitation		X	X
*Benefits Planning	X	X	X
*Employment & Community Transportation	X	X	X

ATTACHMENT 7 - CCC PLUS PROGRAM REGIONS AND LOCALITIES

CENTRAL REGION					
007	AMELIA	085	HANOVER	730	PETERSBURG
025	BRUNSWICK	087	HENRICO	145	POWHATAN
033	CAROLINE	670	HOPEWELL	147	PRINCE EDWARD
036	CHARLESCITY	097	KING AND QUEEN	149	PRINCE GEORGE
041	CHESTERFIELD	099	KING GEORGE	760	RICHMOND CITY
570	COLONIAL HEIGHTS	101	KING WILLIAM	159	RICHMOND CO.
49	CUMBERLAND	103	LANCASTER	175	SOUTHAMPTON
053	DINWIDDIE	111	LUNENBURG	177	SPOTSYLVANIA
595	EMPORIA	115	MATHEWS	179	STAFFORD
057	ESSEX	117	MECKLENBURG	181	SURRY
620	FRANKLIN CITY	119	MIDDLESEX	183	SUSSEX
630	FREDERICKSBURG	127	NEW KENT	193	WESTMORELAND
075	GOOCHLAND	133	NORTHUMBERLAND		
081	GREENSVILLE	135	NOTTOWAY		
TIDEWATER REGION					
001	ACCOMACK	095	JAMES CITY CO.	740	PORTSMOUTH
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	131	NORTHAMPTON	830	WILLIAMSBURG
093	ISLE OF WIGHT	735	POQUOSON	199	YORK
NORTHERN & WINCHESTER REGION					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
CHARLOTTESVILLE WESTERN REGION					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		
ROANOKE/ALLEGHANY REGION					
005	ALLEGHANY	067	FRANKLIN CO.	155	PULASKI
017	BATH	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
063	FLOYD	141	PATRICK		
SOUTHWEST REGION					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

ATTACHMENT 8 - COMMON DEFINITIONS FOR MANAGED CARE TERMS

PER 42 CFR § 438.10(c)(4)

Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by our plan if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Co-payment: See definition for cost sharing.

Cost-sharing: The costs that Members may have to pay out of pocket for covered services. This term generally includes deductibles, coinsurance, and co-payments, or similar charges.

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Emergency services: Services provided in an emergency room by a provider trained to treat a medical or behavioral health emergency.

Excluded services: Services that are not covered under the Medicaid benefit.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Habilitation services and devices: Services and devices that help you keep, learn, or improve skills and functioning for daily living.

Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Home health care: Health care services a person receives in the home including nursing care, home health aide services and other services.

Hospice services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.

Medically Necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or are necessary under current Virginia Medicaid coverage rules.

Network: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our Members an extra amount. While you are a Member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Non-participating provider: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to Members of our plan.

Participating provider: Providers, hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports that are contracted with your health plan. Participating providers are also “in-network providers” or “plan providers.”

Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, behavioral health.

Plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Preauthorization: See Service Authorization.

Premium: A monthly payment a health plan receives to provide you with health care coverage.

Prescription drug coverage: Prescription drugs or medications covered (paid) by your health plan. Some over-the-counter medications are covered.

Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary care physician (PCP): Your primary care physician (also referred to as your primary care provider) is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Primary care provider: Refer to Primary care physician.

Provider: A person who is authorized to give health care or services. Many kinds of providers participate with your plan, including doctors, nurses, behavioral health providers and specialists.

Rehabilitation services and devices: Treatment you get to help you recover from an illness, accident, or major operation.

Service authorization: Also known as preauthorization. Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

Skilled nursing care: care or treatment that can only be done by licensed nurses. Examples of skilled nursing needs include complex wound dressings, rehabilitation, tube feedings or rapidly changing health status.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Urgently needed care (Urgent care): Care is needed for a sudden illness, injury, or condition that is not an emergency but needs to be treated right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

ATTACHMENT 9 - CERTIFICATION OF DATA (NON-ENCOUNTER)

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR §§ 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR §§ 438.600 (et. al.).

The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance and Title XXI.

(INDICATE NAME AND TITLE)
(CFO, CEO, OR DELEGATE)
on behalf of

(INDICATE HEALTH PLAN NAME)

ATTACHMENT 10 – EI FAMILY DECLINING TO BILL PRIVATE INSURANCE



**Infant & Toddler
Connection of Virginia**

Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance

The parent(s) of _____ (child's name) has declined access to their private health/medical insurance for covered early intervention services.

Name of Local Early Intervention System Representative

Signature of Local Early Intervention System Representative

Date

ATTACHMENT 11 - MOC ASSESSMENT (HRA) AND INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS BY POPULATION

Initial HRA and ICP Timeliness Requirements

Subpopulation	Initial HRA Timeframe From Completion of Screening	Initial ICP Timeframe From Completion of Screening
CCC Plus Waiver and EPSDT	<p>With Private Duty Nursing – 30 days*</p> <p>Without PDN – 60 days*</p>	<p>Within thirty (30) calendar days of plan enrollment for CCC Plus Waiver Members who receive Private Duty Nursing Services.</p> <p>Within sixty (60) calendar days of plan enrollment for CCC Plus Waiver Members who do not receive Private Duty Nursing Services.</p> <p>(Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.)¹ The ICP must be developed and implemented by the Contractor no later than the end day of any existing SA.</p>
Nursing Facility	120 days*	<p>Within 120 calendar days of enrollment. (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA. Contractor must make initial contact with the Member and NF within first 30 days of enrollment.</p>
High Risk	30 days	<p>Within 30 days of completion of the MMHS. (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the</p>

¹ SAs data will be shared in the Member’s transition report. Reference the *Continuity of Care* section of this Contract; until 4/1/18 = 90 days (or more until HRA completion); 4/1/18 and after = 30 days+ (or more until HRA completion).

		continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.
Moderate Risk	60 days	Within 60 days of completion of the MMHS. (Contractor must honor all existing ICPs and SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA.
Low Risk	90 days	Within 90 calendar days of completion of the MMHS. Contractor must honor existing ICPs & SAs until the SA ends or for the duration of the continuity of care period, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of the existing SA. Contractor must make initial contact within 30 days of enrollment.
Minimal Risk	N/A	Initial ICP NOT required (See Section 5.3.4.5)

* CCC Plus Waiver and Nursing Facility designation is made by DMAS and sent to the plans on the 834. For these Members the HRA timeliness requirements continue to be calculated from the Member's enrollment date. For those Members in a Nursing Facility or CCC Plus Waiver, a MMHS does not have to be completed to determine when an HRA is needed. Refer to Section 5.2.2, *MCO Member Health Screening* and 5.3.4, *Initial HRA Completion Timeframes*.

The MMHS determines: 1) If the Member is medically complex and therefore what program (Medallion or CCC Plus) he/she is enrolled into, 2) When the HRA has to be completed for high, moderate, and low risk Members, and 3) Stratification for on-going care coordination activities for all Members for whom an initial HRA has not been completed (see below).

Whether the HRA has to be completed face-to-face or not is not determined through the MMHS. See below and §5.2.3 and §5.2.4 of this Contract.

HRA Reassessment and ICP Review (High Risk, Moderate Risk, Low Risk)

Once the Contractor makes the initial risk stratification based on the MMHS for the purposes of determining Initial HRA/ICP timeliness requirements, the Contractor shall then re-stratify members from the initial risk stratification into the existing Care Coordination Sub-Populations, outlined in Section 5.9 (i.e. CCC Plus Waiver, NF, Other Vulnerable, Emerging Vulnerable, and Minimal Need), to determine ongoing Care Coordination activities such as re-assessments and ICP reviews.

Annual LOC Review and NF Reassessments (High Risk, Moderate Risk)

The Contractor works with facility on annual reassessment reviews for continued nursing facility placement.

Care Coordinator to Member Ratios, HRA Face-To-Face Requirements, and Minimal Care Coordinator to Member Contacts

Sub-Population	Ratio	HRA Face-To-Face	Minimal Contacts
CCC Plus Waiver	1:75	Yes – All	Quarterly
Nursing Facility	1:200	Yes – All	Quarterly
Other Vulnerable (SMI, Complex Conditions, GAP)	1:150	Yes – Only those with SMI Others as needed or requested	6 months
Emerging High Vulnerable	1:400	No – Except as needed or requested	6 months
Minimal Need	1:1000	N/A	Quarterly

Stratification of CCC Plus Waiver and Nursing Facility Members is done by DMAS and communicated to the plans via the 834.

Stratifying Members into Other Vulnerable Emerging Vulnerable Minimal Need is done by the Health Plan using guidance provided in §5.1.1 and §5.8 of the CCC Plus contract.

Stratifying Members into the Minimal Risk population for the initial HRA completion timeframe is done by the Health Plan through the MCO Member Health Screening (MMHS) or when the Member is unable to be contacted.

Individualized Care Plan, HRA Reassessments, and Level of Care Reviews

Sub - Population		HRA Reassessment and ICP Review	As Needed Reassessment and ICP Revised	Annual LOC Review and NF Reassessments
CCC Plus Waiver and EPSDT		Every 6 months ² Must be face-to-face.	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor conducts annual face-to-face LOC review for continued eligibility for the Technology assisted individuals in the CCC Plus Waiver ²
Nursing Facility Including Long-Stay Hospital		Every 6 months Must be face-to-face See MDS requirements for non-HRA assessment and reassessment	Upon triggering event such as a hospitalization or significant change in health or functional status	Contractor works with facility on annual reassessment reviews for continued nursing facility placement.
Other Vulnerable		Annually;	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A

² The Contractor shall comply with requirements for the CCC Plus Waiver individuals as established in 12 VAC 30-120-900 et seq.

Sub - Population		HRA Reassessment and ICP Review	As Needed Reassessment and ICP Revised	Annual LOC Review and NF Reassessments
		SMI members must be face-to-face; all others can be telephonic		
Emerging Vulnerable		Annually; SMI members must be face-to-face, all others can be telephonic	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Minimal Need; “Unable to Contact” Populations		Reassessment and ICP review NOT required (See Section 5.3.4.5)	N/A	N/A

ATTACHMENT 12 - INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS CHECKLIST (PER CMS FINAL RULE)

The **Individualized Care Plan (ICP)** must reflect the services and supports that are important for the individual's identified needs and preferences for delivery of such supports and services. According to Section **441.301 (2) (i)** through **(xiii)** of the Final Rule (**CMS 2249-F/2296-F**), a **written ICP** must:

- Reflect that the current residential setting was the individual's choice and is integrated in, and supportive of full access of the individual to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs that have been identified through a functional needs assessment.
- Includes individually identified goals and outcomes.
- Reflect the (paid/unpaid) services/supports, and providers of such services/supports that will assist the individual to achieve identified goals.
- Reflect risk assessment, mitigation, and backup planning.
- Be understandable (e.g. linguistically, culturally, and disability considerate) to both the individual receiving HCBS/the individual's support system.
- Identify the individual and/or entity responsible for monitoring the ICP.
- With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the ICP.
- Be distributed to the individual and others involved in the ICP.
- Include services that afford the individual the option to self-direct.
- Prevent service duplication and/or the provision of unnecessary services/supports.
- Document that any modifications to compliance with the HCB settings requirements for provider owned/operated residential settings are supported by a specific assessed need and justified in the ICP in the following manner:
 1. Identify a specific and individualized assessed need.
 2. Document previous positive interventions and supports utilized prior to any modifications to the ICP.
 3. Document less intrusive methods of meeting the need(s) of the individual that did not work.
 4. Include a clear description of the condition that is directly proportionate to the specific assessed need.
 5. Include a regular collection and review of data to measure the ongoing efficacy of the modification.
 6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 7. Included informed consent of the individual.
 8. Include an assurance that interventions and supports will cause no harm to the individual.

- The ICP must be reviewed and revised upon reassessment of functional need at least once every 12 months, **OR** when the individual's circumstances/needs change, **OR** at the request of the individual.

ATTACHMENT 13 - NOTIFICATION OF PROVIDER INVESTIGATION

Notification of Provider Investigation

This form is to be used to notify the Department of Medical Assistance Services (DMAS) that your organization plans to conduct an audit of this provider. Once an allegation has been vetted and determined to warrant further investigation/audit, it is at this point that a notification should be sent to DMAS via email at

CCCPlusReporting@dmas.virginia.gov

This form should be sent to DMAS for all audits conducted by MCO staff, as well as any audits that may be conducted by contractors. Once an allegation has been vetted and determined to warrant further investigation/audit, it is at this point that DMAS should be notified of the case through the **Notification of Provider Investigation**. This is regardless of whether the target of that allegation is scheduled to be audited immediately, or is merely being placed in the queue to be audited when resources come available. Every Notification of Investigation should be reported on the quarterly fraud, waste and abuse tracking spreadsheet and remain on that spreadsheet until the case has been investigated and closed.

A **Notification of Provider Investigation** does not need to be sent for all “allegations” of provider misconduct. An **allegation** is any referral that an MCO receives that indicates a potential program integrity issue that may warrant investigation. These allegations can come from a variety of sources including hotlines, EOMBs, member complaints, other divisions outside of the SIU, DMAS, HHS-OIG, as well as data analyses that identify potential fraud, waste or abuse through outliers or other aberrant patterns. These allegations should be tracked internally and do not need to be reported on a case-by-case basis to DMAS. These allegations should then be assessed to determine if they warrant further investigation. This assessment can consist of a variety of activities including contacting the source of the allegation, evaluating claims data, examining prior audits of that provider, and potentially even contacting the provider. In most cases, this assessment will not involve requesting and reviewing medical records.

Referred by
Name:
Title:
Phone:
Email:
Managed Care Organization Name
Address
Date of DMAS Notification

Provider Investigation Detail

Provider name

Medicaid ID (NPI)
Tax Identification Number (TIN) – if available
Address
City or County
FIPS:
Provider type
Source/origination of allegation
Description of suspected misconduct
Category of service
Factual explanation of the allegation
Description of planned investigation
Type/description of investigation to be conducted
Specific Medicaid statute, rule, regulation, and/or policy violations being investigated
Date(s) of conduct being reviewed.
Dollar amount of claims being reviewed
Amount paid to provider during the past 3 years or during the period of the alleged misconduct, whichever is greater
Pre-payment Review: Start date of pre-payment review process (if applicable)
End date of pre-payment review process (if applicable)
Please note any attachments you are sending with this notification

ATTACHMENT 14 – CLARIFICATION ON COORDINATION OF BENEFITS WITH MEDICARE AND OTHER INSURANCE – MEDICAID MEMORANDUM (JULY 13, 2018)

Sent July 13, 2018



COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

July 13, 2018

To: CCC Plus Managed Care Organizations

From: Jason Rachel
Acting Director
DMAS Integrated Care Services

Brian Campbell |
Senior Program Advisor
DMAS Integrated Care Services

Subject: Clarification on Coordination of Benefits with Medicare and Other Insurance

This memorandum is a follow up to the September 30, 2017 memo on coordination of benefits to advise and clarify important Contract provisions regarding coordination with Medicare and other insurance. This memo provides additional information to specify coverage liabilities under the Medicaid benefit for coinsurance and deductibles when applied by the primary carrier. The guidance offered in this memo is directed to clarify claims processing rules that would apply regardless of whether the member's primary carrier is delivering Medicare or Commercial insurance benefits in coordination with the Medicaid benefit. Please share this memo with all operations/system configuration, care coordination, network/provider relations and customer service staff who work with the Commonwealth Coordination Care (CCC) Plus Medicaid program and/or population. The clarification provided in this Memo will be incorporated in the CCC Plus Contract revision, January 1, 2019. All Department of Medical Assistance Services (DMAS) contracted health plans will need to ensure that claims configurations and staff training materials including customer service staff messaging match this guidance by August 31, 2018.

Coordination of Benefits

In accordance with the CCC Plus Contract, Section 12.4.11 and 12.4.12, the CCC Plus health plans are required to coordinate benefits with Medicare and other insurance carriers for services covered under the CCC Plus contract. In addition, the contract specifies in Sections 11.6 and 11.7 that the member is not subject to cost sharing and the member is not held financially liable for Medicaid covered services including coinsurance, copayments, deductibles, financial penalties, or any other amount other than

any Patient Pay established by Department of Social Services (DSS) towards Long Term Support Services (LTSS). In order to ensure that obligation is met for CCC Plus members, DMAS is providing further guidance to the Managed Care Organizations (MCO) on coordinating benefits between Medicaid, Medicare and commercial insurance benefits.

The Contractor shall coordinate all benefits with the Member's primary insurance carrier. The plan shall ensure continuity of care, including when the provider is not in the plans network, at least until the member can be safely and effectively transitioned to an in-network provider. Payments to non-par providers must include information to the provider that, under Federal law, any provider who receives Medicaid payment, including through the CCC Plus health plan, must accept payment received as payment in full. Providers may not balance bill the member.

Co-Payment

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the full copayment amount. The Member may not be billed for any balance owed by the provider other than any Patient Pay established by DSS towards LTSS services.

Deductibles

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the full deductible amount. The Contractor is responsible for the deductible payment by reimbursing for services using the *MCO contracted or DMAS reimbursement rate for the specific service. Deductible amounts should be reimbursed to the provider and payment applied to reimburse all services until the payment amounts to the provider equal the member's deductible amount. When Medicaid is the secondary payer after commercial or Medicare benefits are exhausted the MCO would reimburse using the *MCO contracted or DMAS reimbursement rate for the specific service. In some instances the DMAS reimbursement code will differ from what is used by the primary payer however, reimbursement will be coordinated by the contractor based on the service definition in use by DMAS. Providers may not balance bill the member since payment to the MCO provider must be accepted as payment in full.

If a Medicaid covered service is denied by the primary carrier then the Medicaid benefit provides reimbursement at the Medicaid fee schedule. The health plan may choose to pay and chase to coordinate benefits if that option is viable to pursue the third party liability.

Co-Insurance

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the payment of the co-insurance amount using the *MCO contracted or DMAS reimbursement rate for the specific service. Medicaid is the secondary payer after commercial or Medicare benefits. Medicaid payments are made when the reimbursement from the primary insurance amount was less than what Medicaid would reimburse for the exact unit amount and procedure code.

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

When Medicaid is the secondary payer after commercial or Medicare benefits are exhausted, the MCO will reimburse for any amounts using the MCO contracted or DMAS reimbursement rate for the specific service as defined by DMAS. The DMAS contracted MCO is responsible for the co-insurance payment by reimbursing for services using the *MCO contracted or DMAS reimbursement rate* for the specific. When the primary payers reimburse less than the Medicaid reimbursement rate, the MCO shall pay up to the Medicaid rate. This is true even when the primary payers' explanation of benefits indicates there is no additional amount owed to the provider. For example: Early Intervention services as covered in the Medicaid program uses reimbursement rates which may be higher than the commercial rates for outpatient rehabilitation services. Additionally, in some instances the DMAS reimbursement code will differ from what is used by the primary payer however, reimbursement will be coordinated by the contractor based on the service definition in use by DMAS. An example of a service that uses different procedure codes is the DMAS Behavior Therapy service which is reimbursed by the department using H2033. Behavior Therapy includes the Applied Behavioral Analysis service and many commercial payers reimburse ABA services using a range of procedure codes such as 0365T which is different and include a portion of the service covered under H2033 using the DMAS service definition. Providers may not balance bill the member since payment from the MCO to the provider must be accepted as payment in full after primary and Medicaid benefits are applied and reimbursed.

Providers Not in Network with the Member's Primary Carrier (Non-Medicare)

When the primary carrier will deny or has denied a Medicaid covered service because the servicing provider does not participate or is not a provider type contracted or covered by the carrier, then claims for Medicaid covered services can be submitted by that provider and will be processed and paid up to the Medicaid allowed. The service provider may attest to the Contractor that they are not participating with the primary commercial insurance carrier. The DMAS contracted MCO shall verify and manage the network provider according to the appropriate MCO contractual requirements. Submission of an Explanation of Benefits (EOB) shall not be a requirement for providers who attest that they are not participating with the commercial carrier as a provider of the service in question.

Services Not Covered Through Medicare or Commercial Coverage

Prior to processing a claim for payment, the Contractor shall NOT require a provider to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. For those members who do not have the Medicare Part A or Medicare Part B benefit Medicaid is the primary payer for the impacted services. The Contractor's request for an explanation of benefits (EOB) from the provider in these instances would delay timely payment of these services. Examples of these services include, but are not limited to, LTSS waiver services such as personal care and respite care services and over-the-counter medications (OTCs), including those that are not covered under Part D for dual eligible individuals and certain Community Mental Health Rehabilitation Services (CMHRS).

One exception to this rule is private duty nursing (PDN) services as these are frequently covered through commercial insurance. The Contractor may only require an EOB for PDN services if the commercial carriers covers all or part of PDN services.

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

In cases where the Medicaid reimbursement code differs from the code billed to and accepted by Medicare or a commercial carrier, coordination of benefits should be based on the service definition, not simply the reimbursement code. Certain DMAS services are structured differently than other payers.

The Contractor should pursue other coverage as follows:

- Procedure codes beginning with 'S' – Would need a denial from the primary carrier or a letter by the provider attached to the claim. This letter, on the provider's letterhead, would indicate that the primary carrier does not cover this service.
- Procedure codes beginning with 'T' – These codes are not accepted by Medicare but can be used by private insurance. Would need a denial from the primary carrier or a letter attached to the claim to inform that they do not cover.

Third Party Liability "Bypass" Lists

Certain procedure codes can be by-passed for Third Party Liability (TPL) review. All other codes not found below are subject to Coordination of Benefits.

EPSDT Behavioral Therapy:

Commercial carriers use a "T" code (0364T and 0365T) for Behavioral Therapy and Medicaid recognizes H2033 as the code for this service. For commercial claims, the provider would bill the carrier using the "T" codes and receive payment. Then provider would bill H0032-UA for the assessment and H2033 for the service to CCC Plus Contractor with the EOB or denial from commercial plan or letter by the provider attached to the claim and the Contractor will coordinate the benefit for these two codes.

Medicare Bypass* List for CMHRS, ARTS, and CCC Plus Waiver:

The bypass list includes the following codes:

G9012, H0004, H0005, H0006, H0010, H0015, H0020, H0023, H0024, H0025, H0031, H0032, H0035HA, HA0035HA-UG, H0035HA-U7, H0036, H0039, H0046, H2012, H2017, H2019, H2034, H2021-TD, H2021-TE, S0109, S5102, S5160, S5160-U1, S5161, S5185, S9125-TD, S9125-TE, T1000-U1, T1001-U1, T1002, T1003, T1030-TD, T1031-TE, S5126, S5150, T1005, T1012, T1019, 99199-U4, 99509, A0120, H2000, H2015, S5109, S5116, S5165, T1028, T1999, T1999-U5, and T2038 and S9445

Commercial/Private Bypass* List for CMHRS, ARTS, and CCC Plus Waiver:

The bypass list includes the following codes:

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

G9012, H0004, H0005, H0006, H0010, H0020, H0023, H0031, H0032, H0035HA, HA0035HA-UG, H0035HA-U7, H0036, H0039, H0046, H2012, H2017, H2019, H2034, H2021-TD, H2021-TE, S5102, S5160, S5160-U1, S5161, S5185, S9125-TD, S9125-TE, T1000-U1, T1001-U1, T1002, T1003, T1030-TD, T1031-TE, S5126, S5150, T1005, T1019, 99199-U4, 99509, A0120, H2000, H2015, S5109, S5116, S5165, T1028, T1999, T1999-U5, T2038 and S9445.

Early Intervention

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for any covered early intervention services where the family has declined access to their private health/medical insurance and, as such, those services are federally required to be provided at public expense.

Medicare and Commercial Bypass List for Early Intervention:

The bypass list includes the following codes:

- 1) T1023 and T1023-U1: EI Assessment/EI Evaluation;
- 2) T1024, T1024-U1: Development or review of the Individual Family Service Plan (IFSP);
- 3) T2022: EI Targeted case management/service coordination;
- 4) T1027 and T1027-U1: Developmental services, individual and group

Under these circumstances, and in accordance with federal regulations, the Contractor shall require the Early Intervention provider complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form (http://infantva.org/documents/ovw-st-TaskF-Mtg-20090520Form-DecliningPriv_Ins.pdf) and submit it with the bill to the Contractor. The Contractor shall keep a copy of this form on the Member's file for a period of ten (10) years for audit purposes. Billing codes for EI services are reflected in the attached *CCC Plus Covered Services* chart.

Members with Medicare

If your Member's Medicare provider does not participate with your plan, the provider must agree to accept payment from Medicare and Medicaid (if any), including through the CCC Plus Medicaid MCO, as payment in full. If any Medicare provider does not agree, he/she will be in violation of their Medicare Provider Agreement and may be subject to sanctions (per Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A) of the Social Security Act). Pharmaceuticals covered under Medicare Part-D are non-covered under Medicaid; therefore, the plan is not responsible for the Medicare Part-D copayment.

The Contractor shall coordinate benefits with the member's Medicare carrier (fee-for-service or MCO) when 1) the provider is not in the Contractor's network; and 2) without the requirement of service authorization.

Services for which the CCC Plus health plan pays secondary to Medicare do not require an authorization; this is an impediment to provider participation has unfortunately created barriers/delay in access to care and services for some of our duals. If Medicare denies coverage for the service, and

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

the health plan becomes the primary payer, the health plan can require an authorization.

Additional details regarding the prohibition on billing dually eligible individuals is provided by the Center for Medicare and Medicaid Services in the communication available at:
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf>.

Members with Insurance other than Medicare

Per Sections 3 and 12.4.12.3 of the CCC Plus Contract, members determined by DMAS as having comprehensive health coverage will be assigned to the CCC Plus contractor. Members will not be disenrolled due to having other comprehensive health coverage.

Contractors may apply service authorization requirements to Medicaid covered services that are also covered by the member's commercial insurance. Coverage of services and coordination of benefits will be managed as set forth in this memorandum.

The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage (e.g. Medicare, commercial insurance, and Workers' Compensation). Any moneys recovered by third parties shall be retained by the Contractor. The Contractor shall notify DMAS monthly of any Members identified during that past month that were discovered to have comprehensive health coverage.

Provider Communications

Clarification regarding coordination with Medicare has been posted on the DMAS website for providers/stakeholders at:
http://www.dmas.virginia.gov/Content_attachments/mltss/Medical%20Provider%20CCC%20Plus%20Update%209.19.17.docx.

Please let us know if you have any questions or require any additional clarification.

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

ATTACHMENT 15 – MCO COORDINATION OF BENEFITS RESOURCE CHART

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
1	Copay	Copay – Can DMAS clarify if the MCOs should pay the copay up to the DMAS allowable or if plans pay the full amount of the copay.	Copay is paid in full in addition to the max allowable charges. Example: Provider charges \$100, Copay \$40, Primary Payer Max allowable \$70 from primary payer, Primary pays \$30 with \$40 patient responsibility assumed. Medicaid Benefit MCO allowable \$60 MCO pays \$40 to cover copay	Copay is paid in full when the member’s primary coverage is an HMO. <u>PPO and other types of commercial coverage would be reimbursed up to the MCO or DMAS allowed rate for the service.</u> Note: MMIS pays all the same way which supports the VAC in 12VAC30-20-200(2)	Copay is paid in full in addition to the max allowable charges. Provider charges \$100 Copay \$40 Max allowable \$70 from primary payer, primary pays \$30 with \$40 patient responsibility assumed. Medicaid MCO allowable \$60 MCO pays \$40 to cover copay	The Medicaid allowed amount for these FQHC/RHC facilities is equal to the Medicare allowed amount. DMAS must guarantee that FQHCs/RHCs are paid at least as much as would be paid under FFS. These “crossover” payment amounts are included in the capitation rates; therefore DMAS expects MCOs to pay these copayments.	12.4.12.3	12VAC30-20-200(2)

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
2	Deductible	Deductible - Can DMAS to clarify if the MCOs should pay the deductible up to the DMAS allowable or if plans pay the full amount of the deductible.	refer to action	refer to action	Deductibles and co-insurance can be reimbursed using the rates for the service. Deductibles will be reimbursed in increments until the full member liability for the member deductible is covered by the MCO.	<p>Medicare claims from FQHCs and RHCs are based on revenue code and Medicaid claims on procedure code.</p> <p>The Medicaid allowed amount for these FQHC/RHC facilities is equal to the Medicare allowed amount. So for Medicare claims from FQHCs and RHCs, the Medicaid allowed amount will be set to the Medicare allowed amount. Any claims for services not covered by Medicaid will be paid based on the coinsurance and deductible amounts submitted.</p>	11.7 & 12.4.2	12VAC30-20-200(1)(a), 12VAC30-20-80(C)

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
3	Co-Insurance	The memo says that for coinsurance, when the primary payers reimburse less than the Medicaid reimbursement rate, the MCO shall pay up to the Medicaid rate. "This is true even when the primary payer's EOB indicates there is no additional amount owed to the provider." Please clarify the statement in quotes.	MMIS would pay the difference between the primary payer and the Medicaid allowable in all situations. When Medicaid is the secondary payer after commercial or Medicare benefits are exhausted, the MCO will reimburse for any amounts using the MCO contracted or DMAS reimbursement rate for the specific service as defined by DMAS. *See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers. When the primary payers reimburse less than the Medicaid reimbursement rate, the MCO shall pay up to the Medicaid	Reimbursement should always be applied to use the MCO contracted or DMAS reimbursement rate for the specific service as the maximum payment amount when reimbursing for services paid by the primary payer that involve coinsurance. (Ex: Primary allows \$80, Medicaid/MCO allowed is \$100, co-insurance should be reimbursed at \$20 up to the Medicaid/MCO allowable.) This is true even when the primary payers' explanation of benefits indicates there is no additional amount owed to the provider. For example: Early Intervention services as covered in the Medicaid program	When the primary payers reimburse less than the Medicaid reimbursement rate, the MCO shall pay up to the Medicaid rate. This is true even when the primary payers' explanation of benefits indicates there is no additional amount owed to the provider. For example: Early Intervention services as covered in the Medicaid program uses reimbursement rates which may be higher than the commercial rates for outpatient rehabilitation services.	Medicare claims from FQHCs and RHCs are based on revenue code and Medicaid claims on procedure code. The Medicaid allowed amount for these FQHC/RHC facilities is equal to the Medicare allowed amount. So for Medicare claims from FQHCs and RHCs, the Medicaid allowed amount will be set to the Medicare allowed amount. Any claims for services not covered by Medicaid will be paid based on the coinsurance and deductible amounts submitted.	11.7 & 12.4.2	12VAC30-20-200(1)(a), 12VAC30-20-80(C)

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
			rate. This is true even when the primary payers' explanation of benefits indicates there is no additional amount owed to the provider. For example: Early Intervention services as covered in the Medicaid program uses reimbursement rates which may be higher than the commercial rates for outpatient rehabilitation services.	uses reimbursement rates which may be higher than the commercial rates for outpatient rehabilitation services.				

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
4	Deductible and “capping” reimbursement	Please clarify the difference in how deductibles and co-insurance are to be treated. Should commercial deductibles also be capped at the appropriate Medicaid reimbursement rate? Is there a distinction as to how deductibles and co-insurance for Medicare should be treated?	MMIS would pay deductibles up to the Medicare deductible allowed amount (tracked on a per member basis) and when the deductible is met the Medicaid allowed charge is used to reimburse for any allowed amounts in excess of the Medicare amount.	Pay whatever the primary benefit did not pay up to the MCO/DMAS allowed amount.	Pay whatever the primary benefit did not pay up to the MCO/DMAS allowed amount in the same manner as co-insurance until the member's deductible is met, then process as co-insurance until the next coverage calendar begins..	Medicare claims from FQHCs and RHCs are based on revenue code and Medicaid claims on procedure code. The Medicaid allowed amount for these facilities is equal to the Medicare allowed amount. So for Medicare claims from FQHCs and RHCs, the Medicaid allowed amount will be set to the Medicare allowed amount. Any claims for services not covered by Medicaid will be paid based on the coinsurance and deductible amounts submitted.	11.7 & 12.4.2	12VAC30-20-200(1)(a), 12VAC30-20-80(C)

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
5	Primary payer claim denial or non-covered service	When primary coverage doesn't pay any amount the DMAS memo says that we are to pay as primary. Are there any exceptions to the payment as primary, when primary carrier didn't pay? i.e Timely filling	DMAS will be researching specific MCO processing rules and will define applications based on our findings. This issue is mainly related to services that are not covered by commercial or Medicare coverage. 1. Please ensure your system configuration does not seek Medicare EOB's for Medicare non-covered codes (H codes, S codes etc.) 2. The Medicaid MCO payment processing rules and DMAS payment processing rules would apply regarding timely filing and for non Medicare services any service authorization rules may apply. For example, if the provider does not abide by the primary carrier's network	Please ensure your system configuration does not seek commercial carrier EOB's for non-covered services or for those services rendered by providers not in network with the primary carrier.	1. This coordination is done at a service definition level, to simply at a procedure code level due to differences in carrier procedure code usage, Example: HCPCS H codes, A codes, L codes, S codes and E codes may crosswalk to other codes. 2. Please ensure your system configuration does not seek commercial carrier EOB's for non-covered services or for those services rendered by providers not in network with the primary carrier. 3. Please ensure your system configuration does not seek Medicare EOB's for Medicare non-covered codes (H codes, S codes etc.) 4. Unit value discrepancies and MUE edits need to ensure that	N/A	11.7 & 12.4.2	12VAC30-20-200(1)(a), 12VAC30-20-80(C)

MCO COB Resource								
Item #	Topic	Question	Medicare Answer	TPL Answer	MCO Required Action*	FQHC/RHC Exception for Dual Eligible Members	Contract Reference	DMAS Regulation Reference
			<p>rules such as getting authorization (non medicare) or based on medical necessity then the service or claim may be denied by the Medicaid MCO.</p> <p>3. When processing primary payer actions the denial reason codes need to be less restrictive to allow for claims review processes to allow payment for DMAS covered services based on the MCO contract and program rules to ensure correct claims processing occurs when coordinating benefits with the high variance in primary payer policies, however the MCO is allowed to enforce claims processing rules regarding network status, timeliness, correct claims processing guidelines etc.</p>					

ATTACHMENT 16 – MCO MEMBER HEALTH SCREENING (MMHS)

Document Header Fields

Member Last Name: _____
 Member First Name: _____
 *Member Medicaid ID #: _____
 Member ID # (plan): _____
 Member Contact/Phone: _____
 Member Primary Care Provider: _____
 Member Primary Care Provider NPI: _____
 *Date Screening Completed: _____

Unable to Contact Member	
Member Refused to Answer	
Member Complexity Attestation Completed	

(*fields will be validated and errors returned to plan for correction)

PART 1 - Medically Complex Classification Questions:

Question 1: Has a doctor, nurse, or health care provider told you that you had/have any of the following (**please check all applicable boxes**):

<input type="checkbox"/>	Cancer (Active)
<input type="checkbox"/>	COPD or Emphysema
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart Disease, heart attack, heart failure (weak heart)
<input type="checkbox"/>	HIV or AIDS
<input type="checkbox"/>	Kidney Failure or End Stage Renal Disease (ESRD)
<input type="checkbox"/>	Parkinson’s Disease
<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Stroke, Brain Injury or Spinal Injury
<input type="checkbox"/>	Transplant or on a transplant wait list
<input type="checkbox"/>	Other chronic (long term) disabling condition – IF YES, Member Complexity Attestation must be completed

Question 2: Do any of the chronic conditions you checked above impact your ability to do everyday things **AND** require you to receive assistance with any of the following (**please check all applicable boxes**):

	Bathing
	Dressing
	Eating
	Using the bathroom
	Walking

Question 3: Has a doctor, nurse or health care provider told you that you had/have any of the following (please check all applicable boxes):

	Alcoholism
	Bipolar Disorder or Mania
	Depression
	Panic Disorder
	Post-Traumatic Stress Disorder (PTSD)
	Psychotic Disorder
	Schizophrenia or Schizoaffective Disorder
	Substance Use Disorder or Addiction
	Other chronic (long term) mental health condition – IF YES, Member Complexity Attestation must be completed

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

Yes No

Question 5: Do you have an intellectual or developmental disability and require help with any of the following: (**please check all applicable boxes**):

	Learning or Problem-Solving
	Listening or Speaking
	Living on your own
	Making decisions about your health or well-being
	Self-Care (bathing, grooming, eating)
	Travel/Transportation (driving, taking the bus)

PART 2 - Social Determinants of Health and Health Risk Assessment Triage Questions:

QUESTION 1: What is your housing situation today?

	I have housing
	Yes No I am worried about losing my housing
	I do not have housing (check all that apply)

	Staying with others
	Living in a hotel
	Living in a shelter
	Living outside (on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

QUESTION 2(a): In the past **3 months**, did you worry whether your food would run out before you got money to buy more?

Yes	No
-----	----

QUESTION 2(b): In the past **30 days**, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? **Select all that apply.**

Yes	No	Prescription Drugs or Medicine
Yes	No	Utilities
Yes	No	Clothing
Yes	No	Child Care
Yes	No	Phone
Yes	No	Health Care (doctor appointment, mental health services, addiction treatment)
		I choose not to answer this question

QUESTION 3: How many times have you been in the Emergency Room or a hospital in the last 90 days for one of the conditions you listed earlier? _____ (enter number from 0-99)

QUESTION 4: How many times have you had a fall in the last 90 days and needed to visit a doctor, Emergency Room, or hospital because of the fall? _____ (enter number from 0-99)

(Adult Population Question)

QUESTION 5: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

	Yes it has kept me from medical appointment or from getting my medications
	Yes it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

QUESTION 6: Caregiver Status (Adult Population Question)

Yes	No	Do you live with at least one child under the age of 19, AND are you the main person taking care of this child?
-----	----	---

Yes	No	Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?
-----	----	--

QUESTION 7: What is the highest level of school that you have finished? (**Adult Population Question**)

	Some high school but no diploma
	High school diploma or equivalency (GED)
	Some college but no degree
	Workforce Credential or Industry Certification after High School
	Associate's Degree
	Bachelor's Degree or higher
	I choose not to answer this question

QUESTION 8: Do you have a job? (**Adult Population Question**)

	I have a part-time or temporary job
	I have a full time job
	I do not have a job and am looking for one
	I do not have a job and I am not looking for one
	I choose not to answer this question

QUESTION 9: Do you like your current job? (**Adult Population Question**)

Yes	No	Yes, I like my job
Yes	No	I must work more than one job because I can't find a full time job
Yes	No	I work more than 40 hours per week at two or more part time jobs
Yes	No	I have been looking for a job for more than 3 months and I have not been offered a job
Yes	No	I would like help finding a job that I like more or pays more money

QUESTION 10: In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

	Yes
	No
	Unsure
	I choose not to answer this question

QUESTION 11: Do you have other important health issues or needs that you would like to discuss with someone?

	Yes
	No

QUESTION 12: How soon do you want to be contacted by someone to discuss your health issues or needs?

	1-30 Days
	31-60 Days
	61-90 Days
	91-120 Days
	Do not contact me

ATTACHMENT 17 – ADULT PREVENTIVE SERVICES FOR EXPANSION ALTERNATIVE BENEFIT PLAN

Adult Preventive Services for Expansion Alternative Benefit Plan			
Wellness /Preventive Exams CPT Codes	Description	Limitations	Covered Diagnoses
99385	new pt, 18-39 yrs	1 per calendar year	N/A
99386	new pt, 40-64 yrs	1 per calendar year	N/A
99395	established pt 18-39 yrs	1 per calendar year	N/A
99396	established pt, 40-64 yrs	1 per calendar year	N/A
Smoking Cessation Counseling CPT/ HCPCS Codes	Description	Limitations	Covered Diagnoses
99406	individual counseling visit,3-10 min	6 units per calendar year; no prior authorization	ICD-10 code F17.200 (Nicotine dependence, unspecified, uncomplicated), or ICD-10 code Z87.891 (history of tobacco use).
99407	individual counseling visit, >10 min	6 units per calendar year; no prior authorization	ICD-10 code F17.200 (Nicotine dependence, unspecified, uncomplicated), or ICD-10 code Z87.891 (history of tobacco use).
S9446	group pt. education, not otherwise classified, non-physician provider	6 units per calendar year; no prior authorization	ICD-10 code F17.200 (Nicotine dependence, unspecified, uncomplicated),

Adult Preventive Services for Expansion Alternative Benefit Plan

Vaccines CPT Codes	Description and Age Guidelines	Limitations	Covered Diagnoses
			or ICD-10 code Z87.891 (history of tobacco use).
90714	Td		
90715	Tdap		
90736	Shingles zoster, > age 60	Allow for members 60-65	
90750	> age 50	Allow for members 50-65	
90620	Meningococcal, IM, 2 dose		Q89.01, Z90.81, Z21, Z20.811, Include the dx codes in the ICD-10 HIV Diag. Code value set
90621	Meningococcal, IM, 2-3 dose		Q89.01, Z90.81, Z21, Z20.811, Include the dx codes in the ICD-10 HIV Diag. Code value set
90733	Meningococcal, SQ		Q89.01, Z90.81, Z21, Z20.811, Include the dx codes in the ICD-10 HIV Diag. Code value set
90734	Meningococcal, IM		Q89.01, Z90.81, Z21, Z20.811, Include the dx codes in the

Adult Preventive Services for Expansion Alternative Benefit Plan			
			ICD-10 HIV Diag. Code value set
90707	MMR		
90649	HPV, quadrivalent, 3 dose schedule	Males through age 21 years of age Females through 26 years of age	
90650	bivalent,3 dose schedule	Males through age 21 years of age Females through 26 years of age	
90651	nonavalent, 2-3 dose schedule	Males through age 21 years of age Females through 26 years of age	
90716	Chickenpox		
90632	Hepatitis A		N17.0-N17.9, N18.1-N18.9, K70.0, K70.10- K70.11, K70.2, K70.30- K70.31, K70.40- K70.41, K70.9, K71.0, K71.10- K71.11, K71.2- K71.4, K71.50- K71.51, K71.6, K71.7, K71.8, K71.9, K72.00- K72.01, K72.10- K72.11, K72.90- K72.91, K73.0- K73.9, K74.0- K74.5, K74.60- K74.69, K75.0-

Adult Preventive Services for Expansion Alternative Benefit Plan

			K75.9, K76.0- K76.99, K77, Z72.52, Z72.53, Z59.0 Include the dx codes in the ICD-10 HIV Diag. Code value set
90739	Hepatitis B, adult, 2 dose		N17.0-N17.9, N18.1-N18.9, K70.0, K70.10- K70.11, K70.2, K70.30- K70.31, K70.40- K70.41, K70.9, K71.0, K71.10- K71.11, K71.2- K71.4, K71.50- K71.51, K71.6, K71.7, K71.8, K71.9, K72.00- K72.01, K72.10- K72.11, K72.90- K72.91, K73.0- K73.9, K74.0- K74.5, K74.60- K74.69, K75.0- K75.9, K76.0- K76.99, K77, Z72.52, Z72.53, Z59.0 Include the dx codes in the ICD-10 HIV Diag. Code value set

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90746	Hepatitis B, adult, 3 dose		N17.0-N17.9, N18.1-N18.9, K70.0, K70.10- K70.11, K70.2, K70.30- K70.31, K70.40- K70.41, K70.9, K71.0, K71.10- K71.11, K71.2- K71.4, K71.50- K71.51, K71.6, K71.7, K71.8, K71.9, K72.00- K72.01, K72.10- K72.11, K72.90- K72.91, K73.0- K73.9, K74.0- K74.5, K74.60- K74.69, K75.0- K75.9, K76.0- K76.99, K77, Z72.52, Z72.53, Z59.0 Include the dx codes in the ICD-10 HIV Diag. Code value set
90647	Hemophilus influenza, 3 dose		Q89.01, Z90.81, D57.00- D57.02, D57.1, D57.20, D57.211- D57.219, D57.3, D57.40, D57.411- D57.419, D57.80,

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			D57.811- D57.819, Z94.84
90648	Hemophilus influenza, 4 dose		Q89.01, Z90.81, D57.00- D57.02, D57.1, D57.20, D57.211- D57.219, D57.3, D57.40, D57.411- D57.419, D57.80, D57.811- D57.819, Z94.84
Nutritional Counseling CPT Codes	Description and Age Guidelines	Limitations	Covered Diagnoses
97802	Medical Nutrition Therapy, Initial Assessment and Intervention, Individ., Face-to-Face with the patient, each 15 minutes	12 units per calendar year; no prior authorization	E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999, E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11, I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89

Adult Preventive Services for Expansion Alternative Benefit Plan

			*need to include the ICD-10 Diagnosis codes currently in the ICD-10 Pregnancy Diagnosis Codes
97803	Medical Nutrition Therapy Re-Assessment and Intervention, Individual, Face-to-Face with the patient, each 15 minutes	12 units per calendar year; no prior authorization	E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999, E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11, I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89 *need to include the ICD-10 Diagnosis codes currently in the ICD-10 Pregnancy Diag Codes
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	4 units per calendar year; no prior authorization	E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999,

Adult Preventive Services for Expansion Alternative Benefit Plan

			<p>E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11, I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89 *need to include the ICD-10 Diagnosis codes currently in the ICD-10 Pregnancy Diagnosis Codes</p>
G0270	<p>Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes</p>	<p>8 units per calendar year; no prior authorization</p>	<p>E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999, E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11,</p>

Adult Preventive Services for Expansion Alternative Benefit Plan

			<p>I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89 *need to include the ICD-10 Diagnosis codes currently in the ICD-10 Pregnancy Diag Codes</p>
<p>G0271</p>	<p>Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes</p>	<p>4 units per calendar year; no prior authorization</p>	<p>E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999, E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11, I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89 *need to include the ICD-10 Diagnosis</p>

Adult Preventive Services for Expansion Alternative Benefit Plan

			codes currently in the ICD-10 Pregnancy Diagnosis Codes
S9470	Nutritional counseling, dietitian visit	8 units per calendar year; no prior authorization	E66.01, E66.2, Z68.30-Z68.45 E10.10- E10.9999, E11.00- E11.9999, E13.00- E13.9999 E78.00 - E78.01, E78.1 – E78.6 I10, I11.0- I11.9, I12.0- I12.9, I13.0, I13.10-I13.11, I15.0-I15.9, I16.0-I16.9 I25.10, I25.110- I25.119, I25.810- I25.812, I25.82- I25.99 I50.1 - I50.89 *need to include the ICD-10 Diagnosis codes currently in the ICD-10 Pregnancy Diagnosis Codes

DELETED FROM JULY 1, 2020 CONTRACT:

ATTACHMENT 18 – DEPARTMENT OF MEDICAL ASSISTANCE SERVICES PRE-ENROLLMENT / REVALIDATION SITE VISIT CHECKLIST

NPI:

Provider Name:

OFFICE USE ONLY: PASS FAIL

PRE-ENROLLMENT/REVALIDATION SITE VISIT CHECKLIST

Per Federal Regulation 42CFR 455.432, the State Medicaid agency—

(a) Must conduct pre-enrollment and post-enrollment site visits of providers who are designated as “moderate” or “high” categorical risks to the Medicaid program. The purpose of the site visit will be to verify that the information submitted to the State Medicaid agency is accurate and to determine compliance with Federal and State enrollment requirements.

(b) Must require any enrolled provider to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.

Date:

Time:

Attempt:

Site Visit Performed by:

PROVIDER INFORMATION

Instructions: From the provider application and most recent provider maintenance (if any), complete the information below. The type of services provided by the enrolling provider will determine necessary observations during the tour of the facility.

Name:

NPI:

Business Name:

Business Telephone:

Servicing Address:

Provider Type:

Specialty:

Revalidation or New Enrollment:

Contact Name:

Title:

Phone:

Correspondence Email:

ONSITE

Instructions: The site visit to the servicing location of the enrolling/revalidating provider will be unannounced. Upon arrival at the location, verify physical address. Upon entering the business, introduce yourself, provide business card, letter of authorization and DMAS photo ID; ask to speak with provider. Explain the purpose of your visit. Complete the following information.

- | | |
|---|--|
| 1. Presented photo ID? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 2. Provided Letter of Authorization? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. Is the servicing location address correct? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 4. Picture taken of the exterior of the business? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5. Business signage present? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 6. Hours of operation posted? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 7. Is the site/office open? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

8. Type of facility?

- a. Store Front
- b. Office Suite
- c. Warehouse
- d. Private Residence
- e. Multi-Office Building
- f. Other:

g. Do you have additional servicing locations? YES NO If yes, please list below.

9. Is the site operational?

- a. Working phones? YES NO Verify phone#:
- b. Working Computers YES NO Verify email:
- c. Customers at site? YES NO

10. Tour:

- a. Picture of interior? YES NO
- b. Reception area? YES NO
- c. License Displayed? YES NO

Licenses held:

Business license

- 11. Are you accepting patients/clients at this time? YES NO
- i. If not, when do you expect to be open for business?

OWNER BACKGROUND

Instructions: If the contact person is not the owner, ask who the owner is and match names to those documented in the provider application. If no answers are provided, please document that the information is not available.

12. Name of Owner(s)?

- 13. Does the owner have interest in any other medical related business? YES NO
- a. If yes, what percentage? _____

PROVIDER EDUCATION

- 14. Web portal registration
- 15. EFT
- 16. EDI
- 17. Provider Training website.
- 18. Process for updating license
- 19. Accessing online manuals that's applicable to PCTs and memos
- 20. Process for revalidations
- 21. PPM functions
- 22. Blast email
- 23. Was provider education provided? YES NO

NOTES:

Correspondence Email Address Update:

I hereby authorize Provider Enrollment Services to update my correspondence email address to the following to receive future electronic correspondence:

Signature of the Authorized Representative/Provider

ACKNOWLEDGEMENT

By signing below, I verify that the information given on this site visit is accurate and that it was performed at the address given for this enrollment and or revalidation.

Signature of the Provider

By signing below, I verify that I have personally performed this site visit at the location and on the date and time listed above and that the observations I have recorded are correct.

Signature of individual Performing Site Visit

PASS__ FAIL__

ATTACHMENT 19 – 2020 GENERAL ASSEMBLY ACTIONS

This attachment contains a list of new requirements added to the Code of Virginia during the 2020 General Assembly Session that impact the Medicaid program. This is not intended to be an inclusive list. Not all of the actions required changes to this contract; however, the Contractor is responsible for understanding the actions and implementing any necessary programmatic or policy changes in order to comply. This list is subject to change based on future General Assembly actions.

Enrolled Bills -

Bill Number	Title	Description	DMAS Comment
HB728 SB 734	Residential psychiatric placement and services; SOE, et al., to establish work group	This is a Section 1 bill that directs the Secretaries of Education and Health and Human Resources to establish a work group, to consist of the Director of Medical Assistance Services among others, to study the current process for approval of residential psychiatric services for children and adolescents and requires the work group to report its findings and recommendations to the Chairmen of House Appropriations and Senate Finance, and to the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by, December 1, 2020.	Potential future changes and MCO participation may be needed.
HB 826	State plan for medical assistance; payment for services provided by certified doulas.	This is a Section 1 bill that requires the Department of Medical Assistance Services to convene a work group to provide recommendations related to amending the state plan for medical assistance services to include a provision for the payment of medical assistance for services provided by certified doulas. Findings and recommendations are to be reported to the Governor and the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance and	Potential future changes and MCO participation may be needed.

		Appropriations by December 1, 2020.	
HB 902 SB 902	Long-term care services and supports; preadmission screenings.	This bill requires DMAS to allow qualified nursing facility (NF) staff to complete the Long-Term Services and Supports (LTSS) screenings for an individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The bill also directs DMAS to consider alternative assessment tools for LTSS screenings.	Relevant change(s) made in body of contract.
HB 925	Department of Medical Assistance Services to take steps to facilitate the transition of persons between the Home and Community-Based Services waiver program and the Medicaid Works waiver program.	<p>The Department of Medical Assistance Services shall establish a process for (i) conducting a comprehensive needs assessment of a person who chooses to participate in the Medicaid Works program to determine the services such person may need to live and fully participate in his community and (ii) developing a plan of support for such person to guide the person in selection of the best waiver program for his needs.</p> <p>The Department of Medical Assistance Services shall establish a process to enable a person who transitions from a Home and Community-Based Services waiver program to the Medicaid Works program to retain his Home and Community-Based Services waiver slot for up to 180 days following the date of such transition.</p> <p>The Department of Medical Assistance Services shall establish a process to give priority to individuals previously receiving services through the Home and Community-Based Services waiver program who transitioned to the Medicaid Works program and who</p>	Relevant change(s) made in body of contract.

		subsequently seek to resume services through the Home and Community-Based Services waiver program.	
HB 1291 SB 568	Medical assistance services; managed care organization contracts with pharmacy benefits managers.	This bill directs DMAS to require its contracted MCOs include in their pharmacy benefit manager (PBM) contracts a provision prohibiting the "spread pricing," which is used by some PBMs to increase their administrative revenues. The bill requires Medicaid PBMs to instead use "pass-through" pricing that more accurately reflects their administrative costs. The bill becomes effective July 1, 2020.	Relevant change(s) made in body of contract.
SB 213	Personal Maintenance Allowance; DMAS to establish work group to evaluate current amount.	Require DMAS to establish a workgroup to study the current Personal Maintenance Allowance amount for individuals receiving Medicaid-funded waiver services and the impact of that amount on the ability of waiver service recipients to engage in compensated employment, and to establish and maintain independence. The workgroup would be required to report its findings and conclusions to the Governor, the General Assembly, and the Chairman of the Joint Commission on Health Care by November 1, 2020.	Potential future changes and MCO participation may be needed.
HB 807 SB 766	Health care; explanation of benefits, sensitive health care services.	Allows State Corporation Commission to adopt regulations that establish alternative methods of delivery of the explanation of benefits, provided that such alternative method is in compliance with the provisions of federal regulations regarding the right to request privacy protection for protected health information.	Potential future impact to EOB policies.
HB 822	Health insurance; credentialing, health care or professional health-related services.	This bill will require all health carriers that credential providers to develop policies and procedures to reimburse providers that are	Relevant change(s) made in body of contract.

		newly credentialed for the services provided during the credentialing process within 30 days of the credentialing process being completed.	
SB 365	Health care provider; SHHR to convene a work group related to credentialing.	Requires Secretary of Health and Human Resources to convene a work group to gather information and make recommendations on how the Commonwealth could develop or procure a statewide centralized primary source verification system that can be relied upon by the Commonwealth and its health carriers, health care providers, hospitals, and health systems for health care provider credentialing. The work group shall report its findings and recommendations to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 15, 2020.	Potential future changes and MCO (VAHP) participation is required.
SB 804	Employees providing domestic service; definitions, report.	Requires the Secretary of Commerce and Trade to convene a work group to make recommendations, including any necessary statutory and regulatory changes, with regard to protecting domestic service employees from workplace harassment and discrimination, providing remedies for such employees for the nonpayment of wages, ensuring the safety and health of such employees in the workplace, and protecting such employees from loss of income as a result of unemployment or employment-related injury by including coverage of such employees in the Virginia Unemployment Compensation Act and the Virginia Workers' Compensation Act.	Potential future changes to consumer-directed services.

General Assembly Amendments to Governor's Introduced Budget -

Due to the economic uncertainty resulting from the COVID-19 pandemic, the General Assembly has unallotted funding for many of the proposed budget actions. The General Assembly will meet at a yet undetermined date for a Special Session where they will further amend the budget based on a revised economic forecast. The Contract will be responsible for complying with all applicable requirements resulting from the resulting from the Appropriation Act and the pending Special Session.

ATTACHMENT 20 – MCO SERVICES DELIVERY FLEXIBILITIES RELATED TO COVID-19



COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 East Broad Street, Suite 1300
Richmond, VA 23219

March 19, 2020

To: Medallion 4.0 and CCC Plus Managed Care Organizations

From: Karen Kimsey
Director
DMAS

Tammy Whitlock
Deputy Director
Complex Care and Services

Cheryl Roberts
Deputy Director
Programs and Operations

Subject: MCO Services Delivery Flexibilities related to COVID-19

This memo sets out the Agency's initial guidance on the flexibilities available to providers in light of the public health emergency presented by the COVID-19 virus. These flexibilities include expanded telehealth coverage, as well as the waiver of certain program requirements, including specified service authorizations and prescription drug limitations. DMAS is also waiving specific provider requirements, as set out below. These flexibilities are

relevant to the delivery of covered services related to COVID-19 detection and treatment, as well as maximizing access to care and minimizing viral spread through community contact.

Please note that the policy changes set out in this memo are in effect during the public crisis, as set out in the Governor's Emergency Declaration. This is a rapidly emerging situation and the Agency is moving quickly to address all aspects having an impact on both members and providers. Additional changes are forthcoming; DMAS is negotiating with its federal partners to authorize new flexibilities which the Agency will announce as they are approved. Providers are encouraged to frequently access the Agency's website to check the central COVID-19 response page for both FAQ's and guidance regarding new flexibilities as they are implemented. For additional questions about this memo or other COVID-19 related issues, the agency has created a centralized point of access for submission at <http://dmas.virginia.gov/contactforms/#/general>

The guidance offered in this memo is directed to clarify claims processing rules that would apply to all DMAS-covered members regardless of whether the member's primary carrier is delivering Medicare or Commercial insurance benefits in coordination with the Medicaid and FAMIS benefit programs. Please share this memo with all operations/system configuration, care coordination, network/provider relations and customer service staff who work with the Medallion 4.0 and Commonwealth Coordination Care (CCC) Plus benefit plans and/or populations. All Department of Medical Assistance Services (DMAS) contracted health plans will need to ensure that claims configurations, and front line member and provider response staff training materials and staff messaging match this guidance by March 25, 2020. For the items and services that are not reimbursed using the same procedure codes as defined in the DMAS provider memo dated March 19, 2020 the contractors must ensure that network providers are given guidance on how to utilize and access the services in accord with DMAS program guidance.

All MCO benefit management structures should be assessed and adapted to allow the service provision requirements and flexibilities as defined in the DMAS memo dated March 19, 2020 and any subsequent memo related to the current and future ongoing management of COVID-19.

Billing for COVID-19 Testing

Testing is available through the Division of Consolidated Laboratory Services (State Laboratory) and from other private laboratories. For testing at DCLS, patients must meet certain clinical and epidemiologic criteria, and testing will be approved by the Virginia Department of Health. Further information on testing can be found on VDH's website. VDH approval is not required for testing at private laboratories.

VDH-enrolled clinical laboratories and health care facilities may bill DMAS for medically necessary, clinically appropriate COVID-19 lab tests using HCPCS Code U0001 (CDC testing laboratories to test patients for SARS-CoV-2, \$35.91) and U0002 (non-CDC testing for SARS-CoV, \$51.31) with effective dates of service on or after February 4, 2020. DMAS' fee-for-service billing system has been updated to accept the new codes and service authorization is not required. Laboratories will need to be Clinical Laboratory Improvement Amendments (CLIA) certified. DMAS is following the Center for Medicare and Medicaid Services (CMS) guidance for these two services. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover COVID-19 testing.

Billing for COVID-19 Related Services

DMAS covers medically necessary services to treat or alleviate symptoms related to COVID-19. The CDC has provided [Official Coding Guidelines](#) for health care encounters and deaths related to COVID-19. All Medicaid Managed Care Plans (MCOs) and Medicaid fee for service (FFS) cover medically necessary services to treat or alleviate symptoms related to COVID-19.

Coverage of Targeted Services Delivered Via Telehealth

In order to maximize access to medically necessary services during the current public health emergency, DMAS is expanding coverage of telehealth as a method of service delivery. This is an initial policy memo; the agency is working as quickly as possible to leverage additional needed flexibilities in this area; for example, in the area of remote patient monitoring. Medicaid MCOs may offer additional flexibilities.

"Telehealth services" means the use of telecommunications and information technology to provide access to health assessments, diagnosis, intervention, consultation, supervision, and information across distance for both medical and behavioral health services. Telehealth services includes the use of such technologies as interactive and secure medical tablets, remote patient monitoring, and store-and-forward technologies. When delivering services via telehealth, providers are required to adhere to the same standards of clinical practice and record keeping that apply to other covered services.

During the COVID-19 national emergency and effective immediately, the Office of Civil Rights at the Department of Health and Human Services "will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency." This applies to telehealth provided for any reason and does not have to be related to diagnosis and treatment of COVID-19. The full notice and related guidance on acceptable applications can be found [here](#).

DMAS will reimburse for Medicaid-covered services delivered via telehealth where the following conditions are met:

- To the extent feasible under the circumstances, providers must assure the same rights to confidentiality and security as provided in face-to-face services. Providers must ensure the patient's informed consent to the use of telehealth and advise members of any relevant privacy considerations.
- DMAS is waiving the requirement that services delivered via telehealth (real-time, two-way communications) must utilize both audio and visual connection. DMAS is allowing the use of audio connections in addition to audio-visual connections.
- DMAS is waiving the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee. These "telepresenters" shall not be required for payment of the originating site fee. Telehealth in the home is discussed more fully below, but no originating site fee shall be paid for telehealth in the home.
- Providers shall submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service delivered. In some cases, there are existing codes available for certain specifically telehealth-focused services. In others, such as behavioral health, please see the service specific section below for guidance. During the initial phase of the emergency, the Agency will permit providers who have not previously billed for telehealth delivery to bill for covered services delivered via telehealth (including audio and audio-visual) using their usual place of service code as the delivery location, but must document in the member's record the alternative location used and that the service was delivered via telehealth.
- Providers are asked to update their systems and procedures as soon as possible to enable the use of modifiers (GT or GQ) or telehealth POS (02) when billing for services delivered via telehealth. DMAS will require the use of these codes after the initial phase of the emergency is over. Additional information will be included in a future memo.
- Providers using telehealth POS (02) or modifiers for telehealth services covered under the prior policy shall continue to use the modifier GT (via interactive audio and video telecommunications system) or GQ

(via synchronous telecommunications system), or POS code (02) when billing for services delivered via telehealth.

- Both services delivered via telehealth and billed using telehealth modifiers, and services delivered via telehealth and billed without modifiers will be reimbursed at the same rate as the analogous service provided face-to-face.
- Providers shall maintain appropriate documentation to support medical necessity for the service delivery model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care.

Home as Originating Site

During the current emergency, DMAS will allow the home as the originating site. This is particularly important for members who are quarantined, those who are diagnosed with or demonstrating symptoms of COVID-19, or those who are at high risk of serious illness from COVID-19. Clinicians shall use clinical judgment when determining the appropriate use of home as the originating site. No originating site fee shall be paid for telehealth in the home.

Telehealth in the Delivery of Behavioral Health Services

DMAS will allow for telehealth (including telephonic) delivery of all behavioral health services with several exceptions. Services that will be allowable via telehealth include:

- Care coordination, case management, and peer services
- Service needs assessments (including the Comprehensive Needs Assessment and the IACCT assessment in mental health and the Multidimensional Assessment in ARTS) and all treatment planning activities
- Outpatient psychiatric services
- Community mental health and rehabilitation services
- Addiction Recovery and Treatment Services

The per diem rates for therapeutic group homes, psychiatric residential treatment facilities, and inpatient psychiatric hospitalization will not be billable through telehealth; however, within these services, activities including assessments, therapies (individual, group, family), care coordination, team meetings, and treatment planning are allowable via telehealth.

As stated above in the general guidance and until otherwise notified, behavioral health providers delivering services via telehealth (including telephonic communications) shall simply bill and submit a claim as they normally would in their regular practice. The Place of Service (POS) that the provider usually bills should remain the same and no modifiers shall be necessary in order to minimize systems errors during this critical time. Providers shall maintain appropriate documentation to indicate the mode of delivery and to support medical necessity for the ongoing delivery of the service through that model of care. As noted above in the general guidance, providers should move to systems changes to allow Place of Service Codes (02) to reflect telehealth delivery as this will be required at a future date.

Please Note: All program-specific guidance for COVID-19 service flexibilities is located in the Medicaid Memo on COVID-19 Flexibilities dated March 19, 2020.

Face-to-Face Service Delivery Guidance for all DMAS-Covered Services:

DMAS is issuing the following recommendations to assist agencies, health care organizations, and providers, and to assure that members continue to receive necessary interventions.

- All providers shall limit the amount of face-to-face contacts with members. If a provider, member, caregiver, and or anyone in home or facility is experiencing symptoms of a medical illness, all face-to-face contact shall be minimized or avoided.
- All face-to-face requirements including assessments, reassessments, and service delivery are waived for all members residing in the community, with the exception of instances when there is concern for the member's health safety and welfare. Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers.
- Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.

Requirements for Member Co-payments (Applicable across MCOs and FFS)

All member co-pays have been suspended, effective March 13, 2020. No co-pays will be collected from any Medicaid or FAMIS member in order to encourage all members to seek needed medical care and treatment.

Pharmacy Benefit Changes in Response to COVID 19

Effectively immediately, the Fee-for-Service (FFS) and Medicaid managed care health plans will

- 1) Suspend all drug co-payments for Medicaid, FAMIS and FAMIS Moms members,
- 2) Cover a maximum of a 90 day supply for all drugs **excluding** Schedule II drugs. In Virginia, Schedule II drugs include most opioids, amphetamines, methylphenidate, etc. A complete list of Schedule II drugs can be found at <https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3448/>.
- 3) Suspend refill to soon edits for all drugs prescribed for 34 days or less. Drugs dispensed for 90 days will be subject to a 75% refill to soon edit. Patients will only be able to get a subsequent 90 day supply of drugs after 75% of the prescription has been used (approximately day 68).
- 4) Federal and state law prohibit the early refilling of Schedule II drugs except in the case of an emergency. Pharmacists should refer to Virginia Board of Pharmacy's guidance for emergency fill procedures.

Pharmacists and prescribers must continue to comply with all applicable state and federal laws and regulations related to the prescribing and dispensing of controlled substances. Pharmacists are encouraged to review the Virginia Board of Pharmacy's **Emergency Provisions for Pharmacists During the COVID-19 Declared Emergency** for additional guidance.

Waiving Service Authorization Requirements on Select Services

Providers are required to submit for service authorization review: 1) any new request for services; and 2) requests for changes in services such as increase or decrease.

Please see Attachment B for a full list of services for which service authorization is being extended or waived.

Please note that DME providers may deliver up to a 2-month supply at a time (60 days) during the response to the COVID-19 pandemic. DME providers are instructed to bill in monthly increments with the anniversary date (30 days at a time). Providers will be required to keep records of patient/caregiver contact to determine the appropriate need for supplies during each 60-day period if it is determined a second 60-day supply period is needed. Providers are also required to maintain the normal delivery ticket documentation and proof of delivery.

Suspension of Out-of-Network Requirements

For Out-of-Network services, the MCOs shall relax out of network authorization requirements as appropriate and pay the Medicaid fee schedule, in order to expedite needed care for members.

Medallion 4.0 and CCC Plus Managed Care Programs

During the emergency DMAS requires for all MCO's to ensure that claims systems and benefit management rules are aligned with the most current DMAS Memoranda on the COVID-19 service delivery flexibilities. Please refer to the Medicaid Memo posted on March 19, 2020 for up to date more guidance. MCOs may, at their discretion, allow additional enhanced delivery flexibilities within their provider network.

- **Member and Provider Communications**
The department requires copies of all provider and member communications addressing the COVID 19 crisis. Please send that information to
[CCC Plus-CCCPlusMCOs@dmas.virginia.gov](mailto:CCCPlusMCOs@dmas.virginia.gov)
Medallion 4.0-Managedcarehelp@dmas.virginia.gov
- **Daily Update:**
The department is requesting that the plans each morning by 10 am send a daily update of any COVID updates including known complications, concerns, staffing or location changes. In addition, plans should be on a daily call with DMAS team members at 3 pm
- **Weekly reports/Crisis Updates**
The department will be requesting weekly reports about testing and treatment so that we can provide that information to HHR as needed.

CCC Plus MCO Face-to-Face Requirements

The changes to the face-to-face requirements are as follows, effective March 12, 2020:

- a. For CCC Plus members in nursing facilities, all face-to-face requirements including initial health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with member, family/authorized representatives, nursing facility staff and/or documentation, e.g., copy of most recent minimum data set or other available member records. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.
- b. For CCC Plus members residing in the community, with the exception of instances when there is concern for the member's health safety and welfare, all face-to-face requirements including health risk assessments, reassessments (both scheduled and triggering), interdisciplinary care team meetings, and care planning meetings are waived. Face-to-face meetings shall be replaced with phone calls with members and/or documentation from providers. This waiving of the face-to-face requirements shall be used for all CCC Plus members residing in the community where the member's health, safety and welfare is maintained by authorized services and information received by using an alternate method in lieu of the face-to-face meeting. Details on how the information was obtained in lieu of the face-to-face meeting must be documented within the member's record.

- c. Existing face-to-face requirements continue to apply in cases where there is a compelling concern for the member's health, safety and welfare based on the professional judgement of licensed staff.
- d. All Quality Management Reviews (QMRs) will be desk audit only. All needed materials will be requested from the provider to conduct the review. Providers will be allowed flexibility in instances where they have limited staff to submit records. DMAS will schedule a call to discuss the process for reviewing health plan findings from the desk audit reviews.
- e. All face-to-face requirements to conduct the annual level of care evaluations (LOCERI) are waived. This waiving of face-to-face requirement is for both past due and currently due level of care evaluations. For CCC Plus Waiver members who have had a face-to-face health risk assessment (initial or reassessment) from October 1, 2019 through March 12, 2020, the information from this assessment may be used to submit LOCERI data in lieu of the face-to-face meeting to complete and submit the annual level of care evaluation.

Eligibility and Enrollment

Several changes are being made to Eligibility and Enrollment policies and procedures to ensure continued coverage during this emergency. The agency's priority is to ensure continued coverage and access to coverage during this time. DMAS encourages uninsured patients to apply online (www.commonhelp.virginia.gov) as the fastest way to apply for care during an emergency. However, if patients experience interruptions in coverage or need corrections to their coverage during this time, please contact the centralized contact option highlighted at the beginning of this memo.

Fair Hearings and Appeals

Member Appeals

For all appeals filed from March 12, 2020, and throughout the declaration of emergency, if the appeal is for a reduction, termination, or denial of existing services, the MCO should automatically continue the services during the internal appeal with no financial impact to the member. This applies whether the member has requested continued coverage or not. Additionally, if a further appeal is made to DMAS after the MCOs internal appeal process has been exhausted, DMAS will automatically grant continued coverage and the MCO must continue the services during the DMAS appeal with no financial impact to the member.

DMAS is also seeking federal authority to accept client/member appeals filed during the COVID-19 emergency that miss the normal filing deadlines. DMAS expects that this authority will be granted. If so, those appeals will move forward as if the deadlines were met. MCOs should accept internal appeals filed during the emergency even if the normal deadline to file the appeal was not met.

Appeal documents such as case summaries can still be submitted through the normal methods, but electronic means will be the most reliable during the emergency. The Appeals Division fax is 804-452-5454 and e-mail is Appeals@DMAS.Virginia.Gov

Provider Appeals

Pursuant to the Governor's Declaration of a State of Emergency issued on March 12, 2020 (Executive Order 51), the DMAS Director is authorized to waive state requirements and regulations. DMAS is exercising this

authority for deadlines that govern provider appeals that are specified in the Code of Virginia and DMAS' provider appeal regulations. The following changes are being made:

- Providers affected by the COVID-19 emergency can request a hardship exemption to the normal deadline to file an appeal. MCOs should accept appeals as timely filed if a hardship is indicated on the appeal request.
- All deadlines after an appeal has been filed are extended for the period of the declaration of emergency. This applies to the following informal appeal deadlines: case summary, informal-fact-finding conference (IFFC), document submission after the IFFC, and the informal appeal decision. This also applies to the following formal appeal deadlines: documentary evidence, hearing date, post-hearing briefs, recommended decision, exceptions, and the Final Agency Decision. For example, if the declaration of emergency lasts 50 days, these deadlines are extended 50 days.
- All informal fact-finding conferences and formal hearings will be conducted by telephone during the period of emergency.

Attachment A

Table of Codes for Telehealth.

CODE	DEFINITION	Provider Type/Specialty
99201 – 99205 99211- 99215	Initial and subsequent E&M office visit or other outpatient visit	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99221- 99223 99231- 99233	Initial and subsequent hospital care	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
Q3014	Telemedicine Facility Fee	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99304- 99306 99307- 99310	Initial and subsequent physician nursing home care	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000
99354- 99355 99356- 99357	Prolonged service office Prolonged service inpatient	MD: 020/000 NP: 023/000 FQHC: 052/000 RHC: 053/000 Health Dept.: 051/000

ATTACHMENT B

Extended Service Authorizations for the following services:

CCC Plus Waiver Services

Extend SA for 60 days		
HCPCS Code	Mod	Description
T1019		Agency directed personal care
S5126		Consumer directed personal care
S9123		EPSDT Private Duty Nursing-RN
S9124		EPSDT Private Duty Nursing-LPN
G0493		EPSDT Private Duty Nursing-Congregate-RN
G0494		EPSDT Private Duty Nursing-Congregate-LPN
T1000	U1	Private Duty Nursing
T1001	U1	Private Duty Nursing
T1002		Private Duty Nursing-RN
T1003		Private Duty Nursing-LPN
S9125	TD	Skilled Respite RN
S9125	TE	Skilled Respite LPN
T1030	TD	Private Duty Nursing-Congregate-RN
T1031	TE	Private Duty Nursing-Congregate-LPN

Durable Medical Equipment

Waive SA for 60 days		
HCPCS Code	Description	Billing Unit
Respiratory		
A4604	Tubing with integrated heating element for use with positive airway pressure device	Each
A4608	Transtracheal oxygen catheter, each	Each
A7025	High Frequency chest wall oscillation system vest, replacement for with patient owned equipment, each	Each
A7026	High Frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each	Each
A7044	Oral interface used with positive airway pressure device, each	Each
E0430	Portable Gaseous Oxygen System, purchase, Includes Regulator, flowmeter, humidifier, cannula or mask, and tubing	Each

E0433 RR	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and gauge	Day
E0435	Portable liquid oxygen system, purchase, includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter	Each
E0441	Stationary oxygen contents, gaseous, 1 month supply = 1 unit	1 Unit
E0444	Portable oxygen contents, liquid, one month's supply = 1 unit	1 Unit
E0445	Oximeter device for measuring blood oxygen levels, non-invasively	Each
E0445 RR	Oximeter device for measuring blood oxygen levels, non-invasively	Day
E0447	Portable oxygen contents, liquid, one month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm)	1 Unit
E0457	Chest shell (cuirass)	Each
E0457 RR	Chest shell (cuirass)	Day
E0460	Negative pressure ventilator, portable or stationary	Each
E0461 RR	Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface	Each
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	Each
E0465 RR	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	Day
E0466	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)	Each
E0466 RR	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)	Day
E0467	Home Ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions	Each
E0467	Home Ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions	Day

E0470	Respiratory Assist Device, bi-level pressure capability, w/out backup rate feature, used w/noninvasive interface e.g. nasal or facial mask.	Each
E0470 RR	Respiratory Assist Device, bi-level pressure capability, w/out backup rate feature, used w/noninvasive interface e.g. nasal or facial mask.	Day
E0471	Respiratory assist device, bi-level pressure capability, w/backup rate feature, used w/noninvasive interface, eg. Nasal or facial mask	Each
E0471 RR	Respiratory assist device, bi-level pressure capability, w/backup rate feature, used w/noninvasive interface, eg. Nasal or facial mask	Day
E0472	Respiratory Assist Device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g. tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	Each
E0472 RR	Respiratory Assist Device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g. tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	Day
E0480	Percussor, Electric Or Pneumatic, Home Model	Each
E0480 RR	Percussor, Electric Or Pneumatic, Home Model	Day
E0482	Cough stimulating device	Each
E0482 RR	Cough stimulating device	Day
E0483	High frequency chest wall oscillation system, includes all accessories and supplies, each	Each
E0483 RR	High frequency chest wall oscillation system, includes all accessories and supplies, each	Day
E0500	IPPB Machine, all types, w/built-in nebulization; manual or automatic valves; internal or external power source	Each
E0500 RR	IPPB Machine, all types, w/built-in nebulization; manual or automatic valves; internal or external power source	Day
E0565	Compressor, air power source for equipment which is not self contained or cylinder driven	Each
E0565 RR	Compressor, air power source for equipment which is not self contained or cylinder driven	Day
E0575	Nebulizer, Ultra-Sonic large volume	Each

E0575 RR	Nebulizer, Ultra-Sonic large volume	Day
E0601	Continuous Positive Airway Pressure (CPAP) Device	Each
E0601 RR	Continuous Positive Airway Pressure (CPAP) Device	Day
E0618	Apnea Monitor without recording feature	Each
E0619	Apnea Monitor with recording feature	Each
E1352	Oxygen accessory, flow regulator capable of positive inspiratory pressure	Each
E1353	Regulator	Each
E1355	Stand/Rack	Each
E1372	Immersion external heater for nebulizer	Each
E1372 RR	Immersion Heater For Nebulizer	Day
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot	Each
S8121	Oxygen contents, liquid, 1 unit equals 1 pound	Each
S8999	Resuscitation bag (for use by patient on artificial respiration during power failure or other catastrophic event)	Each
Diabetic supplies		
S5560	Insulin delivery device, reusable pen, 1.5 ml size	Each
S5561	Insulin delivery device, reusable pen, 3 ml size	Each
Enteral Nutrition		
B9002	Enteral Nutrition Infusion Pump, Any Type	Each
B9004	Parenteral nutrition unfusion pump, portable	Each
B9006	Parenteral nutrition unfusion pump, stationary	Each
E0791	Parenteral infusion pump, stationary, single or multichannel	Each
Blood pressure		
A4670	Automatic Blood Pressure Monitor	Each
Ostomy supplies		
A4387	Ostomy pouch, closed, with barrier attached, with built in convexity (one piece), each	Each

A5120	Skin Barrier Wipes or swabs, each	Each
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Home Health Services (DMAS Uses Revenue Codes-MCO's use CPT Codes)

Home Health Services-Waive SA for 60 days		
Revenue Code	Mod	Description
0550		Skilled Nursing Assessment
0551		Skilled Nursing Care, Follow-Up Care
0559		Skilled Nursing Care, Comprehensive Visit
0571		Home Health Aide Visit
0424		Physical Therapy, Home Health Assessment
0421		Physical Therapy, Home Health Follow-UP Visit
0434		Occupational Therapy, Home Health Assessment
0431		Occupational Therapy, Home Health Follow-Up Visit
0444		Speech-Language Services, Home Health Assessment
0441		Speech Language Services, Home Health Follow-Up Visit
0542		Non-Emergency Transportation, Per Mile